		ID HUMAN SERVICES MEDICAID SERVICES				MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	
		495394	B. WING		11/	/03/2022
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF BON AIR			01 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	survey was conducte November 3, 2022. C compliance with the f Federal Long Term C Seven complaints we survey; VA00052905 deficiency), VA00054 deficiency), VA00053	re investigated during the				
F 550	VA00053513 (unsubs (unsubstantiated). The census in this 12 104 at the time of the consisted of 42 curre closed record review.		F 550			10/40/22
F 550 SS=D	CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, in this section.	(2)(b)(1)(2)	F 550			12/18/22
	with respect and dign resident in a manner promotes maintenance	ity and care for each and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					12/06/2022

Electronically Signed

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/19/2023

IUMAN SERVICES				FORM	01/19/2023 APPROVED 0938-0391
	· · /			(X3) DATE COMPI	SURVEY
495394	B. WING		-	11/0	03/2022
	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	9'	101 BON AIR CROSSINGS	DRIVE		
	В	ON AIR, VA 23235			
ST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE		(X5) COMPLETION DATE
yardless of diagnosis, ayment source. A facility ain identical policies and fer, discharge, and the er the State plan for all ayment source. ights. t to exercise his or her e facility and as a citizen States. must ensure that the or her rights without scrimination, or reprisal nt has the right to be cion, discrimination, and n exercising his or her d by the facility in the tts as required under this not met as evidenced esident interview, staff ord review, it was aff failed to promote e of 52 residents in the #26 (R26), #217(R217)	F 550	covered and remov Resident # 309 Rec medicine and had r Resident #26 did re others after identifie Criteria 2 All residents with ca potential to be affect deficient practice. A	ed from the floor. ceived her pain elief after identified. ceive her meals with ad alleged deficiency atheters have the cted with the same all residents on pain	/.	
	DICAID SERVICES) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DICAID SERVICES) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	DICAID SERVICES) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 495394 B. WING 495394 B. WING STREET ADDRESS, CITY, Str 9101 BON AIR CROSSINGS BON AIR, VA 23235 BENT OF DEFICIENCIES ISTE DE PRECOED BY FULL DENTIFYING INFORMATION) ID PREFIX TAG PROVIDENS (EACH CORREC CROSS-REFEREN DENTIFYING INFORMATION) r must provide equal gardless of diagnosis, hayment source. A facility ain identical policies and fer, discharge, and the er the State plan for all ayment source. F 550 r must ensure that the or her rights without scrimination, or reprisal F 550 r must ensure that the or her rights without scrimination, or reprisal Criteria 1 Resident # 217 fole covered and remov Resident interview, staff ord review, it was aff failed to promote e of 52 residents in the #26 (R26), #217(R217) Criteria 2 All resident swith ca potential to be affect deficient practice. A	DICAID SERVICES) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: 495394 B WING STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235 IENT OF DEFICIENCIES IENT OF DEFICIENCIES IFS THE FRECENDED BY FULL DENTIFYING INFORMATION) PREFIX TAG PREFIX Rest of diagnosis, agyment source. lights. to extercise his or her of facility and as a citizen States. runust ensure that the or her rights without scrimination, or reprisal not met as evidenced esident interview, it was aff failed to promote a of 52 residents in the #26 (R26), #217(R217) staff failed to serve their s another resident seated	DICAID SERVICES ONE NO DICAID SERVICES ONE NO IDENTIFICATION NUMBER: A BUILDING (x2) MULTIPLE CONSTRUCTION (x3) DATE 495394 B. WING

Event ID: 33UH11

Facility ID: VA0394

If continuation sheet Page 2 of 196

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 550 Continued From page 2 F 550 (R26) was admitted to the facility with diagnoses to be affected by the alleged deficient that included but were not limited to: quadriplegia practice. All residents have the potential to be affected by alleged deficient practice (1). during meal times. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment Criteria 3 reference date) of 09/22/2022, the resident Licensed nurses and C.N.As were scored 15 out of 15 on the BIMS (brief interview re-educated on the covering and for mental status), indicating the resident is placement of foley catheters. Staff were cognitively intact for making daily decisions. educated on residents being served Section G "Activities of Daily Living (ADL) meals at the same time. Licensed Nurses Assessment" coded (R26) as requiring extensive were re-educated on the pain assistance of one staff member for eating. Management Program. On 10/31/2022, an observation of lunch meal Criteria 4 being served in the second floor resident dining The DON/Designee will audit foley room, revealed (R26) received their meal catheters three times a week for one approximately five minutes after another resident month. Then weekly for one month and seated at the same table was served and eating monthly times one month. Pain their meal. management will be audited 3x weekly for one-month, weekly x one month, then On 10/31/2022 at approximately 1:45 p.m., an monthly x1 month. Audits of dining will be interview was conducted with CNA (certified conducted 3 x week for one month and nursing assistant) #1. When informed of the then weekly for one month and monthly x observation regarding (R26) having to wait for one month. These results will be their meal while another resident sitting at the forwarded to the QAPI committee for review. The committee will determine the same table had been served and was eating their meal, CNA #1 stated that it was not proper. need for further audits and/or action. When asked if it was dignified for a resident to wait for their meal while another resident was sitting at the same table had been served and was eating their meal, CNA #1 stated no. On 11/01/2022 at approximately 11:10 a.m., an interview was conducted with (R26). When asked how they felt about waiting for their meal during lunch the day before, (on 10/31/2022) while another resident sitting at the same table had been served and was eating their meal,

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0394

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PRINTED: 01/19/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION		(X3) DATE	
		495394	B. WING				11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				I01 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	 (R26) stated, "I don't lit." When asked if the (R26) stated no. On 11/02/2022 at app (administrative staff m ASM # 2, director of r regional clinical coord the above findings. No further information References: (1) The loss of muscle body. Paralysis of the including both legs, is of the arms and legs i information was obtai https://medlineplus.go 2. For (R217), the fac privacy bag or cover f urine collection bag. (R217) was admitted diagnoses that include neuromuscular dysfur The admission MDS (due at the time of the The facility's "Nursing Evaluation" for (R217 documented in part, " person; Genitourinary urinary organs). Appl Catheter." 	like it but I have to deal with ey thought it was dignified broximately 5:00 p.m., ASM nember) # 1, administrator, nursing and ASM # 4, dinator were made aware of n was provided prior to exit. e function in part of your e lower half of your body, s called paraplegia. Paralysis is quadriplegia. This ined from the website: bv/paralysis.html. cility staff failed to provide for an indwelling catheter I to the facility with led but were not limited to: nction of the bladder (1). (minimum data set) was not e survey. g Comprehensive f) dated 10/21/2022 'Neurological. Oriented To: y (relating to the genital and	F 5	50				

Facility ID: VA0394

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	-	D HUMAN SERVICES				FORM	: 01/19/2023 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUR	ELS OF BON AIR			01 BON AIR CROSSING	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI		(X5) COMPLETION DATE
					DEFICIENCY)		
F 550	catheter collection bay could be seen. Furthe evidence a privacy co catheter collection bay On 10/31/22 at 4:28 p (R217's) room from th catheter collection bay seen. Further observe privacy cover or privat collection bag. On 11/01/2022 at 8:2 (R217's) room from th catheter collection bay could be seen. Furthe evidence a privacy co catheter collection bay Con 11/01/22 at 12:12 conducted with LPN (at the nurse's station. contents of a catheter visible to others LPN s should be placed in a LPN # 1 was then ask When asked if they co catheter collection bay stated yes. The facility's policy "G Personal Privacy" doo Maintain guest/reside	 and the urine contents and the urine contents and the urine contents and the urine contents by er or privacy bag to the g. by an observation of the hallway revealed the g and the contents could be ation failed to evidence a cy bag to the catheter a.m., an observation of the hallway revealed the g and the urine contents er observation failed to evidence a cy bag to the catheter a.m., an observation of the hallway revealed the g and the urine contents er observation failed to evidence a cy bag to the catheter p.m., an interview was licensed practical nurse) #1 When asked if the trollection bag should be #1 stated, "No and that it privacy bag for discretion." and the contents LPN # 1 Guest/resident Dignity & 	F 550		DEFICIENCY)		
		roximately 5:00 p.m., ASM nember) # 1, administrator, nursing and ASM # 4,					

Facility ID: VA0394

If continuation sheet Page 5 of 196

		ID HUMAN SERVICES				FORM): 01/19/2023 I APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	_	(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
				9101 BON AIR CROSSING	GS DRIVE		
THE LAUF	RELS OF BON AIR			BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	5	F 55	50			
		linator were made aware of					
	No further information	n was provided prior to exit.					
	control due to a brain condition. This inform the website: https://medlineplus.go	nation was obtained from ov/ency/article/000754.htm.					
	failed to administer m	(R309), the facility staff edications in a timely o the resident's ringing the					
	The admission MDS (been completed at the review of the Nursing	o the facility on 10/22/22. (minimum data set) had not e time of survey entrance. A Comprehensive Evaluation led R309 was oriented to ne.					
	chair beside their bed the call bell. At 2:14 p assistant) #9 entered the call bell. CNA #9 a needed. R309 told CN medication for their le nurse will be here in a the nurse station whe nurse) #11 was sitting that R309 had rung th medication. LPN #11 "Okay," and continued talking with another si	b.m., R309 was sitting in a l. At 2:11 p.m., R309 rang b.m., CNA (certified nursing R309's room and turned off asked R309 what they NA #9 they needed pain eg. CNA #9 stated: "The a minute." CNA #9 went to re LPN (licensed practical g. CNA #9 informed LPN #11 ne bell, and needed pain nodded her head, said, d to sit at the nurse station, taff member. LPN #11 was mputer. LPN #11 continued					

Facility ID: VA0394

If continuation sheet Page 6 of 196

	-	D HUMAN SERVICES				FORM): 01/19/2023 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S ⁻	TREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
			91	101 BON AIR CROSSING	S DRIVE		
THE LAUP	RELS OF BON AIR		В	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	to sit at the nurse stat members until 2:29 p. stood up and went are medication cart. LPN and removing expired medication cart. At 2:3 interviewed. She state say anything about [R administered pain me p.m. She stated: "[R3 [their] leg. I ended up A review of R309's cli following order, dated (milligrams) [every six pain." On 10/31/22 at 2:41 p she was certain LPN informed her about R3 medication. She stated me." On 10/31/22 at 2:52 p She stated: "That's wi me they are coming in don't come for a long like the staff members her, and that the staff her. She stated: "I fee On 11/2/22 at 1:13 p.t She stated if a resided responds as soon as resident needs the nut the nurse assigned to don't make any promi	tion, talking to other staff .m. At 2:29 p.m., LPN #11 bund the desk to a #11 began opening drawers medications from the 33 p.m., LPN was ed: "I did not hear the CNA (309]. I'll go check." LPN #11 dication to R309 at 2:42 09] wanted me to look at giving two Tylenol." nical record revealed the 10/22/22: "Tylenol 650 mg c hours] po (by mouth) for	F 550				

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	-	D HUMAN SERVICES MEDICAID SERVICES			F	NTED: 01/19/2023 FORM APPROVED B NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495394	B. WING			11/03/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP	CODE	
THE LAUR	ELS OF BON AIR		-	101 BON AIR CROSSINGS DRIVE		
				ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 550	Continued From page	7	F 550			
		be upset if someone told				
		e there right away, and then g while. She stated this is				
		with dignity or respect for				
	She stated if a CNA in	n., LPN #3 was interviewed. Iformed her of a resident's o the resident right away. If				
		right away, she would ask				
	-	resident that the nurse was				
		d would see the resident as stated to do anything else				
		ul of the resident's needs.				
		n., ASM (administrative				
		administrator, ASM #2, the				
	clinical coordinator, w concerns.	d ASM #4, the regional ere informed of these				
	No further information	was provided prior to exit.				
		odations Needs/Preferences	F 558			12/18/22
SS=D	CFR(s): 483.10(e)(3)					
		ht to reside and receive				
	services in the facility accommodation of res					
	preferences except w					
	endanger the health c other residents.	or safety of the resident or				
		is not met as evidenced				
	by:					
		n, staff interview, facility as determined the facility		Criteria 1 Resident # 79 and #15 ca	all bells were	
		Ils within reach for two of 52		clipped to the beds by ma		
		y sample, Resident #79 and		director.		
	Resident #15.					

Event ID: 33UH11

Facility ID: VA0394

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 558 Continued From page 8 F 558 Criteria 2 The findings include: All guests that reside in the facility have the potential to be affected by alleged 1. For Resident #79 (R79), the facility staff failed deficient practice. An audit was conducted to ensure the call bell was within the resident's as a base line and all call bells were within reach: it was observed on the floor. reach. \On the most recent MDS (minimum data set) Criteria 3 assessment, an annual assessment, with an Staff were educated on call bell assessment reference date of 9/15/2022, the placement and assuring call bells are resident scored a 10 of out 15 on the BIMS (brief always in reach. interview for mental status) score, indicating the resident is moderately cognitively impaired for Criteria 4 making daily decisions. Call bell audits will be conducted 3 x a week for four weeks, then weekly x 1 Observation was made on 10/31/2022 at month and monthly for one month. approximately 12:30 p.m. of R79's room. R79 These results will be forwarded to the QAPI committee for review. The was in bed, asleep, the call bell was on the floor, out of the reach of the resident. committee will determine the need for further audits and/or action. On 11/1/2022 at 8:52 a.m. the resident was observed in his room, in his wheelchair, the call bell was on the floor, out of the reach of the resident. The comprehensive care plan dated, 6/28/2022, documented in part, "Need: [R79] is at risk for fall related injury and falls, R/T (related to) impaired mobility, H/O (history of) falls." The "Interventions" documented in part, "Put the resident's call light within reach and encourage him/her to sue it for assistance as needed." An interview was conducted with CNA (certified nursing assistant) #3, on 11/2/2022 at 10:03 a.m. When asked where are call bells supposed to be, CNA #3 stated, within the reach of the patient. When asked if the call bells should be on the floor, CNA #3 stated, "No, that isn't within reach."

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PRINTED: 01/19/2023

		D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUR	RELS OF BON AIR			-	101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page	9	F	558				
	practical nurse) #1, or When asked where an LPN #1 stated within #1 stated, no. The facility policy, "Ca part, "Policy - Call ligh guest's/resident's read manner3. When a g confined to a chair be easy reach of the gue ASM (administrative s administrator, ASM #2 and ASM #4, the regio were made aware of the 11/2/2022 at 5:14 p.m. No further information 2. For Resident #15 (to to keep the call bell w (R15) was admitted to that included by not lin and osteoarthritis (1) On the most recent M significant change ass (assessment reference resident scored 15 out interview for mental s cognitively intact for m	 ataff member) #1, the 2, the director of nursing, onal clinical coordinator, the above concern on the above concern on the above concern on the second prior to exit. a was provided prior to exit. a was provided prior to exit. a the facility staff failed ithin their reach. b the facility with a diagnosis mited to: muscle weakness DS (minimum data set), a sessment with an ARD to face the face of 10/15/2022, the to f 15 on the BIMS (brief tatus), indicating (R15) was haking daily decisions. 						
) a.m., an observation of led it was attached to the						

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUR	RELS OF BON AIR			101 BON AIR CROSSING 30N AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORRE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 558	side of the mattress of the bed approximately corner of the mattress 11/01/2022 at 9:30 a.1 (R15's) call bell revea side of the mattress of the bed approximately corner of the mattress and activate their call attempting to reach for unable to locate and g The comprehensive of 05/18/2022 document has hip fracture r/t (re 05/18/2022." Under " documented in part, ", needs. Be sure call li respond promptly to a Date Initiated: 05/18/2 On 11/03/22 at 8:14 a conducted with LPN (When informed of the stated that they were (R15) did not have the where the call bell wa that the call bell shoul within (R15's) reach. On 11/03/2022 at app (administrative staff m	n the resident's right side of y six to eight inches from the s. m., an observation of led it was attached to the in the resident's right side of y six to eight inches from the s. When asked to locate bell, (R15) was observed r the call bell but was grasp it. are plan for (R15) dated red in part, "Need. (R15) lated to) fall. Date Initiated: Interventions" it Anticipate and meets ght is within reach and Il requests for assistance. 2022." .m., an interview was licensed practical nurse) #4. above observation LPN # 4 familiar with (R15) and that e range of motion to reach s located and further stated d have been positioned roximately 4:02 p.m., ASM tember) # 1, administrator,	F 558				
	the above findings.	was provided prior to exit.					

Facility ID: VA0394

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558 F 578 SS=D	References: (1) The most commor pain, swelling, and red It can occur in any join hands, knees, hips or was obtained from the https://medlineplus.go Request/Refuse/Dscr CFR(s): 483.10(c)(6) §483.10(c)(6) The right discontinue treatment to participate in exper formulate an advance §483.10(c)(8) Nothing construed as the right the provision of medic services deemed medi- inappropriate. §483.10(g)(12) The far requirements specifie subpart I (Advance Di (i) These requirement inform and provide wr residents concerning medical or surgical tre- resident's option, form (ii) This includes a wrif facility's policies to im and applicable State I (iii) Facilities are perm entities to furnish this legally responsible for requirements of this s	a form of arthritis. It causes duced motion in your joints. ht, but usually it affects your spine. This information e website: w/osteoarthritis.html. thue Trmnt;FormIte Adv Dir 8)(g)(12)(i)-(v) ht to request, refuse, and/or , to participate in or refuse imental research, and to directive. In this paragraph should be to f the resident to receive cal treatment or medical dically unnecessary or hcility must comply with the d in 42 CFR part 489, rectives). s include provisions to itten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. then description of the plement advance directives aw. hitted to contract with other information but are still rensuring that the ection are met. ial is incapacitated at the	F 558				12/18/22

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER		- 1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				91	101 BON AIR CROSSINGS DRIVE		
THE LAUF	RELS OF BON AIR			В	ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	has executed an adva may give advance dir individual's resident re- with State law. (v) The facility is not r provide this information or she is able to recein Follow-up procedures the information to the appropriate time. This REQUIREMENT by: Based on clinical rec- and facility document that the facility staff fa- information of an adva residents in the surver (R96). The finding include: For (R96), the facility advance directive or of information regarding On the most recent M admission assessment reference date) of 10/ out of 15 on the BIMS status), indicating the intact for making daily Review of the facility's Minutes" dated 10/25 evidence of having of or documentation of p	te whether or not he or she ance directive, the facility ective information to the epresentative in accordance elieved of its obligation to on to the individual once he ve such information. must be in place to provide individual directly at the is not met as evidenced ord review, staff interview review, it was determined illed to obtain or offer ance directive for one of 52 y sample, Resident #96 staff failed to evidence an documentation of providing an advance directive. DS (minimum data set), an th with an ARD (assessment 05/2022, (R96) scored 14 is (brief interview for mental resident was cognitively decisions. s "Care Conference /2022 for (R96) failed to otain and advance directive providing information	F	578	Criteria 1 Resident #96 has been discharged from the facility. Criteria 2 All residents have the potential to be affected by this practice. The Director Social Services, or designee will comp an audit of all residents to ensure that education was provided on advance directives, and that a copy of the education and/or the advance directive included in the medical record. Criteria 3 The corporate Director of Social Service or designee will provide education to th Admissions and Social Services staff or required education of residents on Advance Directives and proper documentation in the medical record. Criteria 4 An audit will be completed on all new	of lete e is ses, ne	
	•	providing information			An audit will be completed on all new admissions 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly fo	or 1	

Facility ID: VA0394

If continuation sheet Page 13 of 196

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		495394	B. WING		11/03/2022
NAME OF PI	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE LAUF	RELS OF BON AIR		2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 578	Continued From page	e 13	F 578		
	dated "September 20	order sheet) for (R96) 22" documented in part, "Do R). Order Date: 12/06/20."		month. Corrections will be made a needed.	IS
	On 11/02/22 at appro interview was conduct member) #2, director asked to describe the advance directive OS admission they (social the resident's advance have one, the resider party are asked and / how to develop an ad asked where that info OSM #2 stated that it conference minutes. conference minutes. conference minutes for the form was initiated worker and that they and obtain all the info speak with the social they were on leave an On 11/03/2022 at app (administrative staff in ASM #2, director of in	ximately 3:40 p.m., an eted with OSM (other staff of social services. When a process for a resident's M #2 stated that upon al services) obtains a copy of the directive and if they do not at and /or the responsible for offered information on lvance directive. When for mation is documented is documented on the care After reviewing the care or (R96) OSM #2 stated that by the facility's other social had not completed the form formation. When asked to worker, OSM #2 stated that nd could not be reached.		Continued compliance will be mor through routine audits and reporte facility's quality assurance progran Additional education and monitorin be initiated for any identified conce	ed to the m. ng will
F 580 SS=E	above findings. No further informatior	ere made aware of the n was provided prior to exit. jury/Decline/Room, etc.) !)(i)-(iv)(15)	F 580		12/18/22
	§483.10(g)(14) Notific (i) A facility must imm	cation of Changes. ediately inform the resident; ent's physician; and notify,			

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING 30N AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	results in injury and he physician intervention (B) A significant change mental, or psychosoc deterioration in health status in either life-thr clinical complications) (C) A need to alter tree a need to discontinue treatment due to advec commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section. (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite dis	n there is- ing the resident which as the potential for requiring ; ge in the resident's physical, al status (that is, a , mental, or psychosocial eatening conditions or ; atment significantly (that is, an existing form of erse consequences, or to n of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lso promptly notify the ent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and	F 580				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 580 Continued From page 15 F 580 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced bv: Based on clinical record review, staff interview Criteria 1 and facility document review, and it was Resident #2 was discharged on determined that the facility staff failed to notify the 11/4/2022. The were no ill effects noted physician that a resident's medications were not from his missed doses of antibiotics. administered for one of 52 residents in the survey sample, Resident #2 (R2). Criteria 2 All residents on antibiotics are at risk for The findings include: the alleged deficient practice. For (R2), the facility staff failed to notify the Criteria 3 physician that the physician ordered antibiotic, Nurses were re-educated on notification ceftriaxone [1] was not administered on of MD when medications are not 10/27/2022, 10/28/2022, 10/31/2022, 11/01/2022 administered. and on 11/02/2022 and vancomycin [2] was not administered on 10/18/2022. 10/19/2022 and Criteria 4 10/28/2022. Audits will be conducted for medications not given and MD notification 3 x weeks On the most recent MDS (minimum data set), an for four weeks, then weekly for 1 month admission assessment with an ARD (assessment and monthly x 1. These results will be forwarded to the QAPI committee for reference date) of 09/20/2022, the resident scored 9 (nine) out of 15 on the BIMS (brief review. The committee will determine the interview for mental status), indicating (R2) was need for further audits and/or action moderately impaired of cognition for making daily decisions. The physician's orders for (R2) documented in part. "Ceftriaxone Sodium Solution Reconstituted 1 (one GM (gram). Inject 1 gram intramuscularly every 12 hours for infection for 5 (five) days. Start Date: 10/27/2022. D/C (discontinue) Date: 10/27/2022."

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/19/2023

	-	D HUMAN SERVICES				FORM	01/19/2023
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING	S DRIVE		
				30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	(one GM (gram). Inje every 12 hours for infe Start Date: 10/28/202 "Vancomycin HCL (hy MG/ML (milligram/mill every 6 (six) hours for Date: 10/15/2022." The comprehensive c 10/27/2022 document risk for discomfort for receives Antibiotic The infection CDiff. Vanco Ceftriaxone until 11/2/ 10/18/2022. The eMAR [electronic record] dated October the physician's orders ceftriaxone, the eMAF documented on 10/27 on 10/28/2022 at 9:00 documented on 10/31 vancomycin, the eMA documented on 10/18 five documented on 1 at 6:00 p.m., and a bla p.m. Further review c legend that document Follow Up Codes: 5=F The eMAR dated Nov to evidence document order for Ceftriaxone. eMAR failed to evider Ceftriaxone on 11/01/	Solution Reconstituted 1 ct 1 gram intramuscularly ection for 5 (five) days. 2." drochloride) Solution 50 liliter). Give 5 ml by mouth c c-diff (3) for 14 days. Start are plan for (R2) dated ted in part, "Need. (R2) is at adverse side effects: erapy r/t (related to) for mycin 10/27/2022, /22. Date initiated: medication administration r 2022 for (R2) documented as stated above. For R revealed a number five //2022 at 9:00 p.m., a blank 0 a.m. and an "X" /2022 at 9:00 p.m., number 0/19/2022 at 12:00 p.m. and ank on 10/28/2022 at 12:00 of the eMAR revealed a ted in part, "Chart Codes / Hold/See Nurse's Notes."	F 580				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
	ELS OF BON AIR		9	101 BON AIR CROSSING	S DRIVE		
	CELS OF DON AIR		E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	held on 10/27/22 at 9: vancomycin being hel p.m., 10/19/2022 at 12 Further review of the p evidence documentat ceftriaxone on 10/28/2 "X" on 10/31/2022 at 12:00 p Further review of the p evidence documentat for the medications no dates listed above. The nurse's "Progress documentation for cef administered or the pl On 11/03/22 at 9:55 a conducted with ASM (member) #2, director (R2's) October eMAR above ASM #2 stated medications listed above physician's orders. W coded with a number dates coded as a five that there was no doc medication was held t ASM #2 further stated and failed to evidence physician was notified medications on the data On 11/03/2022 at app	ion for ceftriaxone being 00 p.m. or for the d on 10/18/2022 at 6:00 2:00 p.m. and at 6:00 p.m. orogress notes failed to ion regarding the blanks for 2022 at 9:00 a.m. and the 2:00 p.m. and the blank on 0.m. for vancomycin. orogress notes failed to ion of physician notification of being administer on the a Notes" failed to evidence triaxone not being hysician being notified. , an interview was fadministrative staff of nursing. After reviewing , and progress notes dated that (R2) did not receive the ove according to the then asked about the dates five ASM #2 stated that the refer to NN, DON stated umentation why the herefore nurse's notes. I that the nurse's notes umentation as to why the d on the dated notes above e documentation that the of (R2) not receiving their thes listed above. roximately 3:20 p.m., an	F 580				
	On 11/03/2022 at app interview was conduct	ites listed above.					

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	-	ID HUMAN SERVICES					FORM): 01/19/2023 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUR	RELS OF BON AIR				101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	procedure a nurse foll not administered to a the physician is notifie not administered. Afte progress notes for (R2 Ceftriaxone on 10/27/ 10/31/2022, and in re- 10/18/2022, 10/19/202 #4 stated that there w the physician was not not administered on 1 10/31/2022 and Vance administered on 10/18 10/28/2022. On 11/03/2022 at app (administrative staff m ASM # 2, director of m regional clinical coord the above findings. No further information References: (1) Used to treat certa bacteria such as gond transmitted disease), (infection of the femal may cause infertility), membranes that surro cord), and infections o urinary tract, blood, bo This information was o https://medlineplus.go tml.	lows when a medication is resident LPN #4 stated that ed why the medication was er reviewing the nursing 2) dated in regard to /2022, 10/28/2022, gard to Vancomycin on 22 and on 10/28/2022, LPN /as no documentation that tified that Ceftriaxone was 10/27/2022, 10/28/2022 and comycin was not 8/2022, 10/19/2022 and on proximately 4:02 p.m., ASM member) # 1, administrator, nursing and ASM # 4, linator were made aware of n was provided prior to exit.	F	580				

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M						FORM): 01/19/2023 MAPPROVED). 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONST			(X3) DATE	
	495394	B. WING _			_	11/	03/2022
NAME OF PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, ST	TATE, ZIP CODE	•	
THE LAURELS OF BON AIR				N AIR CROSSINGS R, VA 23235	S DRIVE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
 was obtained from the https://medlineplus.gov.tml. (3) A bacterium that caserious intestinal condit Symptoms include wat bowel movements perfever, loss of appetite, tenderness. This inform the website: https://medlineplus.gov.s.html. F 622 F 622 F 622 F 622 SS=D CFR(s): 483.15(c)(1)(i) §483.15(c) Transfer and S483.15(c)(1) Facility rust perfemain in the facility, and discharge the resident (A) The transfer or discoresident's welfare and cannot be met in the facility sufficiently so the resident's sufficiently so the resident's sufficiently so the resident; (D) The health of indiviendangered due to the status of the resident facility in the resident; (D) The resident has facility appropriate notice, to provide a perfective status of the resident; 	eatment. This information website: //druginfo/meds/a604038.h uses diarrhea and more itions such as colitis. rery diarrhea (at least three day for two or more days), nausea, abdominal pain or mation was obtained from //clostridiumdifficileinfection e Requirements (ii)(2)(i)-(iii) nd discharge- equirements- mit each resident to nd not transfer or from the facility unless- charge is necessary for the the resident's needs acility; charge is appropriate health has improved lent no longer needs the ne facility; duals in the facility is a clinical or behavioral iduals in the facility would red; ailed, after reasonable and bay for (or to have paid dicaid) a stay at the facility.	F 5					12/18/22

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		E CONSTRUCTION		(X3) DATE	
		495394	B. WING				11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP COD)E	-	
				9	101 BON AIR CROSSINGS DRIVE			
THE LAUF	RELS OF BON AIR			E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 622	submit the necessary payment or after the t Medicare or Medicaid resident refuses to par resident who become admission to a facility resident only allowabl or (F) The facility ceases (ii) The facility may no resident while the app § 431.230 of this char exercises his or her ri- discharge notice from 431.220(a)(3) of this of discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docume When the facility trans- resident under any of in paragraphs (c)(1)(i) section, the facility m or discharge is docum- medical record and ap- communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the t (i) of this section. (B) In the case of para- section, the specific re- be met, facility attemp	paperwork for third party hird party, including l, denies the claim and the ay for his or her stay. For a s eligible for Medicaid after t, the facility may charge a le charges under Medicaid; s to operate. of transfer or discharge the beal is pending, pursuant to oter, when a resident ght to appeal a transfer or the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the ust document the danger or discharge would pose. entation. sfers or discharges a the circumstances specified 0(A) through (F) of this ust ensure that the transfer nented in the resident's ppropriate information is receiving health care the resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot ots to meet the resident e available at the receiving	F	622				

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		D HUMAN SERVICES			FORM	D: 01/19/2023
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION G	(X3) DATE	D. 0938-0391 SURVEY PLETED
		495394	B. WING		11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				9101 BON AIR CROSSINGS DRIVE		
THE LAUR	RELS OF BON AIR			BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	(2)(i) of this section m (A) The resident's phy	n required by paragraph (c) ust be made by- ⁄sician when transfer or	F 6	22		
	discharge is necessar (A) or (B) of this section (B) A physician when necessary under para- this section. (iii) Information provided must include a minimum (A) Contact information responsible for the car (B) Resident represent contact information (C) Advance Directive (D) All special instruct ongoing care, as appr (E) Comprehensive car (F) All other necessar copy of the resident's consistent with §483.2 any other documentat a safe and effective tr This REQUIREMENT by: Based on staff intervi	y under paragraph (c) (1) on; and transfer or discharge is graph (c)(1)(i)(C) or (D) of ed to the receiving provider um of the following: on of the practitioner re of the resident. tative information including e information tions or precautions for opriate. are plan goals; ry information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ansition of care. is not met as evidenced ew, clinical record review		Criteria 1		
	and facility document the facility staff failed required information w	review, it was determined to provide evidence that all vas provided to the hospital residents in the survey red to the hospital;		Residents identified were all disc from the facility. Criteria 2 All current residents have the po		
	The findings include:			be affected by the alleged deficient practice upon discharge to the he	ent	
	required resident infor at the time of discharg	led to evidence provision of mation to a receiving facility ge for Resident #95. nsferred to the hospital on		Criteria 3 Licensed Nurses will be reeduca the policy for hospital discharges required forms that need to be se	and the	

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES			F	ITED: 01/19/2023 ORM APPROVED NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) [DATE SURVEY
		495394	B. WING			11/03/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
				9101 BON AIR CROSSINGS DRIVE		
	RELS OF BON AIR			BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	9/22/22. Resident #95 was adr 8/19/22 with diagnosis limited to: anemia, hyp The most recent MDS assessment, a 5-day an ARD (assessment coded the resident as the BIMS (brief intervi indicating the resident	nitted to the facility on s that included but were not pertension, and malnutrition. 6 (minimum data set) Medicare assessment, with reference date) of 10/10/22, scoring a 12 out of 15 on ew for mental status) score, t was moderately cognitively	F 62	2 hospital. Criteria 4 The DON or designee will of hospital discharges thre for four weeks, weekly for monthly for one month. Th be forwarded to the QAPI review. The committee will need for further audits and	ee times a week one month and nese results will committee for I determine the	
	totally dependent for the dressing, bathing and assistance for eating. A review of the comprevision date of 9/7/22 Resident is at risk for dehydration risk relate protein malnutrition, a Provide supplements	ded the resident as being bed mobility, transfer, hygiene; extensive ehensive care plan with a 2, revealed, "FOCUS: nutritional and/or ed to: wounds, severe nemia. INTERVENTIONS: as ordered. Document				
	consumption. Provide substitutes as needed There was no evidend documents sent with to on 9/22/22. A request to the facility with the 11/3/22 at 10:00 AM. An interview was cond AM, with RN (register what documents are s hospital, RN #2 stated	e diet preferences and offer ce of hospital transfer the resident to the hospital for clinical documents sent resident was made on ducted on 11/3/22 at 11:15 ed nurse) #2. When asked sent with the resident to the				

Facility ID: VA0394

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	-					FORM): 01/19/2023 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	 on), vital signs and ca do you evidence what RN #2 stated, "It is do verbal report." On 11/3/22 at 1:00 PM member) #1, the adm have any of the requeres resident." On 11/3/22 at 3:30 PM administrator, ASM #3 ASM #4, the regional made aware of the find A review of the facilities policy, dated 9/20222 transfer form is compliand a copy of the card receiving hospital. Not transfer in the medical No further information 2. For (R15), the facil required documentation receiving facility for a 06/12/2022. (R15) was admitted to that included but were falling. On the most recent M significant change assistic (assessment reference resident scored 15 out interview for mental s 	Vassessment/recommendati are plan." When asked how t was sent to the hospital, boumented that I gave the M, ASM (administrative staff inistrator stated, "We do not ested information for this M, ASM #1, the 2, the director of nursing and clinical coordinator were adings. es "Transfer and Discharge" c, revealed the following: "A leted, a list of medications e plan goals is sent to the ursing documents the	F 622				

Facility ID: VA0394

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	2: 01/19/2023 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
			9	101 BON AIR CROSSING	S DRIVE		
THE LAUP	RELS OF BON AIR		E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page	24	F 622				
	09/23/2022 document Change in Condition/s Evaluation are/were: I Physical Assessment: on the resident/patien in condition were: Fur FallPrimary Care P Recommendations: S Review of the EHR (ef failed to evidence doc information provided to 09/23/2022 for (R15). On 11/03/22 at approx (administrator stated the evidence that the require provided to the hospit 09/23/2022. On 11/03/22 at approx interview was conduct practical nurse) #4. V procedure they follow transferred to a hospit complete a form entitl Form" that is sent to the resident's medication, plan and goals, bed he physician and/or the reviewing the electror LPN #4 stated that the E-Interact Transfer For	ximately 10:30 a.m., ASM nember) #1, the hat the facility did not have uired documentation was tal for (R15's) transfer on ximately 2:24 p.m., an ted with LPN (licensed When asked to describe the when a resident is tal LPN # 4 stated that they led "E-Interact Transfer he hospital and includes the , physician's orders, the care iold form, the name of the nurse practitioner, name of report was given to. After nic health record for (R15), ere was evidence of an orm for (R15's) transfer to '2022. After reviewing the					

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	-	(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	documentation of what the hospital for (R15). On 11/03/2022 at app (administrative staff m ASM #2, director of m clinical coordinator we above findings. No further information 3. For Resident #31 (to provide evidence th documents related to sent to the receiving fi transferred to the hos 9/16/22. On the most recent M quarterly assessment reference date) of 10/ having no cognitive in decisions, having sco BIMS (brief interview A review of R31's clin following progress no "8/24/22 6:47 a.m. "S room) nurse at [name [Resident] admitted w (congestive heart failu running some diagnos	tated that there was no at documents were sent to proximately 4:02 p.m., ASM nember) #1, administrator, ursing and ASM #4, regional ere made aware of the n was provided prior to exit. R31), the facility staff failed nat required clinical the continuity of care were facility when R31 was pital on 8/24/22 and IDS (minimum data set), a with an ARD (assessment (25/22, R31 was coded as npairment for making daily red 15 out of 15 on the for mental status). ical record revealed the tes: poke with ER (emergency e of local hospital], vith dx (diagnosis) of CHF ure) exacerbation, still stics at this time."	F 622		DEFICIENCY)		
	requested to go back difficulty breathing, ar	to the ER, stated he felt off,					

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		495394	B. WING			11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUR	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	reveal evidence of an	e 26 clinical record failed to y clinical documentation ty of care for R31 that was	F 62	2			
	8/24/22 and 9/16/22. On 11/2/22 at 11:50 a staff member) #1, the	acility for the transfers on .m., ASM (administrative administrator, stated the					
		uce evidence of the clinical sent to the hospital for R31 22.					
	nurse) #3 stated it is t send clinical documen continuity of care to th is being transferred. S bed hold notice, care face sheet, advance of laboratory test results documents which item facility in a progress m She stated if a resider present, the nurse use member the information hold policy.	the hospital when a resident She stated this includes a plan goals, medication list, directive, and recent a. She stated the nurse has were sent to the receiving note or on a transfer form. Int's family member is ually gives the family on about the facility's bed					
	-	m., ASM #1, ASM #2, the nd ASM #4, the regional ere informed of these					
F 623 SS=E		n was provided prior to exit. Before Transfer/Discharge (6)(8)	F 62	3			12/18/22

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	JLTIPLE CONSTRUCTION DING		(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RELS OF BON AIR			9	9101 BON AIR CROSSINGS DRIVE		
				E	BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	§483.15(c)(3) Notice I Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and manned facility must send a cor representative of the C Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the notif paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (C) The resident's hea allow a more immediat under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1)	before transfer. fers or discharges a nust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or lent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or hder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of widuals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F	623			

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/19/2023 APPROVED 0: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		495394	B. WING		_	11/0	03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S				
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING 30N AIR, VA 23235	'S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Continued From page days.	28	F 623					
	notice specified in par must include the follow (i) The reason for tran (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and add developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility address and tel agency responsible for advocacy of individua established under the for Mentally III Individua	nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how rm and assistance in ind submitting the appeal s (mailing and email) and the Office of the State budsman; / residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act.						

Facility ID: VA0394

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/19/2 FORM APPRO OMB NO. 0938-0	VED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
495394			B. WING		_	11/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				9101 BON AIR CROSSINGS	S DRIVE		
THE LAUF	RELS OF BON AIR			BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORREC CROSS-REFEREN	E PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 623	23 Continued From page 29 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as			523			
	by: Based on staff interv and facility document the facility staff failed RP (responsible party Ombudsman was not hospital for four out of sample; Residents # 9 The findings include: 1. The facility staff fa (responsible party) ar notification at the time #95. Resident #95 was ad 8/19/22 with diagnosi limited to: anemia, hy The resident was tran	is not met as evidenced iew, clinical record review review, it was determined to provide evidence that the and/or Long Term Care ified of a transfer to the f 52 residents in the survey 95, #15, #31 and #81.		the facility. Criteria 2 All current resident hospital have the p by the alleged defice Criteria 3 The corporate Dire provided education worker on ombuds notification upon he audit was complete and Ombudsman r discharges to hosp Criteria 4 The Administrator of	ctor of Social Service to the facility Social man and RP ospital discharge. An ed for November 202 eceived letters about ital.	d es 2 t	
	The resident was tran 9/22/22.	isterred to the hospital on			otification 3 times/we	ek	

Event ID: 33UH11

Facility ID: VA0394

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 623 Continued From page 30 F 623 A request for written RP or ombudsman monthly x 1 month. Notifications will be notification for the resident was made on 11/3/22 made as needed. Continued compliance at 10:00 AM. will be monitored through routine audits and reported to the facility's quality An interview was conducted on 11/3/22 at 11:15 assurance program. Additional education AM, with RN (registered nurse) #2. When asked and monitoring will be initiated for any what notification is provided when the resident is identified concerns. sent to the hospital, RN #2 stated, "Nursing calls the family. I do not know who informs the ombudsman." When asked how do you the RP has been informed, RN #2 stated, it is in the progress note that I called them. On 11/3/22 at 1:00 PM, ASM (administrative staff member) #1, the administrator stated, they did not have any of the requested information for this resident. On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. A review of the facilities "Transfer and Discharge" policy, dated 9/20222, revealed the following: "When a guest/resident is transferred on an emergency basis to an acute care facility, notice of the transfer is provided to the guest/resident and the guest/resident representative as soon as practicable. The Ombudsman is notified. A list of guest/residents can be sent to the ombudsman on a monthly basis." No further information was provided prior to exit. 2. For (R15), the facility staff failed to evidence written notification was provided to the ombudsman, (R15) and (R15's) responsible party for a facility-initiated transfer on 09/23/2022.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/19/2023

	-	D HUMAN SERVICES				FORM	: 01/19/2023 APPROVED . 0938-0391	
CENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		495394	B. WING		_	11/0	03/2022	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE			
THE LAURELS OF BON AIR				101 BON AIR CROSSING 30N AIR, VA 23235	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	(R81) was admitted to that included but were falling. On the most recent M significant change ass (assessment reference resident scored 15 out interview for mental st cognitively intact for m The facility's progress 09/23/2022 document Change in Condition/s Evaluation are/were: I Physical Assessment: on the resident/patien in condition were: Fur FallPrimary Care P Recommendations: S Review of the EHR (e (R15) failed to eviden transfer was provided and (R15's) represent transfer on 09/23/202 On 11/02/22 at 10:22 conducted with LPN (5. When asked if they to the resident and/or party when the reside hospital LPN # 5 state written notice of the tr they call the responsit On 11/2/2022 at appro-	b the facility with diagnoses e not limited to: a history of DS (minimum data set), a sessment with an ARD the date) of 10/15/2022, the t of 15 on the BIMS (brief tatus), indicating (R15) was haking daily decisions. The for (R15) dated ted in part, "Situation: The s (CIC) reported on this CIC Falls PainOutcome of t evaluation for this change notional Status Evaluation: rovider Fedback (sic): end resident to hospital."	F 623					

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	-	D HUMAN SERVICES				FORM	: 01/19/2023 APPROVED	
CENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		495394	B. WING		_	11/0	03/2022	
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
			9	101 BON AIR CROSSING	S DRIVE			
THE LAUP	RELS OF BON AIR		E	30N AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	asked to describe the documentation is com transferred to the hos a resident is dischargy role in written notificat the resident's respons they notify the Ombuc transfer to the hospita facility told them on the that they were suppos ombudsman for a resi further stated that this not doing. On 11/03/2022 at app (administrative staff m ASM # 2, director of m regional clinical coord the above findings. No further information 3. For Resident #31 (It to evidence written not (responsible party) an R31 was transferred t and 9/16/22. On the most recent M quarterly assessment reference date) of 10/ having no cognitive in decisions, having sco BIMS (brief interview A review of R31's clini following progress not	ir role and what ipleted when a resident is pital OSM # 2 stated that if ed to hospital they have no cion to the resident and/or sible party. When asked if dsman of a resident's il OSM # 2 stated that the is day (11/02/2022) today sed to send a notice to the ident transfer. OSM # 2 s was something they were roximately 4:02 p.m., ASM member) # 1, administrator, nursing and ASM # 4, inator were made aware of was provided prior to exit. R31), the facility staff failed trification to the resident/RP d to the ombudsman when o the hospital on 8/24/22 DS (minimum data set), a with an ARD (assessment 25/22, R31 was coded as inpairment for making daily red 15 out of 15 on the for mental status).	F 623					

Facility ID: VA0394

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	-	ID HUMAN SERVICES					FORM): 01/19/2023 MAPPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495394	B. WING			_	11/0	03/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, S	TATE, ZIP CODE			
THE LAURELS OF BON AIR					101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	room) nurse at [name [Resident] admitted w (congestive heart failur running some diagnost "9/16/22This mornin requested to go back difficulty breathing, ar non-emergency numb of local hospital]." Further review of the or reveal evidence that to ombudsman were not the hospital on 8/24/2 On 11/2/22 at 11:50 a staff member) #1, the facility could not produ- resident/RP and ombur R31's discharges to the 9/16/22. On 11/2/22 at 1:05 p.r member) #2, the social interviewed regarding time of a resident's dis stated she had not pro- role in providing writter resident/RP and ombur discharged to the hos just become aware of On 11/2/22 at 3:55 p.r director of nursing, an clinical coordinator, w concerns.	e of local hospital], vith dx (diagnosis) of CHR ure) exacerbation, still stics at this time." Ing at 9:45 a.m., resident to the ER, stated he felt off, ind painCalled ber and was taken to [name clinical record failed to the resident/RP and tified of R31's discharges to 22 and 9/16/22. I.m., ASM (administrative administrator, stated the uce evidence that the udsman were notified for he hospital on 8/24/22 and m., OSM (other staff al services director, was y written notifications at the scharge to the hospital. She eviously been aware of her en notification to the udsman when a resident is spital. She stated she had i this responsibility. m., ASM #1, ASM #2, the nd ASM #4, the regional	F 6	23					

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	-	D HUMAN SERVICES				FORM	01/19/2023	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		495394	B. WING		_	11/0	03/2022	
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
	RELS OF BON AIR		9	101 BON AIR CROSSING	S DRIVE			
	CELS OF BOIN AIR		E	BON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	4. For Resident #81 (to provide evidence th transfer was provided responsible party and facility-initiated transfer On the most recent M quarterly assessment reference date) of 9/2 being cognitively intact having scored 15 out interview for mental si A review of R81's clini following progress not a.m.) Note Text: resid worsening wound to th physician] called his for send the resedent [sid department) for eval ((nurse practitioner) [N emergency contact, e Further review of the or reveal evidence that w was provided to the re party and the long-ter transfer on 8/10/2022 On 11/02/2022 at app request was made via (administrator, for evid of transfer provided to responsible party and ombudsman for the fa 8/10/2022.	R81), the facility staff failed nat written notification of to the resident and/or the ombudsman for a er on 8/10/2022. DS (minimum data set), a with an ARD (assessment 7/2022, R81 was coded as of for making daily decisions, of 15 on the BIMS (brief tatus) assessment. ical record revealed the te: "8/10/2022 07:41 (7:41 ent presented with a he left foot [Name of bot doctor and stated to be] to the ed (emergency evaluation) and treat np lame of NP] and patient x wife aware." clinical record failed to vritten notification of transfer esident and/or responsible m care ombudsman for the roximately 8:00 a.m., a written list to ASM hember) #1, the ence of written notification o the resident and/or	F 623					

Facility ID: VA0394

If continuation sheet Page 35 of 196

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &					FORM	2: 01/19/2023 APPROVED 0: 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
	495394	B. WING		_	11/03/2022		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST				
THE LAURELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
 notification for the tr provided the progress which documented of responsible party. On 11/02/2022 at 10 conducted with LPN LPN #5 stated that the provide any written of resident or the responsible notify them that the hospital. On 11/2/2022 at 1:0 conducted with OSM director of social set they did not have ar notification of transfir responsible party with OSM #2 stated that the ombudsman of the that it was their responsible nursing and ASM #4 coordinator were informatic No further informatic Notice of Bed Hold II CFR(s): 483.15(d) Notice of 	vidence of ombudsman ansfer on 8/10/2022 and ss note documented above verbal notification of the 0:22 a.m., an interview was 1 (licensed practical nurse) #5. he nursing staff did not notification of transfer to the onsible party when they went 1 #5 stated that they spoke party over the telephone to resident was going to the 4 p.m., an interview was <i>A</i> (other staff member) #2, the vices. OSM #2 stated that ny role in providing a written er to the resident or nen they went to the hospital. they had not been notifying ransfers and were not aware bonsibility until 11/2/2022. oproximately 5:00 p.m., ASM r, ASM #2, the director of <i>k</i> , the regional clinical ormed of these concerns.	F 623				12/18/22	

Event ID: 33UH11

Facility ID: VA0394

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CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0938-0391 INTERLINCT FOR LOCARE & MEDICAD SERVICES (x3) MULTIFIC CONSTRUCTION (x4) MULTIFIC CONSTRUCTION (x5) MULTIFIC CONSTRUCTION (x5) MULTIFIC CONSTRUCTION (x5) MULTIFIC CONSTRUCTION (x5) MULTIFIC CONSTRUCTION (x6) M			D HUMAN SERVICES				FOR	D: 01/19/2023 M APPROVED
NMME OF PROVIDER OR SUPPLIER Introduces THE LAURELS OF BON AIR STREET ADDRESS, CITY, STATE, 2P COOL 910 BON AIR, CROSSNOS BOYE (2)(1) TAG BLIMMARY STREMENT OF DEFICIENCES INCOMENTS AND CONSECTOR PROVIDER REGULATORY ON USES (PECRED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Interview PROVIDERS AND CORRECTIVE ACTION STROUGH DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OVER TOW OWERTOW BOYER ACTIONS TROUGH WITH TAG Interview PROVIDERS AND CORRECTIVE ACTION STROUGH DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OVER TOW OWERTOW BOYER F 625 Continued From page 36 nursing facility transfers a resident to a hospital or the resident or resident representative that specifies. F 625 F 625 (1) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. F 625 (10) The reserve bed payment policy in the state plan, under § 447.40 of this sceton, regarding bed-hold policy. F 625 \$433.15(J(2) Bod-hold notice upon transfer. At the time of transfer of a resident for hospitalization or thereident in paragraph (e)(1) of this section. Criteria 1 \$433.15(J(2) Bod-hold notice upon transfer. At the film of transfer of a resident for hospitalization or thereiden the section by the section. This REOUREMENT is not met as evidenced by: Criteria 1 Based on staff interview, clinical record review and facility documer provide to for out of 52 residents in the survey sample that were transferred to the hospital; Residents # 95, #15, #31 and #31. Criteria 3 All current residents being dis	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,			(X3) DATE	SURVEY
NMME OF PROVIDER OR SUPPLIER STREET ADDRESS OT: STATE_P2 CODE THE LAURELS OF BOM AIR STREET ADDRESS OF: STATE_P2 CODE (PX)ID PREPIX SUMMARY STATEMENT OF DEFICIENCIES (EAN) DEFICIENCY MIST & PRECEDED & FULL RECOLLATORY OF LSC DENTIFYING INFORMATION) PROVIDERS FLAY CODE F625 Continued From page 38 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility transfers a resident due to the resident or resident representative that specifies. F 625 (0) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; F 625 (1) The information specified in paragraph (e)(1) of this section, resident to return; and (w) The information specified in paragraph (e)(1) of this section, \$483.15(d)(2) Chinel the resident and the resident to reture; and (w) The information specified in paragraph (e)(1) of this section. Criteria 1 there of transfers a determined the facility staff failed to provide evidence that bed hold notifications were provided to for oru of 52 residents in the survey sample that were transferred to the hospital, Residents # 95, #15, #31 and #81. Criteria 3			495394	B. WING _			11/	/03/2022
THE LAURELS OF BOM AIR BOM AIR, VA 23235 (PM)ID PREFIX TAS ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY ON LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX TAS PROVIDER'S FLAM OF CORRECTION (EACH DEPICIENCY) CMM Filter (EACH DEPICIENCY) F 625 Continued From page 36 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility transfers a resident to a hospital or the resident provide written information to the resident or resident representative that specifies. F 625 (i) The duration of the state bed-hold policy, if any, during which the resident is provide written information to return and resume residence in the nursing facility; F 625 (ii) The nursing facility must provide written information to return and resume residence in the nursing facility; F 625 (iii) The resume residence in the nursing facility; F 625 (iii) The resume residence in the nursing facility; F 625 (iii) The resume residence in the nursing facility; F 625 (iv) The reserve bed payment policy in the state plan, under § 447 ALO of this chapter, any nursing facility; F 625 § 483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or threapeutic leave, a nursing facility document review, it was determined the facility staff failed to provide evidence that bed hold notifications were growided to for out of 52 residents in the survey sample that were transfored to the hospital; Residenti	NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CALL Description PRETX TAG SUMMARY STATEMENT OF DEPICIENCES (EACH CORRECTION FOLL DEFICIENCY MUST BE PRECEEDED BY FULL RECULTIONY OR LSC IDENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APROPRIATE DEFICIENCY) COMMENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APROPRIATE DEFICIENCY) COMMENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APROPRIATE DEFICIENCY) COMMENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APROPRIATE DEFICIENCY) COMMENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APROPRIATE DEFICIENCY) C PRETX TAG D PRETX TAG D PRETX					91	101 BON AIR CROSSINGS DRIVE		
PRETRX TAG IEACH CORRECTIVE ATTON SHOLD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PRETRX TAG IEACH CORRECTIVE ATTON SHOLD BE CROSS-HEREDCE TO THE APROPRIATE DEFICIENCY) Construction Should be cross-HEREDCE TO THE APROPRIATE DEFICIENCY F 625 Continued From page 36 nursing facility transfers a resident to a hospital or the resident or resident ceave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this schepter, if any; (iii) The reserve bed payment policy in the state plan, under § 447.40 of this schepter, if any; (iii) The reserve bed payment policy in the state plan, under § 447.40 of this schepter, if any; (iii) The information specified in paragraph (e)(1) of the section. F 625 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident and the resident to resident and the resident in paragraph (e)(1) of this section. This RECUIREMENT is not met as evidenced by: Based on staff interview, dirical record review and facility document review, it was determined the facility staff failed to provide evidence that bed hold notifications were provided to four out of 52 residents in the survey sample that were transfered to the hospital. Residents # 95, #15, #31 and #81. Criteria 1 Identified residents being discharged to the hospital have the potential to be affected by this alleged deficient practice. 1. The facility staff failed to evidence bed hold Criteria 3	THE LAUR	LELS OF BON AIR			B	ON AIR, VA 23235		
nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies. (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility: (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The reserve bed, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or the reapeutic leave, a nursing facility use provide to the resident and the resident epresentative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Criteria 1 Identified residents were discharged to the hospital. Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide to four out of 52 residents in the survey sample that were transferred to the hospital; Residents #95, #15, #31 and #81. Criteria 2 All current residents being discharged to the hospital. Hospital have the potential to be affected by this alleged deficient practice. 1. The facility staff failed to evidence bed hold Criteria 3	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
#31 and #81. All current residents being discharged to the hospital have the potential to be affected by this alleged deficient practice. 1. The facility staff failed to evidence bed hold Criteria 3	F 625	nursing facility transfet the resident goes on to nursing facility must p the resident or resider specifies- (i) The duration of the any, during which the return and resume resi facility; (ii) The reserve bed p plan, under § 447.40 c (iii) The nursing facility bed-hold periods, whi paragraph (e)(1) of th resident to return; and (iv) The information sp of this section. §483.15(d)(2) Bed-ho the time of transfer of hospitalization or ther facility must provide to resident representativ specifies the duration described in paragrap This REQUIREMENT by: Based on staff intervia and facility document the facility staff failed hold notifications were residents in the surve	ers a resident to a hospital or therapeutic leave, the rovide written information to int representative that state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any; y's policies regarding ch must be consistent with is section, permitting a d pecified in paragraph (e)(1) Id notice upon transfer. At a resident for apeutic leave, a nursing o the resident and the re written notice which of the bed-hold policy of (d)(1) of this section. is not met as evidenced rew, clinical record review review, it was determined to provide evidence that bed e provide to four out of 52 y sample that were	F	625	Criteria 1 Identified residents were discharged the hospital.	to	
		#31 and #81.The findings include:1. The facility staff fail	iled to evidence bed hold			the hospital have the potential to be affected by this alleged deficient pra	ctice.	

Event ID: 33UH11

Facility ID: VA0394

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 625 Continued From page 37 F 625 Resident #95 and/or resident responsible party. the bed hold policy and documentation Resident #95 was transferred to the hospital on that it was given to resident and or RP. 9/22/22. Criteria 4 Resident #95 was admitted to the facility on The DON or designee will conduct audits 8/19/22 with diagnosis that included but were not of discharged residents to assure the bed limited to: anemia, hypertension, and malnutrition. hold policy was sent to the hospital with them 3 x week for four weeks, weekly for The most recent MDS (minimum data set) one month then monthly x 1 month. These assessment, a 5-day Medicare assessment, with results will be forwarded to the QAPI an ARD (assessment reference date) of 10/10/22, committee for review. The QAPI coded the resident as scoring a 12 out of 15 on committee will determine the needs for the BIMS (brief interview for mental status) score, further audits and action. indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan with a revision date of 9/7/22, revealed, "FOCUS: Resident is at risk for nutritional and/or dehydration risk related to: wounds, severe protein malnutrition, anemia. INTERVENTIONS: Provide supplements as ordered. Document consumption. Provide diet preferences and offer substitutes as needed. There was no evidence of bed hold notification for Resident #95 when sent to the hospital on 9/22/22. A review of the nursing progress note dated 10/3/22 revealed, "82-year-old woman transferred to facility for wound care and rehab. Records indicate significant cognitive issues during her stay in hospital. Since her stay here she has experienced hallucinations and has episodic screaming and yelling. She was treated for urinary tract infection. Visited in her room and found resting in bed. She is clearly confused and talking about playing with children on the floor."

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/19/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
	ELS OF BON AIR		9	101 BON AIR CROSSING	S DRIVE		
			B	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	38	F 625				
	A request for bed hold was made on 11/3/22	d notification for the resident at 10:00 AM.					
	AM, with RN (register what notification rega when the resident is s						
	member) #1, the adm	M, ASM (administrative staff inistrator stated, we do not ested information for this					
		2, the director of nursing and clinical coordinator were					
	9/20222, revealed the of a hospital transfer, designee will contact possible length of tran	es "Bed Hold" policy, dated e following: "Within 24 hours the admission director or the resident or RP regarding nsfer and possible bed hold. ffer and resident or RP al record."					
	2. For (R15), the facil evidence that they iss	n was provided prior to exit. ity staff failed to provide sued a bed hold notice to the ible party) when (R15) was n 09/23/2022.					
		o the facility with diagnoses e not limited to: a history of					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page falling.	39	F 625	5			
	On the most recent M significant change ass (assessment reference resident scored 15 out interview for mental si cognitively intact for m The facility's progress 09/23/2022 document Change in Condition/si Evaluation are/were: I Physical Assessment on the resident/patien in condition were: Fur FallPrimary Care P Recommendations: S Review of the EHR (et (R15) failed to eviden bed hold policy was p responsible party in re hospital on 09/23/202 On 11/02/2022 at 10:2 conducted with LPN (LPN #5 stated that wh to the hospital they se resident. LPN #5 stated documented in the pro- On 11/2/2022 at 1:04 conducted with OSM	22 a.m., an interview was licensed practical nurse) #5. nen residents were sent out ent a bed hold policy with the ted that this would be					
	they were not response notice.	sible for providing a bed hold ximately 10:30 a.m., ASM					

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	-	D HUMAN SERVICES				FORM	: 01/19/2023 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	-	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495394	B. WING		_	11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	 (administrative staff m administrator stated th evidence that a bed h (R15) or (R15's) response transfer on 09/23/202 On 11/03/2022 at app (administrative staff m ASM # 2, director of m regional clinical coord the above findings. No further information 3. For Resident #31 (It to provide evidence th notice to the resident/when R31 was discha 8/24/22 and 9/16/22. On the most recent M quarterly assessment reference date) of 10/having no cognitive in decisions, having sco BIMS (brief interview A review of R31's clin following progress not "8/24/22 6:47 a.m. "S room) nurse at [name [Resident] admitted w (congestive heart faillu running some diagnost "9/16/22This mornin requested to go back difficulty breathing, ar 	hember) # 1, the hat the facility did not have old policy was provided to onsible party for (R15's) 2. roximately 4:02 p.m., ASM hember) # 1, administrator, hursing and ASM # 4, linator were made aware of a was provided prior to exit. R31), the facility staff failed hat they issued a bed hold 'RP (responsible party) arged to the hospital on IDS (minimum data set), a with an ARD (assessment '25/22, R31 was coded as hpairment for making daily red 15 out of 15 on the for mental status). ical record revealed the tes: poke with ER (emergency of local hospital], rith dx (diagnosis) of CHF ure) exacerbation, still stics at this time."	F 625				

Facility ID: VA0394

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page of local hospital]." Further review of the	41 clinical record failed to	F	625				
		R31/RP were provided a bed charges on 8/24/22 and						
	staff member) #1, the facility could not produ	m., ASM (administrative administrator, stated the uce evidence that bed hold to R31/RP when R31 was 8/24/22 and 9/16/22.						
	nurse) #3 stated it is t send clinical document continuity of care to the is being transferred. See bed hold notice, care face sheet, advance of laboratory test results documents which item facility in a progress in She stated if a resident present, the nurse use	e hospital when a resident the stated this includes a plan goals, medication list, lirective, and recent . She stated the nurse ns were sent to the receiving ote or on a transfer form. nt's family member is						
		n., ASM #1, ASM #2, the d ASM #4, the regional ere informed of these						
	No further information	was provided prior to exit.						
	to provide evidence th	R81), the facility staff failed at a bedhold notice was nt and/or responsible party ansfer on 8/10/2022.						

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	: 42	F	625				
	quarterly assessment reference date) of 9/2 being cognitively intac having scored 15 out interview for mental s A review of R81's clin following progress not a.m.) Note Text: resid worsening wound to t physician] called his f send the resedent [sid department) for eval ((nurse practitioner) [N emergency contact, e progress notes furthe 14:45 (2:45 p.m.) Lat from [Name of hospita oriented to person, pla remains in place r/t (re treatments in place to care." Further review of the reveal evidence that b to the resident and/or transfer on 8/10/2022 On 11/02/2022 at app request was made via (administrative staff m administrator, for evid provided to the resident	ical record revealed the te: "8/10/2022 07:41 (7:41 ent presented with a he left foot [Name of oot doctor and stated to c] to the ed (emergency evaluation) and treat np lame of NP] and patient x wife aware." The r documented, "8/14/2022 e Entry: Note Text: readmit al] A&O X 3 (alert and ace and time); observation elated to) infection and heels; will continue plan of clinical record failed to bedhold notice was provided responsible party for the						
	On 11/02/2022 at 10:4	40 a.m., ASM #1 stated that lence of bed hold notice						

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í				(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS 3ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page being provided to the party for R81's transfe On 11/02/2022 at 10:2 conducted with LPN ((LPN #5 stated that wh to the hospital they se resident. LPN #5 state documented in the pro- On 11/2/2022 at 1:04 conducted with OSM of director of social servit they were not response notice. On 11/02/2022 at app #1, the administrator, nursing and ASM #4, coordinator were infor No further information PASARR Screening for CFR(s): 483.20(k)(1)- §483.20(k) Preadmiss	 4.43 resident and/or responsible er on 8/10/2022. 22 a.m., an interview was licensed practical nurse) #5. Inen residents were sent out ent a bed hold policy with the ted that this would be ogress notes. p.m., an interview was (other staff member) #2, the ices. OSM #2 stated that sible for providing a bed hold proximately 5:00 p.m., ASM ASM #2, the director of the regional clinical rmed of these concerns. in was provided prior to exit. or MD & ID -(3) sion Screening for natal disorder and individuals 	F	625				12/18/22
	or after January 1, 19 (i) Mental disorder as (i) of this section, unle authority has determin independent physical performed by a person State mental health an	ng facility must not admit, on 89, any new residents with: defined in paragraph $(k)(3)$ ess the State mental health ned, based on an and mental evaluation n or entity other than the uthority, prior to admission, the physical and mental						

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ELS OF BON AIR			5	9101 BON AIR CROSSINGS DRIVE		
	ELS OF DON AIR			F	BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 645	the level of services p and (B) If the individual re- services, whether the specialized services; ((ii) Intellectual disabili (k)(3)(ii) of this section intellectual disability of authority has determin (A) That, because of t condition of the individ the level of services p and (B) If the individual re- services, whether the specialized services for §483.20(k)(2) Excepti section- (i)The preadmission s paragraph(k)(1) of this for determinations in t to a nursing facility of being admitted to the transferred for care in (ii) The State may cho preadmission screenin paragraph (k)(1) of this to a nursing facility of (A) Who is admitted to hospital after receiving hospital, (B) Who requires nurs condition for which the the hospital, and (C) Whose attending the services of the services for and services (C)	dual, the individual requires provided by a nursing facility; quires such level of individual requires or ty, as defined in paragraph n, unless the State or developmental disability ned prior to admission- the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires or intellectual disability. tons. For purposes of this creening program under s section need not provide the case of the readmission an individual who, after nursing facility, was a hospital. pose not to apply the ng program under is section to the admission	F	645			
	before admission to th	he facility that the individual					

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	-	D HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/19/20 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495394	B. WING			11/03/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE		
				9101 BON AIR CROSSINGS DRIV	Έ		
THE LAUR	RELS OF BON AIR			BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	DATE	N
F 645	Continued From page	e 45 s than 30 days of nursing	F 64	15			
	facility services.						
	§483.20(k)(3) Definition	on. For purposes of this					
	()	nsidered to have a mental al has a serious mental					
	disorder defined in 48						
	(ii) An individual is con						
	intellectual disability if	is defined in §483.102(b)(3)					
	or is a person with a r						
	described in 435.1010						
		is not met as evidenced					
	•	ew and clinical record		Criteria 1			
	review, it was determi	ned the facility staff failed to		The PASARR was obtain	ned for resident		
		eadmission screening and		#79.			
		ne of 52 residents in the					
	survey sample, Resid	ent #79 (R79).		Criteria 2			
	The findings include:			All residents have the po affected by this practice.	. An audit will b		
	For R79, the facility st	taff failed to obtain a		completed to ensure all i PASSAR in place that is		а	
	PASARR upon admis			this setting.	appropriate to		
	On the most recent M	DS (minimum data set)		Criteria 3			
		al assessment, with an		Administrative Nurse, or	designee will		
	assessment reference	e date of 9/15/2022, the		provide in-service educa	ation to		
		of out 15 on the BIMS (brief		Admissions and Social S	Services staff or	1	
		tatus) score, indicating the		the requirement for a PA	SSAR for each		
	•	/ cognitively impaired for		resident.			
	facility 10/13/2021.	s. R79 was admitted to the		Criteria 4			
				An audit will be complete			
	The review of the clini			admissions 3 times per v			
	evidence documentat	ion of a PASARR.		then weekly for 4 weeks		or	
	A request for the PAS	ARR was made on		1 month. Corrections wi needed.	III be made as		

Event ID: 33UH11

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY LETED
		495394	B. WING		-	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE LAUR	RELS OF BON AIR			101 BON AIR CROSSINGS ON AIR, VA 23235	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 645	staff member) #1, the did not have a PASAF An interview was cond a.m. with OSM (other asked the process for PASARR, OSM #3 state manager at the hospit residents. If there is r hospital to complete of sometimes they can g portal. OSM #3 state facility in May. The facility policy, "Pr Guest/Resident Revie "The process begins of screening, Level 1/38 generally completed to provider. If the respon screening indicate the illness and/or intellect disability or related cor referred to the local cor program for a compre 2."	imately 3:30 p.m. p.m. ASM (administrative administrator, stated they RR for R79. ducted on 11/2/2022 at 8:44 staff member) #3. When obtaining or completing a ated they ask the case tal for a PASARR on all not one, she asked the one. OSM #3 stated get it through the community a she had just started at the e-Admission Screening and ew," documented in part, with the completion of a 77. The screening is by a hospital or community a ses to the Level 1/3877 e presence of a mental ually/developmental ondition, the person is formunity mental health thensive screening, Level staff member) #1, the	F 645	Continued compliar through routine aud facility's quality asso Additional education be initiated for any i	nce will be monitored lits and reported to t urance program. n and monitoring wil	he	
	administrator, ASM #2	2, the director of nursing, onal clinical coordinator, he above concern on					
F 655 SS=E	No further information Baseline Care Plan	was provided prior to exit.	F 655				12/18/22

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/19/2023 APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
				9	101 BON AIR CROSSING	S DRIVE		
THE LAUR	RELS OF BON AIR			E	BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page CFR(s): 483.21(a)(1)-	-(3)	F	655				
	Planning §483.21(a) Baseline (§483.21(a)(1) The fac implement a baseline that includes the instri- effective and person-of that meet professiona The baseline care pla (i) Be developed withi admission. (ii) Include the minimu- necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fac comprehensive care p care plan if the compr (i) Is developed within	care plan for each resident uctions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's um healthcare information r care for a resident ted to- l on admission orders.						
	 (b) of this section (exc this section). §483.21(a)(3) The far resident and their rep of the baseline care p limited to: (i) The initial goals of 	ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not the resident. resident's medications and						

Facility ID: VA0394

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0: 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING			11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
	ELS OF BON AIR			101 BON AIR CROSSINGS	DRIVE		
			В	SON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 655	on behalf of the facility (iv) Any updated inform of the comprehensive This REQUIREMENT by: Based on resident inti- interview, staff interview complaint investigation provide residents with care plan for five of 52 sample, Residents #1 #109. The findings include: 1. For Resident #162 failed to provide the re- summary of the basel R162 was admitted to On the most recent M admission assessment reference date) of 6/2 4 out of 15 on the BIN status), indicating the impaired for making d The "72 Hour Admissi 6/26/2022 for R162 far responsible party beint the baseline care plant	treatments to be acility and personnel acting y. mation based on the details care plan, as necessary. is not met as evidenced rerview, responsible party ew, facility document review, and in the course of ns, the facility staff failed to a summary of the baseline 2 residents in the survey 62, #309, #72, #111 and (R162), the facility staff esponsible party with a ine care plan. the facility on 6/22/2022. DS (minimum data set), an nt with an ARD (assessment 9/2022, the resident scored IS (brief interview for mental resident was severely aily decisions. on Conference" dated iled to evidence the og provided a summary of h.	F 655	Criteria 1 Residents #162,309 discharged from the # 109 received a cop Criteria 2 All current residents be affected by the al practice. Criteria 3 Social Workers were 72 hour meeting and family copy of baseli Criteria 4 Social Worker/Desig admissions 3 x a we weekly x 4 weeks ar assure post admissi scheduled and Care resident or RP. The forwarded to the QA review. The committ need for further audi	,72,111 have been facility. Resident by of her care plan. have the potential leged deficient e re-educated on the giving resident an ine care plan. mee will audit new tek for one month, ad monthly x 1 to on meeting is Plan is given to se results will be PI committee for the will determine the	to Ie d	
		nical record failed to onsible party being provided					

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE	
		495394	B. WING _			_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	request was made to member) #1, the adm the baseline care plar responsible party. On 11/2/2022 at 10:40 they did not have evic party being give a cop On 11/2/2022 at 12:50 conducted with RN (re coordinator. RN #1 si assessment and care admitted residents. Fireviewed the nursing information on the act wounds, any skin con things that related to a that they reviewed the auxiliary documents a plan process. On 11/2/2022 at 1:04 conducted with OSM director of social serve the admission staff si admission conference residents and they or documented the confet the 72 hour admission welcome meeting whe themselves and they of of the care plan but we	p.m., an interview was (other staff member) #2, the ison the nest of daily living, any ditions, pain and other the resident. RN #1 stated that they started that planning process for newly RN #1 stated that they evaluations and collected tivities of daily living, any ditions, pain and other the resident. RN #1 stated e orders, diagnoses and and then started the care	F	555				

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CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO	0: 01/19/2023 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, S			
THE LAUR	RELS OF BON AIR			101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page stated that the confere completed by telepho On 11/2/2022 at 1:37 conducted with LPN (LPN #3 stated that the was to show the overa they were doing for th behaviors and falls. On 11/3/2022 at 8:06 conducted with ASM # ASM #2 stated that the at the facility was for t medical record provid assessment complete complete the baseline plan at that time. ASM wait two weeks to do assessment and they #2 stated that they had of the care plan to the The facility policy, "Ca 6/24/2021 documente Care Plan will be deva identifying any immed interventions needed person-centered care the resident and their summary of the basel the following: Initial go summary of the reside dietary instructions; A to be administered by personnel acting on b	 a 50 ence was normally ine. p.m., an interview was (icensed practical nurse) #3. e purpose of the care plan all care of the resident, what nem, document their goals, a.m., an interview was #2, the director of nursing. a.m. an interview was #2, the director of nursing. be process for care planning the MDS nurse to review the led from the hospital and the ed upon admission and e and comprehensive care M #2 stated that they did not the comprehensive care M #2 stated that they did not the comprehensive and comprehensive care in part, "2. A Baseline eloped within 48 hours diate needs, initial goals and to provide effective and a. 3. The facility will provide representative with a line care plan that includes oals of the resident; A ent's medications and any services and treatments 	F 655				
	comprehensive care p						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE		
			91	01 BON AIR CROSSINGS	DRIVE		
THE LAUP	RELS OF BON AIR		В	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 655	On 11/3/2022 at 4:00 administrator, ASM #2 ASM #4, the regional made aware of the ab No further information Complaint deficiency. 2. For Resident #309 failed to provide the re representative) with a care plan. R309 was admitted to The admission MDS (been completed at the review of the Nursing dated 10/22/22 revea person, place, and tim On 10/31/22 at 2:52 p not aware that they ha baseline care plan su A review of R309's cli evidence that the resi summary of baseline On 11/2/22 at 1:05 p.r member) #2, the socia interviewed. She state resident's admission, the interdisciplinary te She stated the purpos welcome the resident about discharge plann nursing, therapy, and stated there is nothing	 p.m., ASM #1, the 2, the director of nursing and clinical coordinator were bove concern. a was presented prior to exit. (R309), the facility staff esident and/or RR (resident summary of the baseline b the facility on 10/22/22. b the facility on 10/22/22. c time of survey entrance. A Comprehensive Evaluation led R309 was oriented to ne. a.m., R309 stated they were ad received a copy of the mmary. nical record failed to reveal dent or RR ever received a care plan. 	F 655				

Facility ID: VA0394

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		ID HUMAN SERVICES				FORM): 01/19/2023 APPROVED
STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	-	(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING 30N AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	for something specific the RRs attend by tele does not ordinarily off baseline care plan to On 11/2/22 at 1:52 p.1 marketing was intervia admissions staff sets the family once the re- facility. She stated the come in to the facility meeting occurs by tel On 11/2/22 at 3:55 p.1 staff member) #1, the director of nursing, ar clinical coordinator, w concerns. On 11/3/22 at 8:06 a.1 resident is admitted, to the medical record from and the facility staff of She stated the facility care plan at that time, between the baseline comprehensive care plan thas not been pro- a copy of the care plan No further information 3. For Resident #72 (to provide the resident representative) a base R72 was admitted to	 c. She stated that most of ephone. She stated she fer a summary of the the resident/RR. m., OSM #3, the director of ewed. She stated the an admission meeting with isident is settled into the e family members may either and meet in person, or the econference. m., ASM (administrative administrator, ASM #2, the nd ASM #4, the regional the MDS coordinator reviews on the discharging facility, completes an assessment. develops and implements a and does not distinguish care plan and the plan. She stated the facility poviding the resident/RR with in. n was provided prior to exit. 	F 655				

Facility ID: VA0394

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	-	D HUMAN SERVICES				FORM	01/19/2023
STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	-	(X3) DATE COMP	
		495394	B. WING		_	11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
			91	101 BON AIR CROSSING	S DRIVE		
THE LAU	RELS OF BON AIR		в	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	reference date) of 10/ having no cognitive in decisions, having sco BIMS (brief interview A review of R72's clin evidence that the resi summary of baseline On 11/2/22 at 1:05 p.r member) #2, the social interviewed. She state resident's admission, the interdisciplinary te She stated the purpos welcome the resident about discharge plann nursing, therapy, and stated there is nothing resident/RR in writing for something specific the RRs attend by tele does not ordinarily off baseline care plan to On 11/2/22 at 1:52 p.r marketing was intervia admissions staff sets the family once the re facility. She stated the come in to the facility meeting occurs by tele On 11/3/22 at 8:06 a.r	ht with an ARD (assessment 4/22, R72 was coded as hpairment for making daily red 13 out of 15 on the for mental status). ical record failed to reveal dent or RR ever received a care plan goals. m., OSM (other staff al services director was ed within 72 hours of a a meeting is scheduled with eam and the resident/RR. se of this meeting is to , to begin a discussion hing, and to ask questions of other departments. She g she regularly offers to the , unless she someone asks b. She stated that most of ephone. She stated she fer a summary of the the resident/RR. m., OSM #3, the director of ewed. She stated the an admission meeting with sident is settled into the e family members may either and meet in person, or the	F 655				

Facility ID: VA0394

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF BON AIR				9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	care plan at that time between the baseline comprehensive care p staff has not been pro a copy of the care plan No further information 4. For Resident #111 failed to provide the re- representative) with a care plan. R111 was admitted to admission MDS (mini- been completed at the review of the Nursing dated 10/25/22 revea oriented to time and p On 11/1/22 at 11:58 at interviewed. R111's state aware of R111's care received a summary of care plan. A review of R111's cline evidence that the resis summary of baseline On 11/2/22 at 1:05 p.1 member) #2, the soci interviewed. She state resident's admission, the interdisciplinary te She stated the purpor- welcome the resident about discharge plan	and does not distinguish care plan and the plan. She stated the facility oviding the resident/RR with in. was provided prior to exit. (R111), the facility staff esident and/or RR (resident a summary of the baseline the facility on 10/25/22. An mum data set) had not yet e time of survey entrance. A Comprehensive Evaluation led the resident was person only. , R111's spouse was pouse stated they were not plan goals, and had never of the resident's baseline nical record failed to reveal dent or RR ever received a care plan goals.	F	655			

Facility ID: VA0394

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/19/2023 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING		_	11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
THE LAU	RELS OF BON AIR			101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	stated there is nothing resident/RR in writing for something specific the RRs attend by tele does not ordinarily off baseline care plan to On 11/2/22 at 1:52 p.1 marketing was intervia admissions staff sets the family once the re facility. She stated the come in to the facility meeting occurs by tel On 11/3/22 at 8:06 a.1 resident is admitted, t the medical record fro and the facility staff or She stated the facility care plan at that time, between the baseline comprehensive care plan that the reformation 5. For Resident #103 failed to provide the re representative) with a care plan. R103 was admitted to the most recent MDS admission assessment reference date) of 10/ having no cognitive in	g she regularly offers to the , unless she someone asks 2. She stated that most of ephone. She stated she er a summary of the the resident/RR. m., OSM #3, the director of ewed. She stated the an admission meeting with sident is settled into the e family members may either and meet in person, or the econference. m., ASM #2 stated when a he MDS coordinator reviews on the discharging facility, completes an assessment. develops and implements a , and does not distinguish care plan and the olan. She stated the facility oviding the resident/RR with	F 655				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
	RELS OF BON AIR		9	9101 BON AIR CROSSING	S DRIVE		
				BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page BIMS.	56	F 655				
	The resident stated th	.m., R103 was interviewed. ley did not remember having summary of the baseline					
		nical record failed to reveal dent or RR ever received a care plan goals.					
	interviewed. She state resident's admission, the interdisciplinary te She stated the purpos welcome the resident about discharge plann nursing, therapy, and stated there is nothing resident/RR in writing for something specific the RRs attend by tele does not ordinarily off baseline care plan to	al services director was ed within 72 hours of a a meeting is scheduled with eam and the resident/RR. se of this meeting is to , to begin a discussion ning, and to ask questions of other departments. She g she regularly offers to the , unless she someone asks c. She stated that most of ephone. She stated she fer a summary of the the resident/RR. m., OSM #3, the director of					
	admissions staff sets the family once the re facility. She stated the come in to the facility meeting occurs by tel On 11/3/22 at 8:06 a.r resident is admitted, t the medical record fro	an admission meeting with sident is settled into the a family members may either and meet in person, or the					

Facility ID: VA0394

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUR	ELS OF BON AIR		-	101 BON AIR CROSSINGS SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655 F 656 SS=E	care plan at that time, between the baseline comprehensive care p staff has not been pro- a copy of the care plan No further information Develop/Implement C CFR(s): 483.21(b)(1)(§483.21(b) Comprehe §483.21(b)(1) The fact implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that into objectives and timefra medical, nursing, and needs that are identifi assessment. The corr describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that v under §483.10, includ treatment under §483.2 (iii) Any specialized se rehabilitative services provide as a result of recommendations. If a findings of the PASAF	develops and implements a and does not distinguish care plan and the blan. She stated the facility widing the resident/RR with n. was provided prior to exit. omprehensive Care Plan 3) ensive Care Plans sility must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and cludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive oprehensive care plan must - re to be furnished to attain nt's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and vould otherwise be required 25 or §483.40 but are not esident's exercise of rights ing the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its	F 655		JEFICIENCY)		12/18/22
	rationale in the reside (iv)In consultation with						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		(X3) DATE S COMPL	SURVEY
		495394	B. WING		_	11/0	3/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING	S DRIVE		
				BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	resident's representat (A) The resident's goat desired outcomes. (B) The resident's pre- future discharge. Faci- whether the resident's community was asses local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, in requirements set forth section. §483.21(b)(3) The set by the facility, as outli- care plan, must- (iii) Be culturally-comp This REQUIREMENT by: Based on observation interview, clinical reco document review, it w facility staff failed to d the comprehensive ca- residents in the surve (R15), #21 (R21), #2 and #13 (R13). The findings include: 1a. For (R15), the fac- the comprehensive ca- a fall mat. (R15) was admitted to that included but was weakness and a histor	ive(s)- als for admission and ference and potential for lities must document a desire to return to the ased and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this rvices provided or arranged ned by the comprehensive betent and trauma-informed. It is not met as evidenced in, resident interview, staff ord review and facility ras determined that the evelop and/or implement are plan for six of 52 y sample, Residents #15 (R2), #23 (R23), #19 (R19), cility staff failed to implement are plan for the placement of the facility with a diagnosis not limited to: muscle	F 65	Criteria 1 Resident #15 fall m bed. Resident# 15 corrected to reflect scales. Resident # back in place and o Resident #15's MA reflect and include interventions. Resident #2 suffere medication not bein was discharged fro Resident #23 had o reflect use of side n Resident #19 and a	correct numerical part 15 call bell was put clipped to the bed. R was corrected to non-pharmacological ischarged from the ed no ill effects from ng administered. He om the facility. care plan updated to rails. #13 was seen by the measurements were	ain	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 59 F 656 significant change assessment with an ARD Criteria 2 All residents have the potential to be (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief affected by the alleged deficient practices. interview for mental status), indicating (R15) was cognitively intact for making daily decisions. Criteria 3 The DON/designee will re-educate On 11/01/2022 at approximately 9:00 a.m. and licensed nurses on pain management, 9:30 a.m., (R15) was observed lying in the bed. non-pharmacological interventions, Further observation failed to evidence a fall mat notification of medications not on the floor next to the bed. administered, side rail policy and procedure, call bell placement, and fall The physician's orders for (R15) documented in interventions. Nurse Aides will receive part, "Fall mat to right side of bed every shift. in-service education on fall interventions Order Date: 09/30/2022. Start Date: 09/30/2022." and call bell placement. The comprehensive care plan for (R15 dated Criteria 4 09/18/2022 documented in part, "Need: (R15) is The DON/designee will audit the following: at risk for fall related injury and falls R/T (related Random audits of residents receiving pain to): orthostatic hypotension, hx (history) falls, medications will be conducted for use of peripheral neuropathy. Date Initiated: non-pharmacological interventions. 09/18/2022." Under "Interventions" it Random MAR audits will be conducted for documented in part, "Fall mat to right side of bed. physician notification of medications not Date Initiated: 10/04/2022." administered. Side rail use and consent requirements The facility's policy "care Planning" documented will be audited to ensure use is properly in part, "Every resident in the facility will have a documented. person-centered Care Plan developed and Random call bell placement audits will be implemented that is consistent with resident conducted through room rounds. rights, based on the comprehensive assessment Random audits will be conducted for fall that includes measurable objectives and time mat placement. frames to meet a resident medical, nursing, and mental and psychosocial needs identified in the All audits will be completed 3 times/week comprehensive assessments and prepared by an x 4 weeks, weekly x 4 weeks, then interdisciplinary team " monthly x 1 month. These results will be forwarded to the On 11/03/2022 at approximately 4:02 p.m., ASM QAPI committee for review. The (administrative staff member) # 1, administrator, committee will determine the need for ASM # 2, director of nursing and ASM # 4, further audits and/or action. regional clinical coordinator were made aware of

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/19/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
					S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	9 60	F 65	6			
	the above findings.						
	No further information	was provided prior to exit.					
	1b. For (R15), the facility staff failed to implement						
	the comprehensive care plan to prevent the administration of unnecessary medications.						
	On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions. Section J0400 "Pain Frequency" coded (R15) as "Occasionally." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R15) was coded a "4 (four)."						
	The physician's order part, "Roxicodone Tak Give 1 (one) tablet by	for (R15) documented in blet 5 (five) MG (milligram). mouth every 6 (six) hours Drder Date: 09/30/2022.					
	Regimen Review Rep "September 30, 2022 documented in part, " tab (tablet) po (by mo needed for pain disch pain 6-10 (should be for pain 4-6)." Furthe regimen review revea nurse practitioner date 2022)."	through October 7, 2022" Roxicodone Tablet 5 mg 1 uth) every 6 hours as arge summary states for 7-10) since ibuprofen (2) is r review of the medication led the signature by the ed "10-10-22 (October 10,					
	record) for (R15) date	c medication administration d October 2022					

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	-	D HUMAN SERVICES				FORM): 01/19/2023 APPROVED
STATEMENT C	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING		_	11/0	03/2022
NAME OF PR	ROVIDER OR SUPPLIER		S ⁻	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			91	101 BON AIR CROSSING	S DRIVE		
	RELS OF BON AIR		В	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 656	Continued From page documented the phys Further review of the received five milligran level of five on 10/18/. The comprehensive of 09/18/2022 document risk for pain and has p C2 fracture (fracture of vertebra) with fusion, with Odontaoid fractur projection at the back the neck), OA, (osteo (leg). Date Initiated: ("Interventions" it docu medications as ordered 06/30/2021." On 11/03/22 at approx interview was conduct practical nurse) # 4. // medication regimen re eMAR LPN # 4 stated received the roxicodo reviewing the care pla care plan was not bei On 11/03/2022 at app (administrative staff m ASM # 2, director of m regional clinical coord the above findings.	e 61 ician order as stated above. eMAR revealed that (R15) ns of roxicodone for a pain 2022. are plan for (R15) dated ted in part "Need: (R15) is at pain related to neuropathy, of the second cervical post concussion headache re (a toothlike upward of the second vertebra of arthritis) fracture of femur 09/18/2022." Under imented in part, "Administer ed. Date Initiated: ximately 8:19 a.m., an ted with LPN (licensed After reviewing (R15's) eview, the October 2022 I that (R15) should have not ne on 10/18/2022. After an LPN # 4 stated that the ng followed. proximately 4:02 p.m., ASM nember) # 1, administrator,	TAG F 656			TE	DATE
	oxycodone hydrochlo	-release oral formulation of ride indicated for the erate to severe pain where					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	01/19/2023 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAURELS OF BON AIR				101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
				-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	9 62	F 656				
	This information was https://dailymed.nlm.r	nalgesic is appropriate. obtained from the website: nih.gov/dailymed/drugInfo.cf b4-4a93-a35b-6eebff7b8e53					
	tenderness, swelling, osteoarthritis (arthritis the lining of the joints) (arthritis caused by sy joints). It is also used pain, including menst before or during a me information was obtai	. ,					
		cility staff failed to implement are plan to maintain the call					
	(R15's) call bell revea side of the mattress o	0 a.m., an observation of led it was attached to the in the resident's right side of y six to eight inches from the s.					
	(R15's) call bell revea side of the mattress of the bed approximately corner of the mattress and activate their call attempting to reach for unable to locate and g	grasp it. are plan for (R15) dated					
		are plan for (R15) dated ted in part, "Need. (R15)					

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	-					FORM	: 01/19/2023 APPROVED	
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938 (X3) DATE SURVEY COMPLETED		
		495394	B. WING		_	11/0	03/2022	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE			
THE LAURELS OF BON AIR			9.	101 BON AIR CROSSING	S DRIVE			
THE LAUP	CELS OF BON AIR		В	ON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	Continued From page has hip fracture r/t (re 05/18/2022." Under " documented in part, ". needs. Be sure call li respond promptly to a Date Initiated: 05/18/2 On 11/03/22 at 8:14 a conducted with LPN (When informed of the stated that they were (R15) did not have the where the call bell wat that the call bell shoul within (R15's) reach. plan LPN # 4 stated th being followed. On 11/03/2022 at app (administrative staff m ASM # 2, director of m regional clinical coord the above findings. No further information 1d. For (R15), the fac the comprehensive ca non-pharmacological administration of as n The physician's order part, "Roxicodone Tablet 5 1 (one) tablet by mour needed for pain. Ord	e 63 lated to) fall. Date Initiated: Interventions" it Anticipate and meets ght is within reach and all requests for assistance. 2022." n.m., an interview was licensed practical nurse) #4. above observation LPN # 4 familiar with (R15) and that e range of motion to reach s located and further stated ld have been positioned After reviewing the care that the care plan was not proximately 4:02 p.m., ASM member) # 1, administrator, nursing and ASM # 4, linator were made aware of a was provided prior to exit.				Ϋ́Ε	DATE	
		a Strength Tablet 500 MG. y mouth every 6 hours						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 64 F 656 needed for pain 1-5 (one to five). Order Date: 10/10/2022. Start Date: 10/10/2022." The eMAR (electronic medication administration record) for (R15) dated October 2022 documented the physician's order as stated above. The eMAR revealed that (R15) received 5 mgs of roxicodone on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 10/01/2022 at 1:12 p.m., 10/02/2022 at 1:44 p.m., 10/06/2022 at 10:00 a.m., and on 10/18/2022 at 8:31 p.m. Further review of the eMAR revealed that (R15) received 1000 mg of acetaminophen on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 10/26/2022 at 10:29 a.m. and on 10/27/2022 at 7:46 p.m. The comprehensive care plan for (R15) dated 09/18/2022 documented in part "Need: (R15) is at risk for pain and has pain related to neuropathy, C2 fracture (fracture of the second cervical vertebra) with fusion, post concussion headache with Odontaoid fracture (a toothlike upward projection at the back of the second vertebra of the neck), OA, (osteoarthritis) fracture of femur (leg). Date Initiated: 09/18/2022." Under "Interventions" it documented in part, "Offer Non-Pharmacological Interventions: 1) Massage; 2) Meditation/relaxation; 3) Positioning; 4) Ice/cold pack; 5) Diversional Activity; 6) Guided Imagery; 7) Rest; 8) Social Interaction; 9) Other. Date Initiated: 06/30/2021. Review of the facility's nurse's notes for (R15) dated 10/01/2022 through 10/31/2022 failed to evidence non-pharmacological interventions being attempted on the dates and times listed

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/19/2023

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	RELS OF BON AIR				101 BON AIR CROSSINGS	S DRIVE		
				В	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page above.	65	F	656				
	interview was conduct asked if the staff attern before administering to medication, (R15) stat them the pain medicat On 11/03/22 at approx- interview was conduct practical nurse) # 4. A eMAR and progress r through 10/31/2022 for interventions prior to the roxicodone and aceta was asked about the LPN # 4 stated that the non-pharmacological attempted because it reviewing the care plat care plan was not beil On 11/03/2022 at app (administrative staff m ASM # 2, director of m regional clinical coord the above findings. No further information 2. For (R21), the faci- the comprehensive ca- non-pharmacological administration of as n (R21) was admitted to	ted no and that they give tion. ximately 8:19 a.m., an ted with LPN (licensed After review of (R15's) notes dated 10/01/2022 or non-pharmacological the administration of minophen to (R15), LPN # 4 missing documentation. ney could not say interventions were was not documented. After an LPN # 4 stated that the ng followed. roximately 4:02 p.m., ASM nember) # 1, administrator, nursing and ASM # 4, inator were made aware of a was provided prior to exit.						

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	-	D HUMAN SERVICES				FORM	: 01/19/2023	
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		495394	B. WING		-	11/0	3/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE			
				9101 BON AIR CROSSINGS	DRIVE			
THE LAUP	RELS OF BON AIR			BON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	9 66	F 65	6				
	admission assessmer reference date) of 09/ out of 15 on the BIMS status), indicating (R2 making daily decision Frequency" coded (R "J0600. Pain Intensity Numeric Rating Scale a "5 (five)." The physician's order part, "Oxycodone-Ace MG (milligram). Give every 12 hours as ner 09/15/2022. Start Da The eMAR (electronic record) for (R21) date documented the phys above. The eMAR re 5-325 mgs of oxycod following dates and the non-pharmacological attempted on: 10/01/2 10/05/2022 at 2:17 p. and on 10/10/2022 at The comprehensive of 09/14/2022 document risk for pain and/or had (related to) age relate compression fracture 09/14/2022." Under " documented in part, " Interventions: 1) Mass	e (00-10)." (R21) was coded for (R21) documented in etaminophen Tablet 5-325 1 (one) tablet by mouth eded for pain. Order Date: te: 09/15/2022." c medication administration ed October 2022 ician's order as stated vealed that (R21) received one-acetaminophen on the mes, with no evidence of interventions being 2022 at 9:02 p.m., m., 10/07/2022 at 3:48 p.m., m., 10/09/2022 at 4:06 p.m., 8:05 p.m. are plan for (R21) dated ted in part "Need: (R21) is at as acute/chronic pain r/t d changes, recent fall with Date Initiated: Interventions" it Offer Non-Pharmacological						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	01/19/2023 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			BURVEY ETED
		495394	B. WING		_	11/0	3/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
				9101 BON AIR CROSSING	S DRIVE		
THE LAURELS OF BON AIR				BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656		e 67 activity; 6) Guided Imagery; araction; 9) Other. Date	F 656	5			
	Initiated: 06/30/2021.						
	dated 10/01/2022 thro evidence non-pharma	s nurse's notes for (R21) ough 10/31/2022 failed to acological interventions and times listed					
	interview was conduct asked if they receive a (R21) stated yes. Wh attempts to alleviate to before administering to	roximately 2:25 p.m., an ted with (R21). When as needed pain medication an asked of the nurse heir pain by other means their pain medication (R21) a don't always attempt to other means.					
	interview was conduct practical nurse) # 4 re- and documentation of interventions prior to to needed pain medicati (R21's) eMAR and pro- 10/01/2022 through 1 non-pharmacological administration of oxyo (R21), LPN # 4 was a documentation. LPN not say non-pharmaco attempted because it reviewing the care pla care plan was not bei	0/31/2022 for interventions prior to the codone-acetaminophen to sked about the missing # 4 stated that they could ological interventions were was not documented. After an LPN # 4 stated that the					
	# 1, administrator, AS	M # 2, director of nursing I clinical coordinator, were					

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	-	ID HUMAN SERVICES				FORM	01/19/2023 APPROVED
STATEMENT C	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		OMB NO. 093 (X3) DATE SURVE COMPLETED		
		495394	B. WING		_	11/0	03/2022
NAME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, S	TATE, ZIP CODE	•	
			91	01 BON AIR CROSSING	S DRIVE		
THE LAUR	RELS OF BON AIR		В	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	made aware of the ab No further information References: (1) Indicated for the m enough to require an which alternative trea This information was https://dailymed.nlm.r m?setid=f2137f1a-b4 4. 3. For (R2), the facilit	oove findings. In was provided prior to exit. In anagement of pain severe opioid analgesic and for tments are inadequate. obtained from the website: hih.gov/dailymed/drugInfo.cf 9a-40bd-97ac-cd6b36e295f	F 656				
	admission assessmen reference date) of 09/ scored 9 (nine) out of interview for mental s moderately impaired of decisions. The physician's order part, "Ceftriaxone Sodium (one GM (gram). Inje every 12 hours for infe Start Date: 10/27/202 10/27/2022."	IDS (minimum data set), an ht with an ARD (assessment /20/2022, the resident 15 on the BIMS (brief tatus), indicating (R2) was of cognition for making daily as for (R2) documented in Solution Reconstituted 1 ect 1 gram intramuscularly ection for 5 (five) days. 2. D/C (discontinue) Date: Solution Reconstituted 1 ect 1 gram intramuscularly					
	Start Date: 10/28/202 "Vancomycin HCL (hy MG/ML (milligram/mil	ection for 5 (five) days. 2." /drochloride) Solution 50 liliter). Give 5 ml by mouth r c-diff (3) for 14 days. Start					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 01/19/2023 APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495394	B. WING			_	11/	03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, S	TATE, ZIP CODE			
THE LAURELS OF BON AIR					101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page Date: 10/15/2022."	9 69	F	656					
	10/27/2022 document risk for discomfort for receives Antibiotic The infection CDiff. Vanco Ceftriaxone until 11/2, 10/18/2022. Under "I	erapy r/t (related to) for mycin 10/27/2022, /22. Date initiated: nterventions" it documented edications as ordered. Date							
	record] dated October the physician's orders ceftriaxone, the eMAR documented on 10/27 on 10/28/2022 at 9:00 documented on 10/31 vancomycin, the eMA documented on 10/18 five documented on 1 at 6:00 p.m., and a bla p.m. Further review of legend that document Follow Up Codes: 5=H	/2022 at 9:00 p.m. For the R revealed a number five 8/2022 at 6:00 p.m., number 0/19/2022 at 12:00 p.m. and ank on 10/28/2022 at 12:00 of the eMAR revealed a ted in part, "Chart Codes / Hold/See Nurse's Notes."							
	to evidence documen order for Ceftriaxone. eMAR failed to evider Ceftriaxone on 11/01/ The nurse's "Progress documentation for cef 10/27/2022 at 9:00 p. being held on 10/18/2 10/19/2022 at 12:00 p	2022 or 11/02/2022. s Notes" failed to evidence ftriaxone being held on m. or for the vancomycin 2022 at 6:00 p.m.,							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495394	B. WING			11/	03/2022	
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				9	9101 BON AIR CROSSINGS DRIVE			
THE LAUR	RELS OF BON AIR			E	BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	ceftriaxone on 10/28/2 "X" on 10/31/2022 at 1 10/28/2022 at 12:00 p The nurse's "Progress through 11/03/2022 fc documentation that ce on 11/01/2022 and 11 On 11/03/22 at 9:55 a conducted with ASM (member) # 2, director (R2's) October and Ne progress notes dated (R2) did not receive th according to the phys reviewing the care pla care plan was not bei On 11/03/2022 at app (administrative staff m ASM # 2, director of m regional clinical coord the above findings. No further information References: (1) Used to treat certa bacteria such as gond transmitted disease), (infection of the femal may cause infertility), membranes that surro cord), and infections of	ion regarding the blanks for 2022 at 9:00 a.m. and the 9:000 p.m. and the blank on o.m. for vancomycin. a Notes" dated 11/01/2022 or (R2) failed to evidence effriaxone was administered /02/2022. , an interview was (administrative staff of nursing. After reviewing ovember eMAR, and above ASM # 2 stated that he medications listed above ician's orders. After an LPN # 4 stated that the ng followed. 	F	656				
	cord), and infections of urinary tract, blood, be	•						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023 APPROVED . 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495394	B. WING		-	11/0	03/2022	
NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	-		
				9101 BON AIR CROSSINGS	DRIVE			
THE LAU	RELS OF BON AIR			BON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 656	 https://medlineplus.gottml. (2) Used to treat colitiintestine caused by cooccur after antibiotic twas obtained from the https://medlineplus.gottml 4. For Resident #23 (to develop a care plant On the most recent Madmission assessment reference date) of 10/being moderately cogdaily decisions, havin the BIMS (brief intervitivas coded as requirint of facility staff for bed On the following date: observed lying in bed 10/31/22 at 8:42 a.m. A review of R23's carrievealed no information to deven a stated she initiates re admission. She stated of information to deven nursing assessments (activities of daily livin personalized information to deven a stated information to deven a stated information to deven nursing assessments (activities of daily livin personalized information to deven a stated information t	ov/druginfo/meds/a685032.h s (inflammation of the ertain bacteria) that may reatment. This information e website: ov/druginfo/meds/a604038.h R23), the facility staff failed in for the use of side rails. DS (minimum data set), an it with an ARD (assessment 11/22, R23 was coded as nitively impaired for making g scored seven out of 15 on iew for mental status. R 23 ing the extensive assistance mobility. s and times, R23 was with quarter side rails up: , and 11/1/22 at 8:45 a.m. e plan dated 10/5/22 on related to the resident's itor, was interviewed. She sident care plans on d she uses multiple sources lop the care plan, including , physician's orders, ADL	F 65	6				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 01/19/2023 FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		3) DATE SURVEY COMPLETED
		495394	B. WING			11/03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
			9	0101 BON AIR CROSSINGS DF	RIVE	
THE LAU	RELS OF BON AIR			BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 656	On 11/2/22 at 1:37 p.1 nurse) #3 was intervie resident is using the s the care plan. On 11/2/22 at 3:55 p.1 staff member) #1, the director of nursing, ar clinical coordinator, w concerns. No further information 5. For Resident #19 (to implement the com provide pressure ulce On the most recent M annual assessment w reference date) of 8/1 12 out of 15 on the BI mental status), indica moderately impaired to Section M (skin condi documented R19 hav scar over bony promit dressing/device. It fu risk of developing pre having any unhealed The comprehensive of documented in part, " skin breakdown and p impaired mobility and skin impairment: wou left upper thigh. Date Revision on: 08/25/20	ed in a resident's care plan. m., LPN (licensed practical awed. She stated if the side rails, they should go on m., ASM (administrative administrator, ASM #2, the administrator, ASM #2, the ad ASM #4, the regional ere informed of these a was provided prior to exit. R19), the facility staff failed prehensive care plan to r treatments as ordered. IDS (minimum data set), an with an ARD (assessment /2022, the resident scored MS (brief interview for ting the resident was for making daily decisions. tion) of the assessment ing a pressure ulcer/injury, a nence, or a non-removable rther documented R19 at ssure ulcer/injuries and not pressure ulcer/injuries. Fare plan for R19 [R19] has the potential for pressure ulcers related to urine incontinence. Actual nd to sacrum and blisters to	F 656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	ordered. Date Initiate A total body skin asse 9:01 a.m. documenter The document failed to describe the wound ic assessment was com- nurse) #4. The progress notes fa documentation descri 10/13/2022. The "Wound Evaluations Summary" for R19 dation in part, "Patient pre- sacrum. History of Pro- of the referring provid thorough wound care was performed to day pressure wound (1) st durationWound Size by depth): 1.4x1.4x0.3 sex] w (with) Hx (histo immunodeficiency virri- presents with a new vi- continue Medihoney (this in the past. Dress Primary Dressing(s): once daily for 30 days Superabsorbent silico apply once daily for 3 was discussed with a Nursing Staff Member The physician's order 11/2/2022 documenter	ed: 08/28/2019" essment dated 10/13/2022 at d one new wound identified. to identify the location or dentified. The skin pleted by RN (registered alled to evidence bing the wound identified on on & Management ted 10/26/2022 documented sents with a wound on her resent Illness: At the request er, [Name of physician], a assessment and evaluation V. She has a stage 3 acrum for at least 1 days e (LxWxD) (length by width 2 cm (centimeter)[Age and ory) of HIV (human us), DM (diabetes mellitus) vound over old scar tissue, 2) as she has done well with sing Treatment Plan: Leptospermum honey apply s. Secondary Dressing(s): one bdr (border) & faced 0 daysThis patient's care nother health provider r during this visit"	F	656				
	The progress notes fa documentation descri 10/13/2022. The "Wound Evaluation Summary" for R19 dation in part, "Patient press sacrum. History of Pro of the referring provide thorough wound care was performed to day pressure wound (1) st durationWound Size by depth): 1.4x1.4x0 sex] w (with) Hx (histo immunodeficiency viru presents with a new vice continue Medihoney (this in the past. Dress Primary Dressing(s): once daily for 30 days Superabsorbent silico apply once daily for 3 was discussed with an Nursing Staff Member The physician's order 11/2/2022 documente sacrum w/ (with) ns (r	bing the wound identified on on & Management ted 10/26/2022 documented sents with a wound on her resent Illness: At the request er, [Name of physician], a assessment and evaluation α . She has a stage 3 acrum for at least 1 days e (LxWxD) (length by width 2 cm (centimeter)[Age and bry) of HIV (human us), DM (diabetes mellitus) wound over old scar tissue, 2) as she has done well with sing Treatment Plan: Leptospermum honey apply s. Secondary Dressing(s): one bdr (border) & faced 0 daysThis patient's care nother health provider r during this visit"						

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	-	D HUMAN SERVICES				FORM	: 01/19/2023 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
			9,	101 BON AIR CROSSING	S DRIVE		
THE LAUF	RELS OF BON AIR		В	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	physician's order sum evidence an order for plan documented in the summary on 10/26/20 The TAR (treatment and R19 dated 10/1/2022- "Cleanse areas to sac cream and a border of Start Date: 09/22/202 TAR documented R19 each evening shift du 2022. On 11/2/2022 at 1:37 conducted with LPN (LPN #3 stated that the was to show the over they were doing for the behaviors and falls. L whole facilities respon care plan. On 11/2/2022 at 3:22 conducted with LPN (unit manager. LPN # assessments were so system and came up administration record the nurse would know stated that staging and were done by the would director of nursing or stated that each morn weekly skin assessme nurses and provided in that R19 had a sacral	Date: 09/22/2022." The imary for R19 failed to the Medihoney treatment ne wound evaluation and 22. dministration record) for 10/31/2022 documented, crum w/ ns, apply protective ressing every evening shift. 2 1500 (3:00 p.m.)." The 9 receiving the treatment ring the month of October p.m., an interview was licensed practical nurse) #3. e purpose of the care plan all care of the resident, what em, document their goals, .PN #3 stated that it was the nsibility for implementing the p.m., an interview was licensed practical nurse) #6, 6 stated that weekly skin heduled in the computer	F 656				

Facility ID: VA0394

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
	495394	B. WING _			11/0	03/2022
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY	STATE, ZIP CODE	-	
THE LAURELS OF BON AIR			9101 BON AIR CROSSI	IGS DRIVE		
THE LAURELS OF BON AIR			BON AIR, VA 23235			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
had been notified of the CNA (certified nursing to them. LPN #6 state with the wound physic back on the list to be that when a new would should write a progree wound, notify the respective and the physician. Linclinical record and state 10/13/2022 was the fifthe wound was identified. On 11/02/2022 at 3:5 made of ASM (admined wound physician and assessment to R19's There were no concere observed. ASM #6 m pressure ulcer as 1.2 by depth) and a stage that R19's sacral pressional gotten smaller. A previously had a would was treated with Med well to it. ASM #6 stares R19's wound with the reason since the initia and would have the streatment. ASM #6 stares the assessment to R19's the area as become a stage 3 pression of the stares of the stares and gotten would have the streatment, the area as become a stage 3 pression with the the terms of the stares of the stare	 at. LPN #6 stated that they he wound reopening by a g assistant) who reported it led that they had spoken cian and had R19 placed followed. LPN #6 stated and was discovered the nurse ss note describing the ponsible party, the resident PN #6 reviewed R19's ated that it appeared that irst time the re-opening of fied. 5 p.m., an observation was istrative staff member) #6, LPN #4 providing care and sacral pressure ulcer. arms with wound care becaured R19's sacral x1.2x0.2 cm (length by width e 3 wound. ASM #6 stated that R19 had and in the same area that lihoney and responded very ated that they were treating e Medihoney again for this al evaluation on 10/26/2022 	F 6	556			

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	-	D HUMAN SERVICES				FORM	0: 01/19/2023
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
			9	101 BON AIR CROSSING	S DRIVE		
THE LAUF	RELS OF BON AIR		В	SON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	wound physician. LP been going with them that the wound physic and completed his wo LPN #4 stated that eve printed out the wound unit manager to review unit manager was res the notes and reviewi if there were any char treatments. LPN #4 st changes to the wound manager changed the treatment. LPN #4 st notes were reviewed morning. LPN #4 st notes were reviewed morning. LPN #4 rev 10/26/2022 written by current physician orde was no order in place stated that there was protective cream and evening shift. LPN #4 have been an order in treatment after the 10 by the wound physicia On 11/03/2022 at 10: conducted with RN (re stated that they comp assessment dated 10 stated that they had for sacrum when they we treatment to the sacra they had documented but had not done any was a treatment alrea that there was a smal at that time. RN #4 st	N #4 stated that they had recently. LPN #4 stated ian came in on Wednesday ound notes after rounding. ery Thursday morning they notes and gave them to the w. LPN #4 stated that the ponsible for going through ing the wound details to see nges to the wound tated that if there were any d treatments the unit e orders to reflect the new ated that all of the wound by someone every Thursday iewed the wound note dated ASM #6 for R19 and the ers and stated that there for the Medihoney. LPN #4 only an active order for the a border dressing every d stated that there should in place for the Medihoney /26/2022 wound evaluation an. 17 a.m., an interview was egistered nurse) #4. RN #4 leted the total body skin /13/2022 for R19. RN #4 bund the area on the ent to do the ordered al area. RN #4 stated that the area as a new wound thing else because there dy in place. RN #4 stated I open area with no bleeding	F 656				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/19/2023 APPROVED 0: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	_	
THE LAUF	ELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	order. RN #4 stated t wound and did not ha place they completed form, called the physic get a treatment order, and wrote a progress they were not sure ho wound physicians list manager was respons On 11/3/2022 at 11:00 conducted with ASM # ASM #2 stated that th was to have a written ASM #2 stated that th implemented by being needed and with any stated that R19's care implemented to provid ordered. On 11/03/2022 at 1:15 conducted with ASM # #5 stated that they ha their pressure ulcer re that they saw R19 on not aware of the sacra point. ASM #5 stated again until after the we examined them. On 11/3/2022 at 4:00 administrator, ASM #2 ASM #4, the regional made aware of the ab	actitioner or call to get an hat if they observe a new ve a treatment order in the change in condition cian or nurse practitioner to notified the unit manager note. RN #4 stated that w residents got on the that they thought the unit sible for that. 0 a.m., an interview was #2, the director of nursing. e purpose of the care plan plan of care for their guests. e care plan was g reviewed quarterly, as significant change. ASM #2 e plan was not being de wound treatment as 5 p.m., an interview was #5, nurse practitioner. ASM d not examined R19 after eopened. ASM #5 stated 10/12/2022 and they were al wound reopening at that that they did not see R19 ound physician had	F 65	5			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION		(X3) DATE	
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Reference: (1) Pressure Ulcer A pressure sore is an down when something against the skin. Press the severity of sympto stage. Stage IV is the painful area on the sk when pressed. This is is forming. The skin m soft. Stage II: The ski sore. The area around irritated. Stage III: The open, sunken hole ca below the skin is dam see body fat in the cra pressure ulcer has be damage to the muscle to tendons and joints. obtained from the well https://medlineplus.go 00740.htm. (2) Medihoney Applying honey prepa- using dressings conta- improve healing. Hom- and pus, help clean the reduce pain, and decr- information was obtain https://medlineplus.go 6. For Resident #13 (It to implement the com- preventions and treatu-	area of the skin that breaks g keeps rubbing or pressing ssure sores are grouped by oms. Stage I is the mildest worst. Stage I: A reddened, in that does not turn white a sign that a pressure ulcer may be warm or cool, firm or in blisters or forms an open d the sore may be red and e skin now develops an lled a crater. The tissue aged. You may be able to ater. Stage IV: The come so deep that there is a and bone, and sometimes This information was osite: w/ency/patientinstructions/0 rrations directly to wounds or ining honey seems to ey seems to reduce odors ne wound, reduce infection, rease time to healing. This	F 656				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 79 F 656 F 656 (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as not having any pressure injuries. The comprehensive care plan dated, 9/21/2022 and revised on 10/6/2022 documented in part, "Need: [R13] is at risk for impaired skin integrity/pressure injury R/T (related to): impaired mobility, gout, recent UTI (urinary tract infection), right hip fracture." The "Interventions" documented in part, "9/21/2022 - Braden scare per protocol. Conduct weekly head to toe skin assessment, document and record abnormal findings to the physician. Cue to reposition self as needed. Follow facility policies/protocols for the prevention/treatment of impaired skin integrity. 10/6/2022 - Observe finer and toes nails on shower days to see if they need to be trimmed. Observe skin with showers/care. Notify nurse immediately of any new areas of skin breakdown. Redness, blisters, bruises, discoloration noted during bath or daily care. Pressure reduction cushion to w/c (wheelchair). Pressure reduction mattress to bed or specialty bed: air mattress, check placement and function every shift. 9/21/2022 - Provide diet as ordered. Observed and document food acceptance and offer substitutes as needed. 10/6/2022 - Provided incontinence care with each incontinent episode and as needed and apply moisture barrier cream/ointment per facility policy/orders. Provide therapy and encourage participation as ordered. 9/21/2022 - Turn/reposition resident during rounds and PRN (as needed)." The comprehensive care plan dated 9/21/2022 and revised on 10/23/2022, documented in part, "[R13] has actual skin impairment to skin integrity

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0394

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PRINTED: 01/19/2023

		D HUMAN SERVICES				FORM): 01/19/2023 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	-	(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	10/20/2022, open are "Interventions" docum Encourage good nutri to promote healthier s supplements as order and treatment of skin abnormalities, failure symptoms) of infectio physician. Treatment order. Turn and repos PRN (as needed). 10, bearing as tolerated). The "Braden Scale fo Risk" dated 9/22/2022 "Scoring: At Risk: 15- documented as havin The "Braden Scale fo Risk" dated 9/29/2022 "Scoring: Moderate R was documented as h There were no further Predicting Pressure S record. The "Nursing Compre 10/5/2022 documente category - no risk. Sc any skin conditions - y Care Plan - [R13] has skin integrity r/t (relate R(right) hip fracture h intact a bandage is or	 //5/2022 fractured right hip, a to sacrum." The nented, " 9/21/2022 - tion and hydration in order skin. Provide dietary red. Observe location, size, injury. Report to heal, s/sx (signs and n, maceration etc. to to skin impairment per sition during rounds and /7/2022 - WBAT (weight r Predicting Pressure Sore 2, documented in part, 18." The resident was g a score of "15." r Predicting Pressure Sore 2, documented in part, isk: 13-14." The resident having a score of "14." * Braden Scale for Sore Risk" in the clinical ehensive Evaluation" dated ed in part, "Section K - Skin - core 0.0. Does resident have yes. Actual Skin breakdown a actual skin impairment to ed to) reddened areaSite: ad surgery, incision dry and n. Buttocks have a dressing d on (their) buttock, it on for 	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 0 FORM AF OMB NO. 09	PPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SUF COMPLET	RVEY
		495394	B. WING			11/03/2	2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
	RELS OF BON AIR			9101 BON AIR CROSSINGS DI	RIVE		
	TELS OF BON AIK			BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA [*] ICIENCY)		(X5) OMPLETION DATE
F 656	Assessment" dated, 1 part, "Turgor - poor el for ethnic group; Tem	0/20/2022, documented in asticity; Skin color - normal perature - warm (normal);	F 656	5			
	New Wounds - 1.	dition - Normal. Enter # of					
		& Wound - Total Body Skin ented between 10/5/2022					
	Review of the nurse's and 10/20/2022, failed documentation related	•					
	documented, "PT (phy writer if she could obs						
	documented in part, "	r's note dated 10/28/2022 R (right) heel - DTI (deep · betadine to heel, monitor.					
	any orders for protect treatments for the fee 10/30/2022, documen placement and function physician order dated "Clean right heel with betadine-soaked gaua (abdominal) and wrap The October TAR (treat record) documented to	t. The physician order dated nted, "Air Mattress, check on qs (every shift)." The l, 10/28/2022, documented, NS (normal saline), apply ze, cover with abd o with Kling every day shift. eatment administration the above order. The mented as having been done					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Observations were mat approximately 1:00 bed, with the head of her back, heel boots i observation was mad R13 was in bed, on he boots in place. Observation was mad 11/1/2022 at 11:39 a.r practical nurse) #4. Th necrotic area on the in the outer aspect of the tissue. LPN #4 applies treatment. The reside back with green puffy An interview was cond 11/2/2022 at 3:11 p.m review her nurse's no a.m. Once reviewed, describe what she saw darkened area on the it. LPN #5 stated she wound. She (unit mar nurse practitioner and When asked the proc new wound, LPN #5 s manager know. Whe measurements of a nurse she was told LPNs co only the wound care nur Did the unit manager stated at that time, sh nurse's station. When a skin assessment on When asked how ofter	ade of R13 on 10/31/2022 p.m. The resident was in the bed elevated, lying on n place. A second e on 11/1/2022 at 8:57 a.m. er back, with their heel le of the R13's right heel on m. with LPN (licensed he right heel had a large nner aspect of the right heel, e heel had deep purple d the physician ordered nt was in their bed on their heel boots on both feet. ducted with LPN #5 on the 10/27/2022 at 9:26 LPN #5 was asked to te of 10/27/2022 at 9:26 LPN #5 was asked to w, LPN #5 stated it was a heel with dead skin around let the unit manager of the hager) would inform the d get treatment orders for it. ess when a resident has a stated she lets the unit	F 65	3			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 83 F 656 daily but if not daily at least three to four times a week. LPN #5 stated 10/27/2022 was the first day she had cared for R13. An interview was conducted with LPN # 6, the unit manager. on 11/2/2022 at 3:37 p.m. When asked what she did when LPN #5 informed her of the wound on R13's heel, did she look at it, did she measure it, where is your documentation, LPN #6 stated, we are not allowed to measure wounds, only an RN (registered nurse) and (name of ASM #6 - wound doctor) can measure. When asked if she notified the RN, LPN #6 stated ASM #3, the assistant director of nursing (ADON), was in a meeting. (Name of ASM #2) the director of nursing was in a meeting. LPN #6 stated she talked about it in clinical meeting. When asked if any RN in the building looked at it, LPN #6 stated she contacted the nurse practitioner, who was not in the building and told her she would see it the next day. LPN #6 further stated, she asked LPN #4 to look at it, and she looked at it on the 27th (10/27/2022) and treatment was not initiated until the 28th. When asked to explain the process when a staff person finds an unusual skin observation, LPN #6 stated it is reported to the nurse practitioner, the RP (responsible party), the unit manager, and the ADON. The nurse practitioner gives an order to refer to (name of wound doctor). If she doesn't refer to wound doctor, them she puts a treatment in place. Had LPN #6 read LPN #5's nurse's note of 10/27/2022 and the TAR for October. When asked where a treatment was put in place on 10/27/2022, LPN #6 stated LPN #5 told me she put a treatment in place. I was at home. When I spoke with nurse practitioner, she told me she would see it in the morning. LPN #6 restated only an RN and (name of wound care doctor) cam

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0394

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PRINTED: 01/19/2023

-					FORM	: 01/19/2023 APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY
	495394	B. WING		_	11/0	03/2022
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
		9	101 BON AIR CROSSING	S DRIVE		
KELS OF BON AIR		1	BON AIR, VA 23235			
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BI		(X5) COMPLETION DATE
Continued From page	84	F 656				
the staff were elevatin	g R13's heels, LPN #6					
director of nursing, on When asked the purp #2 stated it is to have	11/3/2022 at 11:11 a.m. ose of the care plan, ASM a written plan of care for					
nurse practitioner, on When asked if she loo #5 stated usually if I a mostly on recertification aware of the heel on F the afternoon the day nurse to but skin prep ASM #5 was asked to she saw it on 10/28/20 heel was intact. The r necrotic, more pressue black. When asked if when she saw it, ASM necrosis nor drainage on 11/1/2022 and saw starting to peel off. W at R13's skin prior to she had not looked at ASM #5 stated R13 d them to put the boots on When asked if R13 ha went to look at the he stated R13 did not ha socks were on. ASM #	11/3/2022 at 12:57 p.m. oks at resident's skin, ASM m told there is a problem, ons. When were you made R13, ASM #5 stated late in before I saw it. I told the on it until the next day. describe the wound when 022, ASM #5 stated the left ight heel was black, not re, it was a deep purple to it had any necrotic tissue 1 #5 stated there was no . ASM #5 stated she saw it y some necrosis that was hen asked if she had looked 10/28/2022, ASM #5 stated the leg until they told me to. idn't want to move. I told on her on Friday to ensure while she was in bed. at the boots on when she el on 10/28/2022, ASM #5 ve the boots on, only her #5 stated she told the nurse					
	S FOR MEDICARE & M DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RELS OF BON AIR SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page measure wounds in th the staff were elevatin stated R13 had elevat An interview was cond director of nursing, on When asked the purp #2 stated it is to have each guest. When ask ASM #2 stated, yes. An interview was cond nurse practitioner, on When asked if she loo #5 stated usually if I a mostly on recertificatio aware of the heel on F the afternoon the day nurse to but skin prep ASM #5 was asked to she saw it on 10/28/20 heel was intact. The ri necrotic, more pressu black. When asked if when she saw it, ASM necrosis nor drainage on 11/1/2022 and saw starting to peel off. Wi at R13's skin prior to she had not looked at ASM #5 stated R13 di them to put the boots they had the boots on When asked if R13 ha went to look at the hea stated R13 did not har socks were on. ASM # to get those boots put	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 495394 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 84 measure wounds in this facility. When asked if the staff were elevating R13's heels, LPN #6 stated R13 had elevating boots. An interview was conducted with ASM #2, the director of nursing, on 11/3/2022 at 11:11 a.m. When asked the purpose of the care plan, ASM #2 stated it is to have a written plan of care for each guest. When asked if it should be followed,	S FOR MEDICARE & MEDICAID SERVICES DE DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLI A BUILDING. 495394 B. WING	S FOR MEDICARE & MEDICAID SERVICES SF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING GROMDER OR SUPPLIER 495394 B. WING RELS OF BON AIR STREET ADDRESS, CITY, S 9101 BON AIR CROSSING BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG Continued From page 84 measure wounds in this facility. When asked if the staff were elevating R13's heels, LPN #6 stated R13 had elevating boots. F 656 An interview was conducted with ASM #2, the director of nursing, on 11/3/2022 at 11:11 a.m. When asked if its houks at resident's skin, ASM #2 stated it is to have a written pian of care for each guest. When asked if it should be followed, ASM #2 stated, yes. ASM #5 stated hat hein the afternoon the day before I saw it. I told the nurse practifications. When were you made aware of the heel on R13, ASM #5 stated thate in the afternoon the day before I saw it. I told the nurse to but skin prep on it until the next day. ASM #5 stated to describe the wound when she saw it on 10/28/2022. ASM #5 stated the left heel was intact. The right heel was black, not necrosis nor drainage. ASM #5 stated the teft heel was intact. The right heel was black, not necrosis nor drainage. ASM #5 stated the teft heel was intact. The right heel was black, not necrosis nor drainage. ASM #5 stated the left heel was intact. The right heel was black was starting to peel off. When asked if she had looked at R13's sking PC/2022. ASM #5 stated she saw it on 111/12022 and saw some necrosis that was starting to peel off. When asked if she had looked at R13's sking he	MENT OF HEALTH AND HUMAN SERVICES SP COR MEDICARE & MEDICAD SERVICES SP COR MEDICARE & MEDICAD SERVICES PERCENT (21) PROVIDENCEPUTRICLA DENTIFICATION NUMBER: 495394 ROWDER OR SUPPLER RELS OF BON AIR STREET ADDRESS, CITY, STATE, ZP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 22325 SUMMARY STATEMENT OF DEFICIENCIS (REC) TERMENT OF NUMBER RELS OF BON AIR SEQUENTIAL Y AND RECORDER INAN OF CORRECTION (REC) CONTRECT AND REPORTED BY FULL (REC) CONTRECT AND REPORTED BY FULL (REC) CONTRECT THE APPORTUNE (REC) CO	MENT OF HEALTH AND HUMAN SERVICES OMB NO SFOR MEDICARE & MEDICALD SERVICES OMB NO SFOR MEDICARE & MEDICALD SERVICES OMB NO SFORMEDICARE & MEDICALD SERVICES OMB NO PERCENCIS CORRECTION (1) PROVIDER SUPPLIER 495394 B. WINO (2) MULTIPLE CONSTRUCTION A BULDING 495394 B. WINO (2) MULTIPLE CONSTRUCTION A BULDING ERELS OF BON AIR RELS OF BON AIR RELS OF BON AIR RELS OF BON AIR RELS OF BON AIR CORRECTIVE WINST BE FRECEDED BY FULL RECOURDER OR SUPPLIER (EACH DEFICIENCY WIST BE FRECEDED BY FULL RECOURDER OR USENTLY WIST BE FRECEDED BY TO BY AND THE SENTLY WIST BE FRECEDED BY TO BY AND THE SHORE WIST AND WIST BE RECOURDER OF THE APPROPRIATE DEFICENCY When asked if the SAID WIST BY THE AND WIST BE AND THE AS WIST AND WIST BE AND THE AS WIST AND AS AND AS STATED AS WIST AND AS AND AS STATED AS WIST AND AS AND AS AND AS AND AS STATED AS AND AS AND AS AN

Facility ID: VA0394

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	-	D HUMAN SERVICES				FORM): 01/19/2023 / APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				<u>OMB NC</u>	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495394	B. WING		_	11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSINGS ON AIR, VA 23235	S DRIVE		
							0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	85	F 656				
	the regional clinical co aware of the above co p.m.	rator, ASM #2, and ASM #4, pordinator, were made oncern on 11/3/2022 at 4:30					
	Care Plan Timing and CFR(s): 483.21(b)(2)(F 657				12/18/22
	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the r An explanation must I medical record if the p and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determindor or as requested by the (iii)Reviewed and revit team after each assess comprehensive and q assessments.	orehensive care plan must days after completion of seessment. erdisciplinary team, that ited to rsician. with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ned by the resident's needs e resident. sed by the interdisciplinary ssment, including both the					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORI	D: 01/19/2023 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495394	B. WING _			11	/03/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
				91	101 BON AIR CROSSINGS DRIVE		
THE LAUF	RELS OF BON AIR			В	ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From page by: Based on observation	. 86 n, staff interview, facility	F	657	Criteria 1		
	document review, clin the course of a compl determined the facility revise the comprehen residents in the surve	ical record review, and in aint investigation, it was v staff failed to review and sive care plan for two of 52 y sample, Resident #160			Resident #23 had his care plan upda with O2 and order obtained for O2. Resident # 160 was discharged from facility prior to survey.		
	and Resident #23. The findings include:				Criteria 2 All current residents have the potent be affected by the alleged deficient practice.	al to	
	review and revise the after four falls. On the most recent M assessment, a signific	the facility staff failed to comprehensive care plan DS (minimum data set) cant change assessment, eference date of 7/27/2021,			Criteria 3 MDS nurses were re-inserviced on updating care plans from the regiona MDS nurse. Licensed nurses were re-inserviced on the requirement of obtaining an order prior to the	I	
	(brief interview for me the resident was seve making daily decision Status, R160 was coo assistance of two or n her activities of daily I Conditions, the reside	4 out of 15 on the BIMS ntal status) score, indicating rely cognitively impaired for s. In Section G - Functional led as requiring extensive nore staff members for all of iving. In Section J - Health ent was coded as having had y during the lookback period.			administration of oxygen. Criteria 4 DON/Designee will conduct audit on plan updates and oxygen order audit week for four weeks, weekly x4 and monthly x1. These results will be forwarded to the QAPI committee for review. The committee will determine need for further audits and/or action	s 3 x	
	fall related injury and abnormality of gait, ce anxiety, depression, u mediations, takes Me "Goal" documented, " related to falls through "Interventions" docum meds (medications) a	Need: [R160] is at risk for falls R/T (related to)					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 01/19/2023 APPROVED 0: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING		_	11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	RELS OF BON AIR		9	101 BON AIR CROSSING	S DRIVE		
			E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	level for falls on admis Complete fall risk per resident unattended in resident to wear non-s bed. Encourage resid footwear as needed. If Keep resident's enviro with: even floors free adequate lighting, call commonly used items repositioning furniture appropriate position. If diagnostics as ordere wheelchair prior to tra- ineffectiveness and si drug use, report abno physician. Observe re- related to: anti-depress increases the risk for activities that minimize providing diversion and (physical therapy/occu and treat as ordered F light within reach and assistance as needed for hydrocodone and / Re: (regarding) wheel Review of the clinical had 10 falls between their death on 7/28/20 following dates: 2/10/2 2/25/2021, 3/8/2021, 4 6/22/2021, 6/24/2021	ssion and as needed. protocol. Do no leave n bathroom. Encourage skid foot ware when out of ent to wear appropriate Follow facility fall protocol. onment as safe as possible from spills and/or clutter; I light within reach, within reach, avoid and keep the bed in the Labs (laboratory test) and d. Lock wheels on nsfers. Observe for de effects R/T psychotropic rmal findings to the esident for side effects asant medication that falls. Provide [R160] with e the potential for falls while id distraction. PT/OT upational therapy) evaluate PRN. Put the resident's call encourage her to use it for l. Request dose reduction Ativan. will educate guest chair safety and reaching. record revealed R160 had 10/14/2020 and the time of 21. The falls were on the 2021, 2/12/2021, 2/23/2021, 4/19/2021, 6/4/2021, and 7/13/2021.	F 657				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	RELS OF BON AIR		-	101 BON AIR CROSSING	S DRIVE		
			E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	An interview was cond (administrative staff m nursing, on 11/3/2022 about the above dates ASM #2 stated for 6/2	, 6/22/2021, and 2/23/2021.	F 657				
	found on the fall mat, because the resident of 2/23/2021 and 6/24 was definitely no new When asked the proc falls, ASM, #2 stated resident, write an incir fall assessment, notify party. The nurse then on the care plan. The are reviewed in clinica	then the goal was met had no injury. For the falls l/2021, ASM #2 stated there interventions put in place. ess for when a resident					
	part, "Every resident i person-centered Plan implemented that is corrights, based on the co that includes measura frames to meet a resid mental and psychoso comprehensive assess interdisciplinary team, interdisciplinary assess develop, review and r comprehensive care p ASM #1, the administ the regional clinical co	ssments will be used to evise the resident's					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495394	B. WING			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAUF	RELS OF BON AIR				9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From page p.m.	÷ 89	F	657			
	No further information	n was provided prior to exit.					
		R23), the facility staff failed for the administration of					
	the most recent MDS admission assessmen reference date) of 10/ being moderately cog daily decisions, havin the BIMS (brief intervi resident was coded a	the facility on 10/5/22. On (minimum data set), an nt with an ARD (assessment /11/22, R23 was coded as initively impaired for making g scored seven out of 15 on iew for mental status. The s having received oxygen the facility, but not since ity.					
	in bed, with oxygen b cannula at a rate of 1	s and times, R23 was lying eing delivered by nasal .5 lpm (liters per minute) by ncentrator: 10/31/22 at 8:42 3:45 a.m.					
	A review of R23's phy evidence of an order	vsician's orders revealed no for oxygen.					
	A review of R23's care revealed no information use of oxygen.	e plan dated 10/5/22 on related to the resident's					
	#1, the MDS coordina stated she initiates re admission. She stated of information to deve	d she uses multiple sources elop the care plan, including , physician's orders, ADL					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/	03/2022
NAME OF PROVID	DER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE LAURELS	S OF BON AIR			101 BON AIR CROSSINGS ON AIR, VA 23235	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677 SS=D F 677 SS=D F 677 F 677 F 677 SS=D F 677 F 6	viewing R23's care j thing about oxygen are wasn't an order. ceiving oxygen whe e facility, and the ox ded since admissio a 11/2/22 at 3:55 p.r ff member) #1, the ector of nursing, an nical coordinator, we neerns. further information PL Care Provided fo (R(s): 483.24(a)(2) 83.24(a)(2) A reside t activities of daily li rvices to maintain g rsonal and oral hyg is REQUIREMENT ased on staff intervi- view, clinical record complaint investigat ovide ADL (activities pendent residents fi rvey sample, Reside t findings include: r Resident #162 (R provide a shower on 27/2022, and 7/7/20	ion for each resident. After plan, she stated: "There's . I must have missed it, or " She stated R23 was not n he was first admitted to ygen must have been n. m., ASM (administrative administrator, ASM #2, the d ASM #4, the regional ere informed of these was provided prior to exit. r Dependent Residents ent who is unable to carry ving receives the necessary ood nutrition, grooming, and iene; is not met as evidenced ew, facility document review and in the course of ion, the facility staff failed to a of daily living) care to or one of 52 residents in the ent #162.	F 657	Criteria 1	s discharged from the ey. ents have the potent e same deficient		12/18/22

Event ID: 33UH11

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 677 Continued From page 91 F 677 admission assessment with an ARD (assessment Criteria 4 DON and/or designee will complete reference date) of 6/29/2022, the resident scored 4 out of 15 on the BIMS (brief interview for mental shower audits three/week x four weeks, status), indicating the resident was severely weekly for four weeks and monthly x 1 impaired for making daily decisions. Section G month. These results will be forwarded to documented R162 requiring extensive assistance the QAPI committee for review. The of one person for personal hygiene and bathing committee will determine the need for not occurring during the 7 day assessment further audits and/or action. period. Review of the ADL (activities of daily living) documentation for R162 dated 6/1/2022-6/30/2022 documented in part, "Shower/Bath." It documented the shower or bath scheduled on day shift 6/23/2022, 6/27/2022 and 6/30/2022. A shower or bath was documented as given on 6/30/2022. The documentation failed to evidence a shower or bath provided on 6/23/2022 or 6/27/2022. Review of the ADL documentation for R162 dated 7/1/2022-7/31/2022 documented in part. "Shower/Bath." It documented the shower or bath scheduled on day shift 7/4/2022, and 7/7/2022. A shower or bath was documented as given on 7/4/2022. The documentation failed to evidence a shower or bath provided on 7/7/2022. The comprehensive care plan for R162 documented in part, "[R162] has an ADL Self Care Performance Deficit and requires assistance with ADL's and mobility r/t (related to): Hip fracture left hip with hemiarthroplasty, Limited Mobility, Pain, bilateral superior and inferior pubic fractures. Date Initiated: 06/23/2022. Revision on: 07/20/2022." Under "Interventions" it documented in part, "...Provide Resident with a sponge bath when a full bath or shower cannot be tolerated. Date Initiated: 06/23/2022. Offer a

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
		495394	B. WING _			_	11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS	S DRIVE		
				B	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	92	F 6	77				
	tub bath or shower tw (as needed). Date Init	o times per week and prn iated: 06/23/2022"						
	conducted with CNA (#8. CNA #8 stated th a week and document they were given or ref a resident refused the reported it to the nurs later in the shift. CNA care they provided to documented in the co was done. CNA #8 st documentation then it not done because you you do. The facility policy, "Ro last revised 6/16/2021 "Guests/residents rec assistance to maintain personal/oral hygiene and/or shampoos are person centered care [sic]; bed linens are cl Additional showers ar requestedIncontinent according to each gue On 11/3/2022 at 4:00	mputer to evidence that it rated that if there was no meant that the work was a have to document what butine Guest/Resident Care" documented in part, eive the necessary n good grooming and Showers, tub baths, scheduled according to or state specific guideliens hanged at this time.						
	clinical coordinator we above concern.	d ASM #4, the regional ere made aware of the						
	No further information	was presented prior to exit.						
	Complaint deficiency.							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Quality of Care F 684 12/18/22 SS=E CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced bv: Based on staff interview, facility document Criteria 1 review, clinical record review and in the course of Residents # 162 and # 2 were discharged a complaint investigation, the facility staff failed to from the facility prior to survey. follow professional standards of care for quality resident care for two of 52 residents in the survey Criteria 2 sample, Resident #162 and Resident #2. All residents with labs and antibiotics have the potential to be affected by the alleged The findings include: deficient practice. A lab audit and MAR audit will be conducted to ensure timely 1. For Resident #162 (R162), the facility staff notification of critical labs and timely failed to timely act upon critical lab results physician notification of missed reported to the facility on 7/8/2022. antibiotics. On the most recent MDS (minimum data set), an Criteria 3 admission assessment with an ARD (assessment Licensed nurses were reeducated on stat reference date) of 6/29/2022, the resident scored critical labs and RP physician notification 4 out of 15 on the BIMS (brief interview for mental of labs. Licensed nurses were reeducated status), indicating the resident was severely on physician notification of medications impaired for making daily decisions. Section I not given. documented R162 having an active diagnosis of anemia. Section O documented R162 receiving Criteria 4 transfusions while not a resident of the facility and DON/Designee will audit critical labs and within the last 14 days. medications not given M-F for4 weeks, weekly x 4 and monthly x1. The results of the audits will be forwarded to the QAPI The physician orders for R162 documented in committee for review. The QAPI part,

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 94 F 684 - "CBC (complete blood count) with diff committee will determine need for further (differential) and BMP (basic metabolic panel) in actions or audits. the next 3 days one time only for anemia for 3 days. Order Date: 07/07/2022." The progress notes documented in part. - "6/24/2022 12:56 (12:56 a.m.) Physician Note. ...[R162] was admitted to [Name of hospital] on 6/18/2022 following ground-level fall. [R162] was found to have a left femoral neck fracture and underwent a left hip hemiarthroplasty. [R162] required 1 unit of packed red cells transfusion ... " - "7/7/2022 18:49 (6:49 p.m.) Nurses Notes. Note Text: Patient and family requesting labs due to patient's history of anemia. Practitioner notified and new order received. Husband, [Name of husband] made aware." - "7/9/2022 08:35 (8:35 a.m.) Nurses Notes. Note Text: daughter [Name of daughter] called looking for results on labs, ... HEMOGLOBIN 5.8 g/dL (grams per deciliter) (R162's test result); 12.0-16.0 (normal range); LL (Critical Low) Final... CALL TO PRIMARY : [Name of physician] reported results awaiting orders." - "7/9/2022 09:06 (9:06 a.m.) Nurses Notes. Late Entry: Note Text: Guest is going to the ER (emergency room) due to critical labs, Hemoglobin was elevated. Daughter requested for [R162] to be sent to [Name of hospital]. Patient was pale in color did not complain of any pain. Will continue to monitor." The laboratory report included in R162's electronic medical record documented a basic metabolic panel and a complete blood count with differential collected on 7/8/2022 at 01:46 (1:46 a.m.), received on 7/8/2022 at 07:25 (7:25 a.m.) and reported on 7/8/2022 at 17:08 (5:08 p.m.). The report documented the critical low

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING _			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				91	01 BON AIR CROSSINGS DRIVE		
THE LAUP	RELS OF BON AIR			в	ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Hemoglobin of 5.8 g/c a red stop sign at the information/Flag. The the red stop sign mea critical results (results) On 11/2/2022 at 8:08 conducted with ASM as stated that critical lab facility by the lab to the that the nurses called practitioner on call reg stated that they did no them about critical lab stated that they did or On 11/2/2022 at appro (administrative staff m nursing stated that the nurse) who obtained the daughter called for the worked at the facility as interviewed. ASM #2 sent R162 to the eme was not working and contact them. Attemp LPN with no answer as On 11/2/2022 at 2:57 conducted with RN (re stated that they had s member when they re done due to their histo RN #3 stated that the physician and relayed and received an order #3 stated that the lab stat (right away) but of	dl highlighted in red text and top of the report under Lab e report legend documented ining the "report contains is with red text)." a.m., an interview was #7, medical doctor. ASM #7 results were called to the ise nurse. ASM #7 stated the physician or nurse garding the labs. ASM #7 ot recall staff contacting os but the documentation in 7/9/2022. oximately 10:40 a.m., ASM nember) #2, the director of e LPN (licensed practical the lab results after the em on 7/9/2022 no longer and could not be stated that the LPN who rgency room on 7/9/2022 provided a phone number to ots were made to reach the and the voice mail full. p.m., an interview was egistered nurse) #3. RN #3 poken with R162's family equested to have lab work ory of anemia on 7/7/2022.	F 6	884			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
				9	101 BON AIR CROSSING	S DRIVE		
THE LAU	RELS OF BON AIR			в	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	RN #3 stated that the for blood work which a in the morning to draw that the lab called the nurse with any critical that when the nurse re over the telephone fro the lab value with the notify the physician or the responsible party the medical record. On 11/3/2022 at 8:11 conducted with LPN (LPN #7 stated that an facility to draw the blo LPN #7 stated that the each nurses station d needed obtaining that LPN #7 stated that the member with verifying date of birth as needed routine lab work was of the order was placed. were any critical lab re facility and notified the doctor or the nurse pr On 11/3/2022 at 11:00 conducted with ASM a ASM #2 stated that the call from the nurse on that R162's daughter were labs drawn and called to the physiciar had been informed of advised the nurse to s	022 and drawn the next day. y contracted an outside lab sent a phlebotomist in early v the blood. RN #3 stated facility and spoke to the lab results. RN #3 stated eceived critical lab results om the lab they should verify lab, obtain their name, nurse practitioner, notify and document everything in a.m., an interview was licensed practical nurse) #7. outside lab came to the od early on the night shift. ere was a lab book kept at ocumenting what lab work the lab staff member used. e nurse assisted the lab g the resident name and ed. LPN #7 stated that the drawn the next draw after LPN #7 stated that if there esults that the lab called the e nurse who called the	F	584				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	investigated and disco been drawn the day b day around 5:00 p.m. had found out that a r ADON (assistant direct lab result on 7/8/2022 practitioner was not n they had educated the regarding prompt phy lab results and complet to ensure that all result the physician and/or t On 11/3/2022 at 12:23 conducted with LPN # critical lab results wer nurse. LPN #8 stated to be called to the physic on 11/3/2022 at 12:23 conducted with RN #2 called any critical result nurse. RN #2 stated be called to the physic On 11/3/2022 at 3:26 they were unable to fi education that they ha notification of critical I On 11/3/2022 at 4:00 administrator, ASM #2 ASM #4, the regional made aware of the ab	SM #2 stated that they had beered that the labwork had before and resulted the same ASM #2 stated that they nurse had notified the former ctor of nursing) of the critical and the physician or nurse otified. ASM #2 stated that a nurses on the units sician notification of critical eted a 30 day audit of labs lits had been reviewed by he nurse practitioner. B p.m., an interview was 48. LPN #8 stated that e called to the facility to the t that any critical labs were visician immediately. 7 p.m., an interview was 2. RN #2 stated that the lab ults to the facility to the that the critical labs should cian immediately. p.m., ASM #2 stated that nd evidence of the ad completed regarding the ab results. p.m., ASM #1, the 2, the director of nursing and clinical coordinator were hove concern.	F 684				

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	-	D HUMAN SERVICES				FORM	: 01/19/2023
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE	
		495394	B. WING			11/0	3/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSINGS I 30N AIR, VA 23235	DRIVE		
			I	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	2LAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	 For (R2), the facilitic ceftriaxone [1] per phy 10/27/2022, 10/28/20, 11/01/2022 and 11/02 administer vancomyci 10/19/2022 and 10/28 orders. On the most recent M admission assessmer reference date) of 09/scored 9 (nine) out of interview for mental s moderately impaired of decisions. The physician's order part, "Ceftriaxone Sodium 3 (one GM (gram). Injeevery 12 hours for infestart Date: 10/27/2022." "Ceftriaxone Sodium 4 (one GM (gram). Injeevery 12 hours for infestart Date: 10/27/2022." "Ceftriaxone Sodium 4 (one GM (gram). Injeevery 12 hours for infestart Date: 10/28/202 "Vancomycin HCL (hy MG/ML (milligram/millevery 6 (six) hours for Date: 10/15/2022." The comprehensive of 10/27/2022 document risk for discomfort for receives Antibiotic The infection CDiff. Vanco Ceftriaxone until 11/2/ 	ty staff failed to administer ysician's orders on 22 and 10/31/2022, //2022 and failed to in [2] on 10/18/2022, 8/2022 per physician's DS (minimum data set), an nt with an ARD (assessment 20/2022, the resident 15 on the BIMS (brief tatus), indicating (R2) was of cognition for making daily s for (R2) documented in Solution Reconstituted 1 ct 1 gram intramuscularly ection for 5 (five) days. 2. D/C (discontinue) Date: Solution Reconstituted 1 ct 1 gram intramuscularly ection for 5 (five) days. 2. D/C (discontinue) Date: Solution Reconstituted 1 ct 1 gram intramuscularly ection for 5 (five) days. 2." rdrochloride) Solution 50 liliter). Give 5 ml by mouth t c-diff (3) for 14 days. Start are plan for (R2) dated ted in part, "Need. (R2) is at adverse side effects: erapy r/t (related to) for mycin 10/27/2022,	F 684				

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE LAUF	ELS OF BON AIR			101 BON AIR CROSSING	S DRIVE		
				ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	99	F 684				
	in part, "Administer m initiated: 10/18/2022."	edications as ordered. Date					
	record] dated October the physician's orders ceftriaxone, the eMAF documented on 10/27 on 10/28/2022 at 9:00 documented on 10/31 vancomycin, the eMA documented on 10/18 five documented on 1 at 6:00 p.m., and a bit	e medication administration r 2022 for (R2) documented as as stated above. For R revealed a number five 7/2022 at 9:00 p.m., a blank a.m. and an "X" /2022 at 9:00 p.m. For the R revealed a number five 8/2022 at 6:00 p.m., number 0/19/2022 at 12:00 p.m. and ank on 10/28/2022 at 12:00 of the eMAR revealed a					
		ted in part, "Chart Codes / Hold/See Nurse's Notes."					
	to evidence documen						
	documentation for cef 10/27/2022 at 9:00 p. being held on 10/18/2 10/19/2022 at 12:00 p Further review of the evidence documentat ceftriaxone on 10/28/2 "X" on 10/31/2022 at 10/28/2022 at 12:00 p The nurse's "Progress	o.m. and at 6:00 p.m. progress notes failed to ion regarding the blanks for 2022 at 9:00 a.m. and the 9:000 p.m. and the blank on o.m. for vancomycin. s Notes" dated 11/01/2022					
	-	or (R2) failed to evidence eftriaxone was administered /02/2022.					

If continuation sheet Page 100 of 196

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	: 100	F 684				
	(R2's) October and Na progress notes dated (R2) did not receive th according to the phys On 11/03/2022 at app interview was conduc practical nurse) # 4. // progress notes for (R2 10/28/2022, 10/31/20 and on 10/28/2022, 1 LPN # 4 stated that the that the physician was was not administered and 10/31/2022, 11/0 vancomycin was not a 10/19/2022 and on 10 the physician's order administration of ceftr LPN # 4 stated no. On 11/03/2022 at app (administrative staff m ASM # 2, director of m regional clinical coord the above findings. No further information References: (1) Used to treat certa bacteria such as gond transmitted disease),	(administrative staff of nursing. After reviewing ovember eMAR, and above ASM # 2 stated that he medications listed above ician's orders. roximately 3:20 p.m., an ted with LPN (licensed After reviewing the nursing 2) dated 10/27/2022, 22, 10/18/2022, 10/19/2022 1/01/2022 and 11/02/2022, nere was no documentation is notified that ceftriaxone on 10/27/2022, 10/28/2022 1/2022 and 11/02/2022 and administered on 10/18/2022, 0/28/2022. When asked if was followed for the iaxone and vancomycin roximately 4:02 p.m., ASM hember) # 1, administrator, nursing and ASM # 4, inator were made aware of in was provided prior to exit.					

Event ID: 33UH11

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			11/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAURELS OF BON AIR					9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	membranes that surro cord), and infections of urinary tract, blood, but This information was https://medlineplus.go tml. (2) Used to treat coliti intestine caused by co occur after antibiotic t was obtained from the https://medlineplus.go tml.	meningitis (infection of the bund the brain and spinal of the lungs, ears, skin, ones, joints, and abdomen. obtained from the website: ov/druginfo/meds/a685032.h s (inflammation of the ertain bacteria) that may reatment. This information	F	684			
F 686 SS=D	serious intestinal cond Symptoms include wa bowel movements per fever, loss of appetite tenderness. This infor the website: https: https://medlineplus.go s.html. Treatment/Svcs to Pro CFR(s): 483.25(b)(1)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the individemonstrates that the (ii) A resident with pre	ditions such as colitis. atery diarrhea (at least three r day for two or more days), , nausea, abdominal pain or rmation was obtained from ov/clostridiumdifficileinfection event/Heal Pressure Ulcer (i)(ii) rity re ulcers. hensive assessment of a just ensure that- is care, consistent with is of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and	F	686			12/18/22

Facility ID: VA0394

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 686 Continued From page 102 F 686 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation. staff interview. facility Criteria 1 document review and clinical record review, it Resident #162 was discharged from the was determined the facility staff failed to provide facility prior to survey. Resident #13 and care and services for the assessment and resident #19 remain in the facility. All treatment of pressure injuries for three of 52 wounds have been assessed, measured residents in the survey sample, Residents #13, and the guests are receiving treatments #19, and #162. as ordered by their physician. The findings include: Criteria 2 All residents with wounds have the 1. For Resident #13 (R13) the facility staff failed potential to be affected by the alleged to complete a full wound assessment of a newly deficient practice. A skin sweep of the identified wound DTI (deep tissue injury (2)) once facility has been conducted and all identified. The wound was not measured until six wounds are properly assessed, days after its discovery. measured, and receiving treatment. On the most recent MDS (minimum data set) Criteria 3 assessment, an admission assessment, with an Licensed nurses will be re-educated on assessment reference date of 10/11/2022, the the Skin Management program, change of resident scored a zero out of 15 on the BIMS condition, and hysician notification policy. (brief interview for mental status) score, indicating The wound MD conducted an in-service the resident was severely cognitively impaired for on measuring and describing wounds for making daily decisions. In Section M - Skin the licensed nurses. Conditions, the resident was coded as not having any pressure injuries. Criteria 4 Director of Nursing and/or designee will R13 was readmitted to the facility on 10/5/2022 conduct an audit of the requirements of after a fractured hip repair. the Skin Management Program three times per week x 4 weeks, weekly x 4 The "Nursing Comprehensive Evaluation" dated weeks, then monthly x 1 month. These 10/5/2022 documented in part, "Section K - Skin results will be forwarded to the QAPI category - no risk. Score 0.0. Does resident have committee for review. The committee will any skin conditions - yes. Actual Skin breakdown determine the need for further audits Care Plan - [R13] has actual skin impairment to and/or action.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: VA0394

PRINTED: 01/19/2023

		D HUMAN SERVICES				FORM): 01/19/2023 APPROVED		
· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495394	B. WING			11/03/2022			
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE				
THE LAU	RELS OF BON AIR			101 BON AIR CROSSING 30N AIR, VA 23235	S DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 686	skin integrity r/t (relate R(right) hip fracture h intact a bandage is or on but no open wound precaution." The "Skin & Wound - Assessment" dated, 1 part, "Turgor - poor el for ethnic group; Tem Moisture - moist; Con New Wounds - 1. There were no "Skin & Assessments" docum and 10/20/2022. Review of the nurse's and 10/20/2022, failed documentation related The nurse's note date documented in part, " to top of sacrum. No h practitioner) made aw (ointment) to the area made aware of new o The nurse's note date documented, "PT (ph writer if she could obs heel, noted lg (large) no drainage noted, sk edematous, tender to The nurse practitioner	ed to) reddened areaSite: ad surgery, incision dry and h. Buttocks have a dressing d on (their) buttock, it on for Total Body Skin 0/20/2022, documented in asticity; Skin color - normal perature - warm (normal); dition - Normal. Enter # of & Wound - Total Body Skin ented between 10/5/2022 notes between 10/5/2022 d to evidence any d to the skin. ed 10/20/2022 at 3:22 p.m. Resident has an open area bleeding noted. NP (nurse rare. New order for A&D . RP (responsible party) rdered." ed 10/27/2022 at 9:26 a.m. ysical therapy) asked this serve this guest rt (right) darken harden purple area, in prepped, ankle	F 686						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495394	B. WING			_	11/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			<	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	586				

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE			
		495394	B. WING				11/03/2022		
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, S	TATE, ZIP CODE			
THE LAUR	ELS OF BON AIR				101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	administration record) order. The treatment v been done on 10/29/2 The wound physician documented in part, " Unstageable (3) (due full thickness. Etiology unstageable necrosis day; wound size - 8.2 exudate - light serosa black necrotic tissue (tissues - 50%. An add was documented on 1 documented, "Yester time I had seen this p Given the wound's ap combination of DTI a is my opinion that this days old, but not olde portion was still soft a half was evolving, sta completely dried out/r The physical therapy to evidence document right heel. Review of the notes dated, 10/27/20 documentation of the Observations were ma at approximately 1:00 bed, with the head of her back, heel boots i observation was made R13 was in bed, on her	The October TAR (treatment of documented the above was documented as having 2022 through 10/31/2022. notes dated, 11/2/2022, Focused Wound Exam: to necrosis) of the right heel / - pressure; MDS stage - ; duration > (greater than) 1 x 11.1 x 0.1 (centimeters); nguinous; thick adherent eschar) - 50%; other visible lendum to the above note 11/3/2022. The addendum day, 11/2/2022, was the first atient and her wound. pearance, being a and newly forming eschar, it wound is at least three r than one week. The DTI nd pliable and the eschar rting to harden, but not nature." notes for 10/27/2022 failed tation of the wound on the he occupational therapy 22, failed to evidence wound on the right heel. ade of R13 on 10/31/2022 p.m. The resident was in the bed elevated, lying on	F 6	86		DEFICIENCY)			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495394	B. WING			11/03/2022		
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE			
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Observation was made 11/1/2022 at 11:39 a.r practical nurse) #4. The necrotic area on the in the outer aspect of the tissue. LPN #4 appliet treatment. The reside back with green puffy An interview was cond (administrative staff m doctor, on 11/2/2022 at he had not seen this m facility was on 10/26/2 An interview was cond 11/2/2022 at 3:11 p.m review her nurse's no a.m. Once reviewed, describe what she saw darkened area on the it. LPN #5 stated she wound. She (unit mar nurse practitioner and When asked the proc new wound, LPN #5 st manager know. Whe measurements of a nu- she was told LPNs co- only the wound care nu- bid the unit manager stated at that time, sh nurse's station. When a skin assessment on When asked how ofter done, LPN #5 stated at daily but if not daily at	le of the R13's right heel on m. with LPN (licensed he right heel had a large nner aspect of the right heel, e heel had deep purple d the physician ordered nt was in their bed on their heel boots on both feet. ducted with ASM nember) #6, the wound at 1:34 p.m. ASM #6 stated resident. His last visit to the 2022. ducted with LPN #5 on n. LPN #5 was asked to te of 10/27/2022 at 9:26 LPN #5 was asked to w, LPN #5 stated it was a heel with dead skin around let the unit manager of the nager) would inform the I get treatment orders for it. ess when a resident has a stated she lets the unit	F 686					

Facility ID: VA0394

If continuation sheet Page 107 of 196

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023 APPROVED . 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
495394			B. WING		_	11/03/2022				
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	ATE, ZIP CODE					
			9101 BON AIR CROSSINGS DRIVE							
THE LAURELS OF BON AIR				BON AIR, VA 23235						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
F 686	Continued From page she had cared for R13 An interview was con		F 68	6						
	member) #8, the occu worked with R13 on 1 how often she was pr	upational therapist who 0/27/2022. When asked oviding therapy to R13, ximately two weeks. OSM								
	usually seen with phy time. When asked if s	3's dementia, she was sical therapy at the same she had documented the								
		DSM #8 stated, no. When OSM #8 stated her heel t touch it.								
	physical therapist, on 3:25 p.m. When aske	ducted with OSM #9, the 11/2/2022 at approximately d if she discovered the								
	getting the resident dr boots on. OSM #9 sta	, OSM #9 stated she was ressed, R13 had the heel ated she must have been								
	that was the first time stated, yes, and we w	nd saw it. When asked if , she had seen it, OSM #9 /ent directly to the nurse.								
	boots on while they w	ad had the green heel lift rere treating R13, OSM #9 call but they had been there								
	An interview was con	ducted with LPN # 6, the 2/2022 at 3:37 p.m. When								
	asked what she did w the wound on R13's h	hen LPN #5 informed her of neel, LPN #6 stated, we are								
	(registered nurse) and doctor) can measure.	re wounds, only an RN d (name of ASM #6 - wound When asked if she notified								
	director of nursing (AI	d ASM #3, the assistant DON), was in a meeting. e director of nursing was in								
	,	ated she talked about it in								

Facility ID: VA0394

If continuation sheet Page 108 of 196

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &					FORM	: 01/19/2023
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE : COMPL	
	495394	B. WING		_	11/0	03/2022
NAME OF PROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
THE LAURELS OF BON AIR		9	101 BON AIR CROSSING	S DRIVE		
		E	30N AIR, VA 23235			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
building looked at it, the nurse practitional and told her she wo #6 further stated, sh and she looked at it treatment was not in stated the process w unusual skin observenurse practitioner, the unit manager, and the practitioner gives an wound doctor). If sh doctor, them she put When asked where on 10/27/2022, LPN she put a treatment When I spoke with r she would see it in t only an RN and (nai measure wounds in the staff were eleval stated R13 had elev Observation was ma ASM #6, the wound 4:23 p.m. ASM #6 s pressure, it was not stated the resident s started to scrape the measured at 8.2 x 1 #6 stated the wound stated the inner asp and the edges were put in place and app On 11/3/2022 at 12:	hen asked if any RN in the LPN #6 stated she contacted er, who was not in the building uld see it the next day. LPN he asked LPN #4 to look at it, on the 27th (10/27/2022) and hitiated until the 28th. LPN #6 when a staff person finds an ration, is it is reported to the he RP (responsible party), the he ADON. The nurse norder to refer to (name of he doesn't refer to wound tts a treatment in place. a treatment was put in place #6 stated, "[LPN #5] told me in place. I was at home. hurse practitioner, she told me he morning." LPN #6 restated me of wound care doctor) can this facility. When asked if ting R13's heels, LPN #6 vating boots. ade of R13's heel wound with care doctor, on 11/2/2022 at tated the wound was truly diabetic wound. ASM #6 still had feeling when he e wound. The wound was 1.1 x 0.1 centimeters. ASM d was 1/2 DTI and 1/2 with was debrided by ASM #6 and ect of the wound was softer debrideable. New treatment	F 686				

Facility ID: VA0394

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	and ASM #4, the region were made aware of the An interview was com- nurse practitioner, on When asked if she lood #5 stated, "Usually if I mostly on recertification was made aware of the afternoon the day beforen nurse to put skin prep ASM #5 was asked to she saw it on 10/28/20 heel was intact. The mecrotic, more pressuant black. When asked if when she saw it, ASM necrosis nor drainage on 11/1/2022 and saw starting to peel off. W at R13's skin prior to she had not looked at ASM #5 stated R13 d them to put the boots they had the boots on When asked if R13 has went to look at the he stated R13 did not ha socks were on. ASM as to get those boots put measured the wound, The facility policy, "Sk documented in part, " the facility should ider interventions to prevenuavoidable pressure Guests/residents with	onal clinical coordinator, he concern for harm. ducted with ASM # 5, the 11/3/2022 at 12:57 p.m. oks at resident's skin, ASM am told there is a problem, ons." ASM #5 stated she he heel wound late in the ore she saw it and told the on it until the next day. describe the wound when 022, ASM #5 stated the left ight heel was black, not re, it was a deep purple to it had any necrotic tissue 1 #5 stated there was no . ASM #5 stated she saw it / some necrosis that was hen asked if she had looked 10/28/2022, ASM #5 stated the leg until they told me to. idn't want to move. I told on her on Friday to ensure while she was in bed. ad the boots on when she el on 10/28/2022, ASM #5 ve the boots on, only her #5 stated she told the nurse c on. When asked if she ASM #5 stated, no.	F	586				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/19/2023 APPROVED 0: 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	SURVEY
		495394	B. WING			11/0	03/2022
NAME OF PRO	OVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
			9	101 BON AIR CROSSING	S DRIVE		
THE LAURE	ELS OF BON AIR		E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page identified, evaluated a treatment to promote Ongoing monitoring a to ensure optimal gue Practice Guidelines: 1 admission/re-admissio evaluated for skin inter- baseline total body sk the electronic medical Scale will be complete admission/re-admissio quarterly, and with a s- by a licensed nurse to pressure injury develor admitted with an skin appropriate intervention promote healing, a ph treatment, and wound and characteristics do nurse will initiate docu- health record, which in skin impairment as fol Record (EHR) facilitie document on the skin pressure injury and va weekly until the areas taken of pressure injur The interdisciplinary to guest/resident exhibits treatments that may ph igh risk of developing complicate their treatr include: Cognitive imp steroids that may affe impaired/decreased m functional ability, co-m end stage renal disea	110 Ind provided appropriate prevention and healing. Ind evaluation are provided st/resident outcomes. Upon on all guest/residents are grity by completing a in evaluation documented in record. 2. The Braden ed upon on, weekly for 4 weeks, significant change of status o determine the risk of opment. 4. Guests/resident impairment will have: ons implemented to ysician's order for location, measurements, oumented. 5. The licensed imentation in the electronic ncludes description of the lows: in Electronic Health s, the licensed nurse will and wound evaluation for ascular ulcers, document is resolved, photos may be ry and vascular ulcers. 6. eam considers whether the s conditions or is receiving lace the guest/resident at g pressure injury or ment such conditions may pairments, drugs such as ct wound healing., nobility and decreased norbid conditions, such as se, thyroid disease or aired, diffuse or localized	F 686				

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED 0: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495394			· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495394	B. WING			_	11/0	03/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
THE LAUF	RELS OF BON AIR			-	101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	atherosclerosis or low peripheral insufficience incontinence, abnorm hydration deficits, gue aspect of care and/or injury. 7. An initial are admission/readmissio risk or has a pressure comprehensive care p identifying the contribu- breakdown, including or actual impairment, preventative devices, seated support surface pain, physician activity proper body alignment appropriate. 8. The lie preventative measure 9. The licensed nurse document changes re- include - dressing, sur complication and pain A weekly total body sk for each guest/resider The licensed nurse w skin evaluation. The skin impairment to the identified during daily skin impairment is ide guest/resident, respor physician, DON/desig applicable. 13. Guest injury and lower extre evaluated, measured, (pressure injury and v accordance with the p	ver extremity arterial or ey, bowel/bladder al labs, malnutrition, est/resident refusal of some treatment. and a resolved e plan is developed upon in if the guest/resident is at injury and the blan may address: uting risk factors for history of skin impairment hydration, nutrition, including recumbent and es, preventatives skin care, y, positioning requirements, it, and education - when censed nurse will document es on the care plan/kardex. will monitor evaluate and garding skin, possible b) in the medical record 11. kin evaluation is completed to by the licensed nurse. ill document findings of the CNA's will report any new e licensed nurse that is care. 12. If a new area of entified, notify the nsible party, attending nee and treatment team, if t's/resident's with pressure mity ulcers will be and staged weekly ascular ulcers only) in practice guidelines until by be initiated unless the	F	686					

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	-	D HUMAN SERVICES				FORM	0: 01/19/2023
STATEMENT C	S FOR MEDICARE & I PF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
			9	101 BON AIR CROSSING	S DRIVE		
THE LAUR	ELS OF BON AIR		B	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	References: (1) This information w following website: https://cdn.ymaws.cor ce/resmgr/npuap_pre A pressure injury is lo and underlying soft tis prominence or related device. The injury car open ulcer and may b as a result of intense or pressure in combin tolerance of soft tissue may also be affected perfusion, co-morbidit tissue. (2) This information w following website: https://cdn.ymaws.cor ce/resmgr/npuap_pre Deep Tissue Pressure non-blanchable deep discoloration Intact or localized area of pers red, maroon, purple d separation revealing a filled blister. Pain and precede skin color cha appear differently in d injury results from inter pressure and shear for interface. The wound the actual extent of tis without tissue loss. If subcutaneous tissue,	a was provided prior to exit. The as obtained from the m/npuap.site-ym.com/resour ssure_injury_stages.pdf: calized damage to the skin asue usually over a bony at to a medical or other to present as intact skin or an the painful. The injury occurs and/or prolonged pressure ation with shear. The e for pressure and shear by microclimate, nutrition, ties and condition of the soft ras obtained from the m/npuap.site-ym.com/resour ssure_injury_stages.pdf: e Injury: Persistent red, maroon or purple non-intact skin with istent non-blanchable deep iscoloration or epidermal a dark wound bed or blood temperature change often anges. Discoloration may arkly pigmented skin. This ense and/or prolonged brces at the bone-muscle may evolve rapidly to reveal asue injury, or may resolve necrotic tissue, granulation tissue, fascia,	F 686		DEFICIENCY)		
	without tissue loss. If subcutaneous tissue, muscle or other under	necrotic tissue,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	01/19/2023 APPROVED
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	
		495394	B. WING		_	11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
	RELS OF BON AIR			9101 BON AIR CROSSING	S DRIVE		
				BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page		F 686	3			
	DTPI to describe vaso neuropathic, or derma (3) This information w following website: https://cdn.ymaws.con ce/resmgr/npuap_pre Unstageable Pressure full-thickness skin and skin and tissue loss in damage within the uld because it is obscured slough or eschar is re 4 pressure injury will b (i.e. dry, adherent, int fluctuance) on the hea not be softened or rer 2. For Resident #19 (I to document a comple newly identified woun wound physician's or wound. On the most recent M annual assessment w reference date) of 8/1 12 out of 15 on the BI mental status), indica moderately impaired f Section M (skin condi documented R19 hav scar over bony promin dressing/device. It fu	atologic conditions. vas obtained from the m/npuap.site-ym.com/resour ssure_injury_stages.pdf: e Injury: Obscured d tissue loss Full-thickness in which the extent of tissue cer cannot be confirmed d by slough or eschar. If moved, a Stage 3 or Stage be revealed. Stable eschar act without erythema or el or ischemic limb should moved. R19), the facility staff failed ete wound assessment of a d and failed to follow the ders for treatment of the IDS (minimum data set), an rith an ARD (assessment /2022, the resident scored MS (brief interview for					
	having any unhealed A total body skin asse 9:01 a.m. documented	pressure ulcer/injuries. essment dated 10/13/2022 at d one new wound identified. to identify the location or					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 114 F 686 F 686 describe the wound identified. The skin assessment was completed by RN (registered nurse) #4. The clinical record failed to evidence documentation describing the wound identified on 10/13/2022. The "Wound Evaluation & Management Summary" from the wound physician, for R19 dated 10/26/2022 documented in part, "...Patient presents with a wound on her sacrum. History of Present Illness: At the request of the referring provider, [Name of physician], a thorough wound care assessment and evaluation was performed to day. She has a stage 3 pressure wound (1) sacrum for at least 1 days duration ... Wound Size (LxWxD) (length by width by depth): 1.4x1.4x0.2 cm (centimeter)...[Age and sex] w (with) Hx (history) of HIV (human immunodeficiency virus), DM (diabetes mellitus) presents with a new wound over old scar tissue, continue Medihoney (2) as she has done well with this in the past. Dressing Treatment Plan: Primary Dressing(s): Leptospermum honey apply once daily for 30 days. Secondary Dressing(s): Superabsorbent silicone bdr (border) & faced apply once daily for 30 days...This patient's care was discussed with another health provider Nursing Staff Member during this visit ... " The physician's order summary report dated 11/2/2022 documented in part, "Cleanse areas to sacrum w/ (with) ns (normal saline), apply protective cream and a border dressing every evening shift. Order Date: 09/22/2022." The physician's order summary for R19 failed to evidence an order for the Medihoney treatment plan documented in the wound evaluation and

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/19/2023

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495394		(X1) PROVIDER/SUPPLIER/CLIA	, í				(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				91	101 BON AIR CROSSING	S DRIVE		
THE LAUR	ELS OF BON AIR			в	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 686	Continued From page summary on 10/26/20 The TAR (treatment a R19 dated 10/1/2022- "Cleanse areas to sac cream and a border d Start Date: 09/22/202 TAR documented R19 each evening shift du 2022. The TAR failed ordered by the wound The comprehensive c documented in part, " skin breakdown and p impaired mobility and skin impairment: woul left upper thigh. Date Revision on: 08/25/20 it documented in part, ordered. Date Initiate On 11/2/2022 at 3:22 conducted with LPN (unit manager. LPN # assessments were sc system and came up administration record the nurse would know stated that staging an were done by the wou director of nursing or stated that each morn weekly skin assessmed i that R19 had a sacral had healed and it had	e 115 22. dministration record) for 10/31/2022 documented, crum w/ ns, apply protective ressing every evening shift. 2 1500 (3:00 p.m.)." The Preceiving the treatment ring the month of October to evidence the treatment physician on 10/26/2022. are plan for R19 [R19] has the potential for pressure ulcers related to urine incontinence. Actual nd to sacrum and blisters to Initiated: 08/08/2019; 22." Under "Interventions" "provide treatment as d: 08/28/2019" p.m., an interview was licensed practical nurse) #6, 6 stated that weekly skin heduled in the computer on the medication screen in the computer so that it was due. LPN #6 d measurements of wounds and physician, the assistant a registered nurse. LPN #6 wound previously which reopened either last week		386			ATE	DATE
	or the week before that	at. LPN #6 stated that they ne wound reopening by a						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495394			` ´	PLE CONSTRUCTION G	-	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			11/0	03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	CNA (certified nursing to them. LPN #6 state with the wound physic back on the list to be that when a new wound should write a progres wound, notify the resp and the physician. LF clinical record and stat 10/13/2022 was the fi wound was identified. On 11/02/2022 at 3:59 made of ASM (admini wound physician and assessment to R19's There were no concert observed. ASM #6 m pressure ulcer as 1.27 by depth) and a stage stated that R19's sacr improved and gotten s R19 had previously has area that was treated responded very well to they were treating R1 Medihoney again for the evaluation on 10/26/2 staff continue with the that due to R19's prev- area, scar tissue and skin and bone undernu up easily and become very quickly. On 11/03/2022 at 7:58 conducted with LPN #	g assistant) who reported it ed that they had spoken cian and had R19 placed followed. LPN #6 stated nd was discovered the nurse as note describing the bonsible party, the resident PN #6 reviewed R19's ated that it appeared that rst time the reopening of the 5 p.m., an observation was strative staff member) #6, LPN #4 providing care and sacral pressure ulcer. rns with wound care easured R19's sacral x1.2x0.2 cm (length by width a 3 pressure ulcer. ASM #6 ral pressure ulcer had smaller. ASM #6 stated that ad a wound in the same with Medihoney and o it. ASM #6 stated that	F 68	86				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		495394	B. WING _			_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	his wound notes after that every Thursday in wound notes and gav to review. LPN #4 sta was responsible for g reviewing the wound any changes to the w stated that if there we wound treatments the orders to reflect the m stated that all of the w by someone every Th reviewed the wound r written by ASM #6 for physician orders and order in place for the that there was only an protective cream and evening shift. LPN #4 have been an order in treatment after the 10 by the wound physicia On 11/03/2022 at 10: conducted with RN (re stated that they comp assessment dated 10 stated that they had for sacrum when they we treatment to the sacra they had documented but had not done any was a treatment alread that there was a smal at that time. RN #4 st complete a change in physician or nurse pra	Wednesday and completed rounding. LPN #4 stated norning they printed out the e them to the unit manager oing through the notes and details to see if there were ound treatments. LPN #4 re any changes to the unit manager changed the ew treatment. LPN #4 round notes were reviewed ursday morning. LPN #4 round the current stated that there was no Medihoney. LPN #4 stated n active order for the a border dressing every 4 stated that there should n place for the Medihoney /26/2022 wound evaluation an. 17 a.m., an interview was egistered nurse) #4. RN #4 leted the total body skin /13/2022 for R19. RN #4 bund the area on the ent to do the ordered al area. RN #4 stated that the area as a new wound thing else because there dy in place. RN #4 stated I open area with no bleeding	F	586				

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	-					FORM	: 01/19/2023 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		495394	B. WING		_	11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			9'	101 BON AIR CROSSING	S DRIVE		
THE LAUP	RELS OF BON AIR		В	ON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	wound and did not ha place they completed form, called the physi get a treatment order, and wrote a progress they were not sure ho wound physicians list manager was respons On 11/03/2022 at 1:19 conducted with ASM a #5 stated that they ha their pressure ulcer re- that they saw R19 on not aware of the sacra point. ASM #5 stated again until after the w examined them. The facility policy, "Sk revised 7/14/2021 doo admission/re-admissi evaluated for skin inte baseline total body sk the electronic medica Guests/residents adm impairment will have: implemented to promo order for treatment, a measurements and cl 5. The licensed nurse in the electronic healt description of the skin Electronic Health Reco licensed nurse will do wound evaluation for ulcers. Document we resolved12. If a new	ve a treatment order in the change in condition cian or nurse practitioner to , notified the unit manager note. RN #4 stated that we residents got on the that they thought the unit sible for that. 5 p.m., an interview was #5, nurse practitioner. ASM id not examined R19 after eopened. ASM #5 stated 10/12/2022 and they were al wound reopening at that that they did not see R19 ound physician had cin Management" last cumented in part, "1. Upon on all guests/residents are egrity be completing a cin evaluation documented in I record4. hitted with any skin Appropriate interventions ote healing, A physician's nd Wound location, haracteristics documented. e will initiate documentation h record, which includes a n impairment as follows: In cord (EHR) facilities, the cument on the skin and pressure injury and vascular	F 686				

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		D HUMAN SERVICES					FORM): 01/19/2023 MAPPROVED
STATEMENT C	FOR MEDICARE & I F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
THE LAUR	ELS OF BON AIR				101 BON AIR CROSSING 30N AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	nursing)/designee and applicable14. The I attending physician w needed" On 11/3/2022 at 4:00 administrator, ASM #2 ASM #4, the regional made aware of the ab No further information (1) Pressure Ulcer A pressure sore is an down when something against the skin. Pres the severity of sympto stage. Stage IV is the painful area on the sk when pressed. This is is forming. The skin m soft. Stage II: The sk sore. The area around irritated. Stage III: The open, sunken hole ca below the skin is dam see body fat in the cra pressure ulcer has be damage to the muscle to tendons and joints. obtained from the well	cian, DON (director of d treatment team, if icensed nurse will notify the ith any changes as p.m., ASM #1, the 2, the director of nursing and clinical coordinator were hove concern. was presented prior to exit. area of the skin that breaks g keeps rubbing or pressing soure sores are grouped by oms. Stage I is the mildest worst. Stage I: A reddened, in that does not turn white a sign that a pressure ulcer hay be warm or cool, firm or in blisters or forms an open d the sore may be red and e skin now develops an lled a crater. The tissue aged. You may be able to ater. Stage IV: The come so deep that there is e and bone, and sometimes This information was	F	686				
	Applying honey prepa using dressings conta	rations directly to wounds or ining honey seems to ey seems to reduce odors						

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	-	D HUMAN SERVICES				FORM	01/19/2023 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			9	101 BON AIR CROSSING	S DRIVE		
THE LAUR	RELS OF BON AIR		E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 686	Continued From page and pus, help clean the reduce pain, and decre- information was obtain https://medlineplus.go 3. For Resident #162 failed to complete and on admission, docume- time of identification, a for treatment. On the most recent Ma admission assessment reference date) of 6/2 4 out of 15 on the BIM status), indicating the impaired for making d documented R162 has ulcer present upon ad The comprehensive c documented in part, " skin integrity/pressure Impaired cognition, im- fractures, Left hip hen superior and inferior p Initiated: 06/23/2022. Under "Interventions" "Conduct weekly head document and report physician. Date Initiat skin with showers/carr of any new areas of s Blisters, Bruises, disc or daily care. Date In	120 le wound, reduce infection, ease time to healing. This hed from the website: v/druginfo/natural/738.html (R162), the facility staff accurate skin assessment ent a pressure injury at the and obtain a physician order DS (minimum data set), an at with an ARD (assessment 9/2022, the resident scored IS (brief interview for mental resident was severely aily decisions. Section M ving one Stage 3 pressure mission/entry or reentry. are plan for R162 [R162] is at risk for impaired injury R/T (related to): paired mobility, fall with hiarthroplasty, bilateral	F 686				
	and as needed and a cream/ointment per fa	•					

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RELS OF BON AIR			9′	101 BON AIR CROSSINGS DRIVE		
	KELS OF BON AIR			в	30N AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	documented, "[R162] integrity related to Pressure ulcer Stage: 3, Date Initiate 07/20/2022." The "Nursing Compres 6/22/2022 for R162, do "Location of skin co incision with dermabor no bruising and +1 (pl bruising to extremities The physician orders part, - "Cleanse Coccyx are calcium alginate and do for stage 3. Order Da 06/29/2022" - "Cleanse Coccyx are calcium alginate and do for stage 3. Order Da 06/30/2022" - "Cleanse Coccyx are calcium alginate and do for stage 3. Order Da 06/30/2022" - "Cleanse Coccyx are calcium alginate and do for stage 3. Order Da 06/30/2022" The physician orders for the pressure ulcer The TAR (treatment a 6/1/2022-6/30/2022 fo "Cleanse coccyx area calcium alginate and do for stage 3. Start Dat (discontinue) Date: 06 documented the treat 6/29/2022. The TAR	has an actual impaired skin essure injury. Site: coccyx ed: 07/06/2022. Revision on: chensive Evaluation" dated locumented in part, inditions/wounds:Surgical and; CDI (clean, dry, intact) lus one) edema, scattered s" for R162 documented in ea with normal saline. Apply dry dressing in the evening ate: 06/29/2022. Start Date: ea with normal saline. Apply dry dressing in the evening ate: 06/29/2022. Start Date: ea with normal saline. Apply dry dressing in the evening ate: 06/29/2022. Start Date: failed to evidence an order prior to 6/29/2022. Start Date: failed to evidence an order prior to 6/29/2022. Mate dry dressing in the evening et e: 07/08/2022. D/C 6/29/2022." The TAR ment completed on failed to evidence eatment to the pressure	F	\$86			

Facility ID: VA0394

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	-	D HUMAN SERVICES				FORM	: 01/19/2023 APPROVED	
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMPI		
		495394	B. WING		_	11/0	03/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
			9101 BON AIR CROSSINGS DRIVE					
	RELS OF BON AIR		В	ON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	: 122	F 686					
	documented in part, " normal saline. Apply dressing every evenin Date: 06/30/2022. D/ TAR documented the 7/1/2022-7/7/2022. T documented, "Cleans saline. Apply calcium every day shift for sta 07/09/2022. D/C Date documented the treat 7/9/2022. The progress notes for - "6/22/2022 18:35 (6: Summaryskin intact hip closed with derma - "6/29/2022 18:35 (6: Summaryskin intact hip closed with derma - "6/29/2022 18:49 (6: Assessment Numbe - "7/6/2022 18:49 (6: Assessment Numbe Comments: skin audit presented with MASD damage) to buttocks, alginate and dry dress Review of the ADL (ar documentation for R1 6/1/2022-6/30/2022 d Care Statement: 1. Ha standard care which i and reporting change	e coccyx area with normal alginate and dry dressing ge 3. Start Date: cor/09/2022." The TAR ment completed on or R162 documented in part, cor R162 documented in						

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING 30N AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	The Skin & Wound Ex for R162 documented Stage: Stage 3: Full-til Location: Coccyx; Aca Admission; How long present? (wound age that it is auto calculate Measurements: Area: squared), Length: 2.7 3.6 cm, Depth: Not ag applicable, Tunneling The "Initial Wound Ex Summary" dated 6/29 by the wound physicia "Stage 3 Pressure V ThicknessWound S D (diameter)): 4.2 x 5 (centimeters)Treatn and the possible need procedures on this wo 06/29/2022 to the pat surrogate; husband, [indicated agreement to procedure(s)" The "Wound Evaluate Summary" dated 7/6/2 the wound physician of "Stage 3 Pressure V ThicknessWound S 0.1 cmsmaller, spok [Name of husband] an bedside, addressed a about her wound"	ff $6/23/2022-6/30/2022$. valuation dated $6/29/2022$ in part, "Type: Pressure; nickness skin loss; quired: Present on has the wound been when first assessed, after ed): Unknown; Wound 6.7 cm2 (centimeters cm (centimeters), Width: uplicable, Undermining: Not Not applicable" aluation & Management /2022 for R162 completed an documented in part, Vound Coccyx Full ze (L (length) x W (width) x $3 \times 0.1 \text{ cm}$ nent options-risks-benefits I for subsequent additional pund were explained on ent and health care Name of husband]; who o proceed with the on & Management 2022 for R162 completed by documented in part, Vound Coccyx Full ze (L x W x D): $3.8 \times 3.2 \times$ are w (with) patient, husband	F 686				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	RELS OF BON AIR		9	101 BON AIR CROSSING	S DRIVE		
	CELS OF BON AIR		E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	nursing stated that the completed the Skin & 6/29/2022, the ADON nursing) who complet comprehensive assess the unit manager who skin assessment on 7 at the facility and coul On 11/2/2022 at 1:46 conducted with ASM # #6 stated that they did reviewing their wound 7/6/2022, ASM #6 stat documentation the Stat have developed quick co-morbidities and co stated that the wound assessed. On 11/2/2022 at 3:22 conducted with LPN (unit manager. LPN # admission had full ski LPN #6 stated that stat wounds were done by assistant director of n LPN #6 stated that we discovered the nurse note describing the wo party, the resident and On 11/3/2022 at 10:38 conducted with CNA (#8. CNA #8 stated th provided every two ho	hember) #2, the director of e unit manager who Wound Evaluation on (assistant director of ed the admission nursing asment on 6/22/2022, and completed the Total body /6/2022, no longer worked d not be interviewed. p.m., an interview was #6, wound physician. ASM d not remember R162. After notes dated 6/29/2022 and ted that based on their age 3 pressure injury could dy due to R162's low weight, gnitive status. ASM #6 was not deep when first p.m., an interview was licensed practical nurse) #6, 6 stated that all new n assessments completed. aging and measurements of the wound physician, the ursing or a registered nurse. hen a new wound was should write a progress bund, notify the responsible d the physician.	F 686				

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	-	D HUMAN SERVICES				FORM	: 01/19/2023 APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE COMP		
		495394	B. WING		_	11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			9	101 BON AIR CROSSING	S DRIVE		
THE LAUP	RELS OF BON AIR		B	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	episode and care pro- skin was assessed du bathing and incontine redness or open area immediately for assess On 11/3/2022 at 11:00 conducted with ASM a ASM #2 stated that R them and was upset a #2 stated that the forr had met with the daug mentioned an area or them. ASM #2 stated another nurse to go w R162's skin. ASM #2 a dressing on the coc open area which appe pressure injury at that they questioned the s found that they had be an order. ASM #2 stated what the staff were tre #2 stated at that point physician and obtaine wound treatment. AS determined that the a admission and the ad documented it or gotte that time. ASM #2 state did not find any new o #2 stated that they ha admissions to have a ASM #2 stated that the R162 no longer worke stated that LPN (licen one of the nurses who	vided. CNA #8 stated that uring resident care including nce care and any new s were reported to the nurse isment. 0 a.m., an interview was #2, the director of nursing. 162's daughter had called about several issues. ASM ner administrator and they ghter and the daughter had the resident's buttocks to that they had gotten with them and had assessed stated that they had found cyx area covering a small eared to be a Stage 2 time. ASM #2 stated that taff about the dressing and een treating the area without ted that they were not sure eating the area with. ASM c, they contacted the d a physician's order for M #2 stated that they had rea was present on	F 686				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING	S DRIVE		
				BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page the facility.	126	F 686	3			
		4 a.m., an interview was 9. LPN #9 stated that they 62 or the wound care					
	conducted with LPN # assessments were co residents by the nurse LPN #8 stated that an reviewed the assessm LPN #8 stated that this there were two sets o	8 p.m., an interview was 8. LPN #8 stated that skin mpleted on newly admitted e admitting the resident. RN (registered nurse) nent and signed it off also. s process ensured that f eyes assessing the skin.					
	conducted with RN (resisted that the admission skin assessment. RN CNA with them when assessment to have a the assessment. RN the unit manager cond	7 p.m., an interview was egistered nurse) #2. RN #2 sion nurse completed the #2 stated that they took a they completed the skin unother set of eyes during #2 stated that the next day, ducted a repeat skin e that nothing was missed.					
		2, the director of nursing and clinical coordinator were					
	No further information	was presented prior to exit.					
F 690 SS=D			F 690				12/18/22
	§483.25(e) Incontiner	ice.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS DRIVE 30N AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	§483.25(e)(1) The factor resident who is contin- admission receives see maintain continence us condition is or becom- not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who entri- indwelling catheter is resident's clinical con- catheterization was ne- (ii) A resident who entri- indwelling catheter or is assessed for remov- as possible unless that demonstrates that cath and (iii) A resident who is receives appropriate to prevent urinary tract in continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a resident receives appropriate to restore as much norm possible. This REQUIREMENT by: Based on observation record review, and fac- was determined that f	cility must ensure that thent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. sident with urinary on the resident's asment, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nefections and to restore ent possible. esident with fecal on the resident's asment, the facility must t who is incontinent of bowel treatment and services to	F	690	Criteria 1 Resident # 217 foley was removed from the floor.	n	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 690 Continued From page 128 F 690 Criteria 2 one of 52 residents in the survey sample, All residents with Foley catheters have the Residents # 217 (R217). potential to be affected by the alleged The findings include: deficient practice. An audit was conducted of all residents with foley catheters to For (R217), the facility staff failed to keep the assure compliance. indwelling urinary catheter collection bag off the floor. Criteria 3 Licensed Nurses and C.N.As were re (R217) was admitted to the facility with educated on care of a foley catheter, diagnoses that included but were not limited to: specifically assuring the catheter is not neuromuscular dysfunction of the bladder (1). touching floor and is below the level of the bladder. The admission MDS (minimum data set) was not due at the time of the survey. Criteria 4 The DON or designee will conduct audits The facility's "Nursing Comprehensive on foley catheters 3 x week for 4 weeks, Evaluation" for (R217) dated 10/21/2022 weekly x 4 and monthly x 1. Results will documented in part, "Neurological. Oriented To: be reported to the QAPI Committee person; Genitourinary (relating to the genital and monthly and the committee will determine urinary organs). Appliances: Indwelling need for further audits or actions Catheter." The physician's orders for (R217) documented in part, "Routine catheter care every shift. Order date: 10/24/2022. Start Date: 10/24/2022." On 10/31/22 at 4:28 p.m., an observation of (R217's) room from the hallway revealed the indwelling urinary catheter collection bag laying on the floor next to the bed. On 11/01/22 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1 at the nurse's station. When asked to describe the placement of a resident's catheter collection bag LPN #1 stated that it should be attached to the side of the bed. When the resident is in the bed and not touching the floor. When asked why

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PRINTED: 01/19/2023 FORM APPROVED

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495394	B. WING		_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE LAUR	RELS OF BON AIR			101 BON AIR CROSSINGS SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690 F 692 SS=E	bag from making cont stated that it prevente informed of the obser- stated that the collecti laying on the floor. The facility's policy "C Tract Infection (CAUT in part, "9. Keep the of the floor." On 11/02/2022 at app (administrative staff m ASM #2, director of no clinical coordinator we above findings. No further information References: (1) A problem in which control due to a brain, condition. This inform the website: https://medlineplus.go Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted n (Includes naso-gastric both percutaneous endosc enteral fluids). Based comprehensive assess ensure that a resident	ep the catheter collection fact with the floor LPN #1 d contamination. When vation stated above LPN #1 ion bag should not been catheter Associated Urinary T) Prevention" documented collection bag and tubing off roximately 5:00 p.m., ASM hember) #1, administrator, ursing and ASM #4, regional ere made aware of the a was provided prior to exit. In a person lacks bladder spinal cord, or nerve hation was obtained from by/ency/article/000754.htm. atus Maintenance (3) hutrition and hydration. c and gastrostomy tubes, idoscopic gastrostomy and opic jejunostomy, and I on a resident's issment, the facility must	F 690				12/18/22

Facility ID: VA0394

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SINTEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER QUEWLENCULA IDENTIFICATION NUMBER: (XI) DENTIFICATION NUMBER: <th< th=""><th></th><th>-</th><th>ID HUMAN SERVICES</th><th></th><th></th><th>PRINTED: 01/1 FORM APPF OMB NO. 0938</th><th>ROVED</th></th<>		-	ID HUMAN SERVICES			PRINTED: 01/1 FORM APPF OMB NO. 0938	ROVED
INMAGE OF RROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE THE LAURELS OF BON AIR STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 2P CODE IMMENT STATEMENT STATEMENT STATEMENT SUBJECT CONSTRUCTIVE ACTION SURCE THE PROPORTING DEFICIENCY STREET ADDRESS, CITY, STATE, 2P CODE IF 692 Continued From page 130 OF NUTLING ADDRESTON CITERT ADDRESS, CITY, STATE, 2P CODE IF 692 Continued From page 130 OF CONSTRUCTIVE ADDRESTON CITERT ADDRESS, CITY, STATE, 2P CODE S483.25(Q)(2) IS OFFER SUBJECT CONSTRUCTIVE ADDRESTON </td <td colspan="2">STATEMENT OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td></td> <td></td> <td>(X3) DATE SURVE</td> <td></td>	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVE	
NMME OF ROWDER OR SUPPLIER STREET ADDRESS (ITY STREE, 2P CODE STOR BON AR (MULTION CONTRICT OF DEFICIENCIES (EACH DEFICIENCY MUST BE REACEED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) In (EACH DEFICIENCY MUST BE REACEED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) In (EACH ORRECTIVE ALON SOULD BE (CASS REFERENCE ALON CORRECTION (EACH ORRECTIVE ALON SOULD BE (CASS REFERENCE ALON CORRECTION) In (EACH ORRECTIVE ALON SOULD BE (CASS REFERENCE ALON CORRECTIVE ALON ALON ALON ALON ALON ALON ALON ALON			495394	B. WING		11/03/202	2
THE LAURELS OF BON AIR BON AIR, VA 23235 (M) ID PHEFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEEDED BY ULL REGULTORY OR LSC IDENTIFYING INFORMATION) PD PHEFIX PAGE PROCINEEDTIG VALUES DE PROCEEDED BY ULL REGULTORY OR LSC IDENTIFYING INFORMATION) PD PHEFIX PAGE PROCINEEDTIG VALUES DE PROCEEDED BY ULL REGULTORY OR LSC IDENTIFYING INFORMATION) PD PHEFIX PAGE PROCINEEDTIG VALUES DE PROCEEDED BY ULL REGULTORY OR LSC IDENTIFYING INFORMATION) PD PHEFIX PAGE PROCINEEDTIG VALUES DE PROCEEDED BY ULL REGULTORY OR LSC IDENTIFYING INFORMATION) PD PHEFIX PAGE PROCINEEDTIG VALUES DE PAGE DEFICIENCY COMMENTIFY DEFICIENCY COMMENTIFY DEFI	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
Prefers TvG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TxG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCESD Conversion F 692 Continued From page 130 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences: indicate otherwise; F 692 F 692 § 483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility document review, and clinical record review, it was determined the facility staff failed to evidence documentation of the monitoring of physician ordered fluid restriction. There was no documentation to show the total amount of fluids the resident #6 the facility staff failed to evidence documentation of the monitoring of physician ordered fluid restriction. The findings include: Criteria #1 All guests on fluid restriction could be affected by alleged deficient practice. An audit was conducted on all guests on fluid restrictions to maintain compliance. On the most recent MDS (minimum data set) assessment reference date of 10/4/2022, coded the resident as socing al 15 out of 15, indicating the resident as tor cognitively impained for making Criteria #4 Audits of guests on fluid restriction will be completed three times a week for 4 weeks, then weeky X 4 weeks and montify X 1.	THE LAUF	RELS OF BON AIR					
of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility document review, and clinical record review, it was determined the facility staff failed to monitor a physician ordered fluid restriction for one of 52 residents in the survey sample, Resident #6 (R6). The findings include: For Resident #6 the facility staff failed to evidence documentation of the monitoring of physician ordered fluid restriction. There was no documented not show the total amount of fluids the resident had daily and no documented review if the fluid restriction. On the most recent MDS (minum data set) assessment reference date of 10/4/2022, coded the resident is not cognitively impaired for making the resident is not cognitively impaired for making the resident is not cognitively impaired for making	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	DULD BE COMP	LETION
heart failure (CHF). Committee monthly and the committee Observation was made on 10/31/2022 at 2:31 actions.	F 692	of nutritional status, s desirable body weight balance, unless the re- demonstrates that this preferences indicate of §483.25(g)(2) Is offer- maintain proper hydra §483.25(g)(3) Is offer- there is a nutritional p provider orders a ther This REQUIREMENT by: Based on observation document review, and was determined the fa a physician ordered fl residents in the surve The findings include: For Resident #6 the fa documentation of the ordered fluid restriction documentation to sho the resident had daily if the fluids amounts w ordered fluid restriction On the most recent M assessment, a quarter assessment, a quarter assessment reference the resident is not cog daily decisions. R6 has heart failure (CHF).	 uch as usual body weight or trange and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when roblem and the health care apeutic diet. is not met as evidenced n, resident interview, facility d clinical record review, it acility staff failed to monitor uid restriction for one of 52 y sample, Resident #6 (R6). acility staff failed to evidence monitoring of physician on. There was no w the total amount of fluids and no documented review vere within the physician on. IDS (minimum data set) rly assessment with an e date of 10/4/2022, coded g a 15 out of 15, indicating gnitively impaired for making as a diagnosis of congestive 	F 6	Criteria #1 Guest #6 Fluid restrictions were discontinued by the MD due to no compliance. Criteria #2 All guests on a fluid restriction co affected by alleged deficient prac audit was conducted on all guests restrictions to maintain compliance Criteria # 3 Licensed nurses will be re educat fluid restrictions documentation o at the end of 24 hours. Criteria #4 Audits of guests on fluid restrictio completed three times a week for weeks, then weekly x 4 weeks an monthly x 1. Results will be reported to the QA Committee monthly and the comr will determine need for further au	uld be tice. An s on fluid ce. ted on f intake n will be • 4 nd API mittee	

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	SS DRIVE		
				-			0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	e 131	F 69	2			
		s sitting in their wheelchair.	1 00	-			
		was a water container with a					
	straw. The container h	held 550 cc (cubic The container was empty.					
	,	ducted with R6. When					
		er they drink a day, R6					
	stated she was told to containers (water con						
		de on 10/31/2022 at 4:16					
	•	er coming into the resident's					
	room and refilled the r fresh water and ice.	resident's container with					
	3:00 p.m. shift), 300 n	estriction - 1800 ml ng - 300 ml 7-3 (7:00 a.m. to nl for 3-11 (3:00 p.m. to ml for night (11:00 p.m. to					
	documented in part, "	care plan dated, 9/15/2022, Need: [R6] is at nutritional					
	and/or dehydration ris	sk R/T (related to) eight fluctuations r/t CHF &					
		. Resident is non-compliant					
	with fluid restriction." ⁻ documented in part, "	The "Interventions" 1800 cc fluid restriction."					
	September 2022 docu The following was doo 9/27/2022 - 11-7 shift 9/28/2022 - 7-3 shift = documented for 3-11 s	= 100 cc					
	11-7 = 120 cc. 9/30/2022 - 7-3 shift = 11-7 shift = 100 cc.	= 300 cc, 3-11 shift = 300 cc,					

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	-					FORM): 01/19/2023 APPROVED		
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED		
		495394	B. WING		_	11/0	03/2022		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE				
			9101 BON AIR CROSSINGS DRIVE						
	RELS OF BON AIR		В	ON AIR, VA 23235					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 692	The TAR for October above order. The follo For all days of October documented the resid on 10/3/2022 and 10/ documentation. On 1 resident only received resident only received For all the days for Oc was documented the except on 10/5/2022, cc. On 10/7/2022, it w received 240 cc. 10/2 10/30/2022, nothing w shift. For all the days in Oc was documented the On 10/17/2033, 10/22 10/27/2022, it was do received 120 cc. The TAR for November above order. The follo For 11/1/2022 and 11, was documented the For 11/1/2022 and 11, was documented the For 11/1/2022 and 11, was documented the The CNA (certified nu documented in part, " preferred fluidsEnco	2022 documented the owing was documented: er for 7-3 shift, it was lent received 300 cc, except 21/2022, there was no 0/4/2022 for 7-3 shift, the d 100 cc. On 10/7/2022, the d 120 cc. ctober for the 3-11 shift, it resident received 300 cc, the resident received 250 vas documented the resident /2022, 10/11/2022 and vas documented for the 3-11 tober for the 11-7 shift, it resident received 100 cc. 2/2022, 10/23/2022 and cumented the resident er 2022, documented the owing was documented: /2/2022, for 7-3 shift, it was lent received 300 cc. /2/2022, for the 3-11 shift, it resident received 300 cc. /2/2022, for the 11-7 shift, it resident received 100 cc.	F 692						

Facility ID: VA0394

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
			9101 BON AIR CROSSINGS DRIVE					
THE LAUP	RELS OF BON AIR			В	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page restriction.	133	F	692				
	The following was dod each day what the res 10/1/2022 = 940 cc 10/2/2022 = 480 cc - 10/2/2022 = 480 cc - 10/2/2022 = 480 cc - 10/2/2022 = 100 cc - 10/2/2022 = 100 cc - 10/2/2022 = 240 cc - 10/2/2022 = 1250 cc - 10/2/2022 = 1250 cc - 10/2/2022 = 1200 cc - 10/12/2022 = 1200 cc - 10/12/	Eating/Fluid Acceptance." cumented the amount for sident received: no dinner meal fluids vas documented for the no dinner meal fluids no breakfast or lunch meal						

Event ID: 33UH11

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HUMAN SERVICES			FORMA	APPROVED		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SU	(X3) DATE SURVEY		
IDENTIFICATION NOWIDER.	A. BUILDII	NG				
495394	B. WING _		11/03	/2022		
		STREET ADDRESS, CITY, STATE, 2	ZIP CODE			
		9101 BON AIR CROSSINGS DRI BON AIR, VA 23235	VE			
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
134 b breakfast or lunch meal documented for the entire ocumented for the entire no breakfast or lunch meal no breakfast or lunch meal documented for the entire documented for the entire	F		IENCY)			
	EDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495394 EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) 134 breakfast or lunch meal locumented for the entire ocumented for the entire ocumented for the entire no breakfast or lunch meal no lunch or dinner meal no breakfast or lunch meal locumented for the entire locumented for the entire the kitchen provides, the vide and the amount the hks every day, the resident	EDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI B. WING_ 495394 B. WING_ 495394 B. WING_ IMUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) ID PREFU TAG 134 F 6 breakfast or lunch meal ID PREFU TAG Iocumented for the entire ID PREFU TAG no breakfast or lunch meal ID PREFU TAG Ino for November 2022, ating/Fluid Acceptance." Jumented the amount for the the kitchen provides, the	EDICAID SERVICES X1) PROVIDER/SUPPLER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 495394 B. WING 9101 BON AIR CROSSINGS DRI BON AIR, VA 22235 EMENT OF DEFICIENCIES WINST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC 134 F 692 134 F 692 breakfast or lunch meal ID ID ID ID ID ID ID ID ID ID ID ID ID I	EDICAID SERVICES OMB NO.1 X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: ASUNDIG A BUILDING (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SL COMPLE 495394 B. WING 11/03 495394 B. WING 11/03 STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235 11/03 EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDERS PLAN OF CORRECTION (RACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 134 F 692 breakfast or lunch meal Io no breakfast or lunch meal iocumented for the entire Derecember of the entire no breakfast or lunch meal Io no breakfast or lunch meal iocumented for the entire Iocumented for the entire iocumented for the entire Iocu		

Facility ID: VA0394

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PRINTED: 01/19/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 1 APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
	495394		B. WING				11/0	03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
				9	101 BON AIR CROSSINGS DRIVE				
	RELS OF BON AIR			в	30N AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE		(X5) COMPLETION DATE	
F 692	Continued From page receiving 2640 cc/day	ι.	F	692					
		notes failed to evidence resident refusing to follow fluid restriction.							
	CHF - ongoing - conti nurse practitioner not documented in part, " CHF - ongoing - conti nurse practitioner not documented in part, " CHF - ongoing - conti	A/P (Approach/Plan): 1. nue fluid restriction." The e dated, 10/28/2022 A/P (Approach/Plan): 1. nue fluid restriction." The es dated 10/31/2022, A/P (Approach/Plan): 1.							
	director of food and n asked if R6 was on a stated yes. OSM #6 p that documented the OSM #6 explained the amounts on the food	other staff member) #6, the utrition services. When fluid restriction, OSM #6 presented a food tray ticket 1800 cc fluid restriction. e kitchen puts the following trays: 360 cc on the s on the lunch tray and 240							
	at 9:54 a.m. When as being on a fluid restrict stated they drink the to points to the 18-ounce stated the staff told he these containers each get fluids on their mean two drinks in the morr lunch and dinner tray. the fluid restriction pre-	ducted with R6 on 11/3/2022 ked if they are aware of ction, R6 stated, yes. R6 wo containers of water and e mark on the container. R6 er she had to drink two of n day. When asked if they al trays, R6 stated they get ning and iced tea on their . When asked if she follows escribed by the physician, at they told me to drink.							

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	-	ID HUMAN SERVICES				FORM): 01/19/2023 I APPROVED	
CENTER	<u>S FOR MEDICARE & I</u>	MEDICAID SERVICES				<u>OMB NC</u>	<u>. 0938-0391</u>	
· · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495394	B. WING		_	11/0	03/2022	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE			
			9	101 BON AIR CROSSING	S DRIVE			
THE LAUF	RELS OF BON AIR		E	30N AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	Continued From page	÷ 136	F 692					
	practical nurse) #5 on When asked how she fluids R6 drinks and w	ducted with LPN (licensed 11/3/2022 at 10:06 a.m. knows what amount of vhere is it documented the						
	each day, LPN #5 sta	the resident has received ted she measures what she ted the resident has a water						
	•	comes in and gets her						
	water. LPN #5 stated	0						
		luids on her tray and the						
		r what she can have. When						
	asked if anyone totals	s the amount of fluids the						
		h day? LPN #5 reviewed						
		n asked if that was the total						
	-	e day, LPN #5 stated, no.						
		ixes one of her medications						
		ing and then can also give						
		ft. When asked if the 180 cc						
		cc she gives the resident,						
	LPN #5 stated, no. W							
	LPN #5 stated, "I don	ne resident gets in a day, 't know "						
	LFIN #5 Stated, Tubh	t know.						
	An interview was con	ducted with ASM						
	(administrative staff m	nember) #2, the director of						
	•	2 at 10:52 a.m. When asked						
	the purpose of a fluid	restriction, ASM #2 stated						
	[R6] has a history of h	neart failure. When asked						
	who monitors the 180	0 fluid restriction for R6,						
	ASM #2 stated the die	etician, the doctor and the						
	nurse on the unit. AS	SM #2 stated she is aware of						
		stated they only have						
		e nurse gives the resident.						
		locumentation was reviewed						
		isked if someone should be						
	-	resident stays within her						
		#2 stated the documentation						
	speaks for themselve	s. There is no daily intake		1				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/19/2023 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	SURVEY PLETED
		495394	B. WING			11	/03/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	RELS OF BON AIR				0101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	Continued From page for the resident.	137	F	692			
	in part, "Purpose: To e ordered fluid restriction allocationGuidelines fluid restriction via phy Manager meets with t determine the amount provided by each dep meals, snacks, supple beverage preferences allocation. 2. The Diet guest/resident and ad preferences to adhere guest/resident and far fluid restriction and do record. The fluid restri dietary software, note snack labels, and clear	s: 1. Upon notification of a visician order, the Dietary he Charge Nurse to t of total fluid that will be artment, medication pass, ements, and guest/resident are considered in the fluid tary Manager visits with the					
	the regional clinical co	rator, ASM #2, and ASM #4 pordinator, were made pncern on 11/3/2022 at 4:30					
F 695 SS=D		was provided prior to exit. tomy Care and Suctioning	F	695			12/18/22
	needs respiratory care care and tracheal suc						

Facility ID: VA0394

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 695 Continued From page 138 F 695 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation. staff interview. facility Criteria 1 document review, and clinical record review, the Resident # 23 Oxygen order was obtained facility staff failed to maintain complete from MD. respiratory services per professional standards Criteria 2 for one of 52 residents in the survey sample, All residents who receive O2 have the Resident #23. potential to be affected by the alleged The findings include: deficient practice. An audit was conducted for all guests on O2 to assure orders were For Resident #23 (R23), the facility staff failed to in place for the O2. obtain a physician's order to administer oxygen. Criteria 3 On the most recent MDS (minimum data set), an Licensed nurses will be re-educated on admission assessment with an ARD (assessment obtaining an order when O2 is needed for reference date) of 10/11/22, R23 was coded as a resident. being moderately cognitively impaired for making daily decisions, having scored seven out of 15 on Criteria 4 DON/designee will complete audits of the BIMS (brief interview for mental status. R23 was coded as not receiving oxygen during the residents with O2 three times a week for 4 look back period. weeks, weekly x 4 weeks and monthly x 1. The results will be forwarded to the QAPI On 10/31/22 at 8:42 a.m., and 11/1/22 at 8:45 committee for review. The committee will a.m., R23 was observed lying in bed, with oxygen determine the need for further audits being delivered by nasal cannula at a rate of 1.5 and/or action. Ipm (liters per minute) by way of an oxygen concentrator. A review of R23's physician's orders revealed no evidence of an order for oxygen. A review of R23's care plan dated 10/5/22 revealed no information related to the resident's use of oxygen.

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 01/19/2023

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 APPROVED D: 0938-0391
STATEMENT C	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _		(X3) DATE		
		495394	B. WING		_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUR	ELS OF BON AIR			101 BON AIR CROSSINGS ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	BEAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695 F 697 SS=E	nurse) #3 was intervie should not be adminis without a physician's of is a medication like ar reviewing R23's physi "No, I don't see an ord On 11/2/22 at 3:55 p.r staff member) #1, the director of nursing, an clinical coordinator, w concerns. A review of the facility failed to reveal any int obtaining a physician' oxygen. No further information Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mana The facility must ensu provided to residents consistent with profess the comprehensive pe and the residents' goa This REQUIREMENT by: Based on resident int clinical record review review, it was determin failed to implement a program for three of 5	 n., LPN (licensed practical eved. She stated oxygen stered to any resident order. She stated: "Oxygen ny other medication." After ician's orders, she stated: der for [oxygen]." n., ASM (administrative administrator, ASM #2, the id ASM #4, the regional ere informed of these policy, "Use of Oxygen," formation related to s order for the use of was provided prior to exit. 	F 695	Criteria 1 Resident # 15 pain corrected to reflect scales for administr Residents #96 and discharged from the	appropriate pain ration. #21 have been		12/18/22

Event ID: 33UH11

Facility ID: VA0394

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 697 Continued From page 140 F 697 The findings include: Criteria 2 All residents who have pain medications 1. For (R15) the facility staff failed to attempt ordered have the potential to be affected non-pharmacological interventions prior to the by the alleged deficient practice. administration of a prn (as needed) pain medications, roxicodone (1) and acetaminophen Criteria 3 Licensed nurses will be re-educated on (2)the Medication Administration policy and (R15) was admitted to the facility with a diagnosis parameters for administering prn pain that included but was not limited to: right leg medications. fracture. Criteria 4 On the most recent MDS (minimum data set), a DON/designee will complete (5) random significant change assessment with an ARD audits of residents with prn pain (assessment reference date) of 10/15/2022, medications 3x week for 4 weeks, weekly (R15) scored 15 out of 15 on the BIMS (brief x 4 and monthly x 1 to assure appropriate interview for mental status), indicating (R15) was parameters are followed. These results cognitively intact for making daily decisions. will be forwarded to the QAPI committee Section J0400 "Pain Frequency" coded (R15) as for review. The committee will determine "Occasionally." Under "J0600. Pain Intensity" it the need for further audits and/or action. documented, "A. Numeric Rating Scale (00-10)." (R15) was coded a "4 (four)." The physician's order for (R15) documented in part. "Roxicodone Tablet 5 (five) MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 09/30/2022. Start Date: 09/30/2022." "Acetaminophen Extra Strength Tablet 500 MG. Give 2 (two) tablets by mouth every 6 hours needed for pain 1-5 (one to five). Order Date: 10/10/2022. Start Date: 10/10/2022." The eMAR (electronic medication administration record) for (R15) dated October 2022 documented the physician's order as stated above. The eMAR revealed that (R15) received 5 mgs of roxicodone on the following dates and

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/19/2023

	-	D HUMAN SERVICES				FORM	01/19/2023	
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
	495394		B. WING		_	11/03/2022		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, S	TATE, ZIP CODE	-		
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 697	interventions being at 1:12 p.m., 10/02/2022 10:00 a.m., and on 10 Further review of the or- received 1000 mg of a following dates and tin- non-pharmacological attempted on: 10/26/2 10/27/2022 at 7:46 p.1 The comprehensive c 09/18/2022 document risk for pain and has p C2 fracture (fracture or- vertebra) with fusion, with Odontaoid fracture projection at the back the neck), OA, (osteod (leg). Date Initiated: 0 "Interventions" it docu Non-Pharmacological 2) Meditation/relaxation Ice/cold pack; 5) Dive Imagery; 7) Rest; 8) S Date Initiated: 06/30/2 Review of the facility's dated 10/01/2022 throw evidence non-pharma being attempted on the above. On 11/02/22 at approximatering the set of the staff atterned of the staff atterned of the staff atterned the staff atterned	ce of non-pharmacological tempted on: 10/01/2022 at 2 at 1:44 p.m., 10/06/2022 at 0/18/2022 at 8:31 p.m. eMAR revealed that (R15) acetaminophen on the mes, with no evidence of interventions being 2022 at 10:29 a.m. and on m. are plan for (R15) dated ted in part "Need: (R15) is at oain related to neuropathy, of the second cervical post concussion headache re (a toothlike upward of the second vertebra of arthritis) fracture of femur 09/18/2022." Under umented in part, "Offer Interventions: 1) Massage; on; 3) Positioning; 4) rsional Activity; 6) Guided Social Interaction; 9) Other. 2021. a nurse's notes for (R15) ough 10/31/2022 failed to acological interventions he dates and times listed kimately 2:15 p.m., an ted with (R15). When npt to alleviate their pain their as needed pain ted no and that they give	F 697					

Facility ID: VA0394

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	-	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB NC</u>). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495394		B. WING _			11/	03/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
				91	01 BON AIR CROSSINGS DRIVE		
THE LAUF	RELS OF BON AIR			В	ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 697	 Continued From page 142 On 11/03/22 at approximately 8:19 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the procedure when administering as needed pain medication LPN # 4 stated that the nurse assesses the resident's pain by obtaining the 		F	697			
	severity of the resider to ten, with ten being	nt's pain on a scale of zero the worse pain, the location pe of pain such as throbbing					
	or stabbing. LPN # 4 then start with non-ph	stated that the nurse would narmacological interventions					
	that does not alleviate	, ice pack, or heat, and if e the resident's pain, they prescribe medication.					
	When asked how ofte	en non-pharmacological stated that it should be					
	medication is adminis	before the as needed pain stered. When asked where					
	type of pain and non-						
	it would be document	empted LPN # 4 stated that ed in the nurse's notes or ked why it is important to					
	attempt non-pharmac to the administration of	ological interventions prior of as needed pain					
	use of pain medicatio	tated that it could decrease n. After review of (R15's)					
		notes dated 10/01/2022 or non-pharmacological the administration of					
	roxicodone and aceta	minophen to (R15), LPN # 4 missing documentation.					
	LPN # 4 stated that th non-pharmacological	ney could not say interventions were					
	attempted because it	was not documented.					
	The facility's policy "P documented in part, "	Pain Management" Procedure: 14. The staff will					

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PRINTED: 01/19/2023 FORM APPROVED

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE S COMPL	
		495394	B. WING _			-	11//	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS ON AIR, VA 23235	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	 implement the care pl guest/resident, and ac interventions for pain, On 11/03/2022 at app # 1, administrator, AS and ASM # 4, regional made aware of the at No further information References: (1) Are an immediate- oxycodone hydrochlo management of mode the use of an opioid a This information was https://dailymed.nlm.r m?setid=d48c22ff-bbl . (2) Used to relieve m headaches, muscle a colds and sore throats and reactions to vacc reduce fever. Acetam to relieve the pain of of caused by the breakd joints). This information website: https://medlineplus.got tml. 2. For (R21) the faciliti non-pharmacological administration of a pri medications, oxycodo 	lan, monitor the dminister therapeutic , if ordered." proximately 4:02 p.m., ASM SM # 2, director of nursing al clinical coordinator, were bove findings. n was provided prior to exit. -release oral formulation of ride indicated for the erate to severe pain where analgesic is appropriate. obtained from the website: nih.gov/dailymed/drugInfo.cf b4-4a93-a35b-6eebff7b8e53 hild to moderate pain from ches, menstrual periods, s, toothaches, backaches, inations (shots), and to ninophen may also be used osteoarthritis (arthritis down of the lining of the on was obtained from the bov/druginfo/meds/a681004.h ty staff failed to attempt interventions prior to the	F 6	97				

Facility ID: VA0394

If continuation sheet Page 144 of 196

						FORM): 01/19/2023 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	that included but was pain. On the most recent M admission assessmen reference date) of 09/ out of 15 on the BIMS status), indicating (R2 making daily decision Section J0400 "Pain "Frequently." Under ' documented, "A. Nur (R21) was coded a "5 The physician's order part, "Oxycodone-Ace MG (milligram). Give every 12 hours as ner 09/15/2022. Start Da The eMAR (electronic record) for (R21) date documented the phys above. The eMAR re 5-325 mgs of oxycode following dates and the non-pharmacological attempted on: 10/01/2 10/05/2022 at 2:17 p. and on 10/10/2022 at The comprehensive of 09/14/2022 document risk for pain and/or hat (related to) age relate compression fracture 09/14/2022." Under "	not limited to: low back IDS (minimum data set), an ant with an ARD (assessment 19/2022, (R21) scored 14 b (brief interview for mental 21) was cognitively intact for s. Frequency" coded (R21) as 70600. Pain Intensity" it meric Rating Scale (00-10)." 5 (five)." for (R21) documented in etaminophen Tablet 5-325 1 (one) tablet by mouth eded for pain. Order Date: te: 09/15/2022." c medication administration ed October 2022 ician's order as stated vealed that (R21) received one-acetaminophen on the mes, with no evidence of interventions being 2022 at 9:02 p.m., m., 10/07/2022 at 3:48 p.m., m., 10/09/2022 at 4:06 p.m., 8:05 p.m. tare plan for (R21) dated ted in part "Need: (R21) is at as acute/chronic pain r/t d changes, recent fall with Date Initiated:	F 697				

Facility ID: VA0394

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	-	D HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I						0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY LETED
		495394	B. WING			11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				9	101 BON AIR CROSSINGS DRIVE		
I HE LAU	RELS OF BON AIR			В	ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	Interventions: 1) Mass Meditation/relaxation; pack; 5) Diversional A 7) Rest; 8) Social Inter Initiated: 06/30/2021. Review of the facility's dated 10/01/2022 thro evidence non-pharma being attempted on the above. On 11/02/2022 at apprinterview was conduct asked if they receives (R21) stated yes. Whe attempts to alleviate the before administering fistated that the nurses alleviate their pain by On 11/03/22 at approximterview was conduct practical nurse) #4 re- and documentation of interventions prior to the needed pain medicatii (R21's) eMAR and pro- 10/01/2022 through 1 non-pharmacological administration of oxyo (R21), LPN #4 was as documentation. LPN not say non-pharmacci attempted because it On 11/03/2022 at app #1, administrator, ASI	sage; 2) 3) Positioning; 4) Ice/cold activity; 6) Guided Imagery; fraction; 9) Other. Date a nurse's notes for (R21) bugh 10/31/2022 failed to acological interventions he dates and times listed broximately 2:25 p.m., an ted with (R21). When as needed pain medication hen asked of the nurse heir pain by other means their pain medication (R21) a don't always attempt to other means. ximately 8:19 a.m., an ted with LPN (licensed garding the implementation f non-pharmacological the administration of as on to (R21). After review of ogress notes dated	F	697			

Facility ID: VA0394

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	-	ID HUMAN SERVICES				FORM): 01/19/2023 APPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	-	(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING			11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUR	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
				-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	e 146	F 69	7			
	aware of the above fir		1.00				
	No further information	n was provided prior to exit.					
	References:						
		nanagement of pain severe					
		opioid analgesic and for					
		tments are inadequate. obtained from the website:					
		nih.gov/dailymed/drugInfo.cf					
	m?setid=f2137f1a-b4 4.	9a-40bd-97ac-cd6b36e295f					
	3. For (R96) the facili	ty staff failed to attempt					
	non-pharmacological	interventions prior to the					
	administration of a pri medications, tramado						
	· · ·	o the facility with a diagnosis not limited to: low back					
	pain.	Hot Infined to. Iow back					
	On the most recent M	IDS (minimum data set), an					
	admission assessmer	nt with an ARD (assessment					
	,	05/2022, the (R96) scored					
		MS (brief interview for ting (R96) was cognitively					
	intact for making daily						
		Frequency" coded (R96) as					
		'J0600. Pain Intensity" it neric Rating Scale (00-10)."					
	(R96) was coded an "						
	The physician's order	for (R96) documented in					
		t 50 MG (milligram). Give					
		y 6 hours as needed for e: 09/29/2022. Start Date:					
	09/29/2022."	c. 03/23/2022. Otart Date.					

Facility ID: VA0394

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	-	ID HUMAN SERVICES				FORM): 01/19/2023 MAPPROVED
STATEMENT C	S FOR MEDICARE & I PF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495394	B. WING		_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
	ELS OF BON AIR		-	101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER	S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 697	Continued From page	9 147	F 697				
	record) for (R96) date						
		ician's order as stated vealed that (R96) received					
	-	n the following dates and ce of non-pharmacological					
	interventions being at	tempted on: 10/01/2022 at					
		2 at 8:11 p.m., 10/09/2022 at 2 at 4:00 a.m., 10/12/2022 at					
		22 at 8:05 p.m. and at 11:10 :55 a.m., 10/15/2022 at					
	10:47 p.m., 10/19/202	22 at 9:34 a.m., 10/21/2022					
	at 12:22 a.m., 10/26/2 10/27/2022 at 5:45 a.	•					
		m., 10/30/2022 at 8:24 p.m.					
	dated 10/01/2022 thro	s nurse's notes for (R96) ough 10/31/2022 failed to acological interventions					
		ne dates and times listed					
	interview was conduc	roximately 2:20 p.m., an ted with (R96). When					
	(R96) stated yes. Wh	as needed pain medication nen asked of the nurse					
	before administering t	heir pain by other means their pain medication (R96) gives them their medication.					
		ximately 8:19 a.m., an					
		ted with LPN (licensed garding the implementation					
		f non-pharmacological the administration of as					
		on to (R96). After review of					
	(R96's) eMAR and pro 10/01/2022 through 1						

Facility ID: VA0394

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/19/2023 M APPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495394	B. WING		11/	/03/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUR	ELS OF BON AIR			101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	Continued From page non-pharmacological administration of oxyc (R), LPN #4 was aske documentation. LPN not say non-pharmaco attempted because it On 11/03/2022 at app #1, administrator, ASI ASM #4, regional clini aware of the above fir No further information References: (1) Used to relieve mo severe pain. Tramado and capsules are only expected to need med around-the-clock. Tra medications called op This information was of https://medlineplus.go ml. Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensu require dialysis receiv with professional stan comprehensive perso the residents' goals an This REQUIREMENT by:	 148 interventions prior to the codone-acetaminophen to de about the missing # 4 stated that they could cological interventions were was not documented. roximately 4:02 p.m., ASM M #2, director of nursing and ical coordinator, were made ndings. was provided prior to exit. oderate to moderately of extended-release tablets or used by people who are dication to relieve pain madol is in a class of iate (narcotic) analgesics. obtained from the website: w/druginfo/meds/a695011.ht 	F 697			12/18/22
	review, and clinical re	cord review, the facility staff mplete dialysis program for		The identified dialysis records for #36 were obtained and placed in		

Event ID: 33UH11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 698 Continued From page 149 F 698 one of 52 residents in the survey sample, medical record. Resident #36. Criteria 2 The findings include: All guests receiving dialysis have the potential to be affected by this practice. For Resident #36 (R36), the facility staff failed to An audit was completed of dialvsis evidence communication and coordination with resident medical records, and dialysis the resident's dialysis provider. communications were obtained as needed. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment Criteria 3 reference date) of 9/23/22, R36 was coded as The DON/designee will provide in-service being cognitively intact for making daily decisions, education to licensed nursing staff on having scored 13 out of 15 on the BIMS (brief follow-up to dialysis centers when interview for mental status). R36 was coded as documentation is not provided. receiving dialysis services during the look back period. Criteria 4 Dialysis communications will be audited 3 A review of R36's clinical record revealed the times per week x 4 weeks, then weekly x following physician order dated 5/23/22: "Dialysis 4 weeks, then monthly x 1 month. Thursday, Thursday, Saturday." Further review of Missing documentation will be obtained the clinical record revealed the resident had when needed, and additional in-service education and/or corrective action will be consistently received the dialysis services as ordered in September and October 2022. provided. A review of R36's dialysis communication book On-going compliance will be monitored revealed only one hemodialysis communication through routine audits of dialysis records. sheet. It was dated 9/13/22. This document The results of the audits will be reviewed contained information from the facility to the at the quality assurance meeting. dialysis center, and information from the dialysis Additional education and monitoring will provider to the facility. The book contained no be initiated for any identified concerns. additional evidence of communication between the facility and the dialysis center. A review of R36's care plan dated 10/30/19 and revised on 10/4/22 revealed, in part: "Encourage resident to go for scheduled dialysis appointments. Resident receives dialysis on Tuesday, Thursday, and Saturday."

FORM CMS-2567(02-99) Previous Versions Obsolete

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 01/19/2023 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	ELS OF BON AIR			9'	101 BON AIR CROSSINGS	DRIVE		
	Den Ain			В	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	8 Continued From page 150		F	698				
	nurse) #3 was intervie uses a communication information about resi center. She stated the to the dialysis center of information includes r any changes in medic information. She state the dialysis communic to the dialysis conter. records information the including any fluid vol results, medications a any other important in center sends the book She stated if a residen without the dialysis center information she needs the resident. She state dialysis center portion On 11/2/22 at 3:55 p.r staff member) #1, the director of nursing, an clinical coordinator, w concerns. A review of the facility revealed, in part: "The appropriate section of communication form p	dents with the dialysis a facility sends information on each dialysis day. This esident's weight, vital signs, sations, and other pertinent ed the facility nurse sends cation book with the resident The dialysis center staff us facility needs to know, umes, laboratory test idministered, weight, and formation. The dialysis is back to the facility staff. Int returns from dialysis ommunication book, she er to get what the is to continue to take care of ed she would also call if the of the form is blank. m., ASM (administrative administrator, ASM #2, the id ASM #4, the regional ere informed of these						
	No further information	was provided prior to exit.						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				91	101 BON AIR CROSSINGS DRIVE		
THE LAUF	RELS OF BON AIR			В	ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 700 F 700 SS=D	Bedrails			700 700			12/18/22
	alternatives prior to in a bed or side rail is us correct installation, us	npt to use appropriate stalling a side or bed rail. If sed, the facility must ensure se, and maintenance of bed t limited to the following					
		the resident for risk of rails prior to installation.					
	bed rails with the resid	the risks and benefits of dent or resident tain informed consent prior					
		that the bed's dimensions e resident's size and weight.					
	and maintaining bed r This REQUIREMENT by: Based on observation document review and was determined the fa assessment, education	d specifications for installing rails. is not met as evidenced n, staff interview, facility clinical record review, it acility staff failed to evidence on and consent for the use of 52 residents in the survey			Criteria 1 Resident # 62 and #58 had a device assessment and siderail consent forms completed. Resident # 23 was dischar from facility. Criteria 2 All residents who have side rails or ass bars have the potential to be affected b	ged sist by	
		R62), the facility staff failed sment, provide education			the same alleged deficient practice. Ar audit was conducted of all guests to assure consents and assessments we		

Event ID: 33UH11

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/19/2023 APPROVED 0: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				91	101 BON AIR CROSSINGS DRIVE		
THE LAUF	RELS OF BON AIR			в	ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 700	On the most recent M assessment, a quarte assessment reference resident scored a 14 of interview for mental s resident was not cogr daily decisions. In Set the resident was code assistance of one per R62 was observed on approximately 1:00 p. assist rails on the bed made of R62 on 11/1/ with bilateral assist rai Review of the physical failed to evidence a p assist rails. The comprehensive of documented in part, " complication due to B with mobility. Does no "Interventions" docum as ordered. Device: E and record with reside benefits of bilateral assist Review of the clinical	for the use of side rails. DS (minimum data set) rly assessment, with an a date of 8/16/2022, the but of 15 on the BIMS (brief tatus) score, indicating the nitively impaired for making action G - Functional Status, ad as requiring extensive son for moving in the bed. 10/31/2022 at m. in bed with bilateral A second observation was 2022 at 11:33 a.m. in bed ils. an orders on 11/2/2022, hysician order for the use of are plan dated 4/12/2022 Need: [R62] is at risk for ilateral assist bars to assist ot restrict mobility." The nented in part, "Utilize device Bilateral assist rails. Discuss ent and family, the risks and assist rails use."	F	700	DEFICIENCY) completed. Criteria 3 Licensed nurses will be re-educated o the Side rail policy. Criteria 4 DON/designee will complete five (5) random audits of side rails three x a w for 4 weeks, then weekly x 4 and mon x 1. These results will be forwarded to QAPI committee for review. The committee will determine the need for further audits or actions.	eek :hly	
	documentation of an a rails, education for the (bars). On 11/3/2022 11:00 a conducted with ASM (assessment for the use of e use of the assist rails .m., an interview was					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 01/19/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	_	
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	the process for the us stated when a resider supposed to have an appropriateness. She get a consent and edu (responsible party). process that gets sca We should do this on or prior to putting rails Facility policy titled, "F dated effective 10/14/ "Guidelines5. Any physical restraint or s current, signed restra record. The facility wil restraint would treat th symptoms and assist attaining or maintainin practicable level of ph well-being. In addition potential risks and be restraint in use by the least restrictive altern attempted. If the resp representative is not a authorization for use of authorization will be d consent is obtained ASM #1, the administ the regional clinical co aware of the above co p.m. 3. For Resident #23 (It to evidence assessme	e of bed rails, ASM #2 th has rails, they are evaluation for stated they get an order, ucate the guest or RP t is a written consent nned in the medical record. admission if they have rails on the bed. Restraint Management" 22 read in part: guest/resident using a int consent in the medical I explain how the use of the ne guest's/residents medical the guest/resident in ng his/her highest ysical and psychosocial a, the facility will explain the nefits of that specific guest/resident, and the atives that have been onsible party/legal able to provide signed of the restraint, telephone ocumented until written	F 7	00				

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/19/2023 APPROVED 0: 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY
		495394	B. WING			11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		_ _	STREET ADDRESS, CITY, S	STATE, ZIP CODE	•	
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	GS DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	rails. On the most recent M admission assessmer reference date) of 10/ being moderately cog daily decisions, having the BIMS (brief intervi was coded as requirin of facility staff for bed On the following dates observed lying in bed 10/31/22 at 8:42 a.m. A review of R23's clin evidence of an assess for the use of side rail resident/RP (responsi potential risks and be signed consent for the A review of R23's care revealed no information use of side rails. On 11/2/22 at 10:58 a staff member) #1, the was no side rail assess consent for R23. On 11/2/22 at 1:37 p.r nurse) #3 was intervie should not be implem been assessed, educa been signed. She staff	DS (minimum data set), an ant with an ARD (assessment 11/22, R23 was coded as nitively impaired for making g scored seven out of 15 on lew for mental status. R 23 and the extensive assistance mobility. and times, R23 was with quarter side rails up: , and 11/1/22 at 8:45 a.m. ical record failed to reveal sment of the resident's need s, of education for the ible party) regarding the nefits of side rail use, and a e use of side rails for R23. e plan dated 10/5/22 on related to the resident's , ASM (administrative administrator, stated there asment, education, or m., LPN (licensed practical eved. She stated side rails ented unless a resident has ated, and a consent has ted the admission nurse is	F 70				
	responsible for compl	ted the admission nurse is eting these tasks. She s using the side rails, they					

Facility ID: VA0394

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/19/2023 APPROVED 0: 0938-0391
STATEMENT C	FOR MEDICARE & T	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
THE LAUR	ELS OF BON AIR			101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	director of nursing, an clinical coordinator, w concerns. No further information 3. For Resident #58 (fee vidence a consent for On the most recent M assessment, a quarte assessment, a quarte assessment reference resident scored 11 ou interview for mental si indicating they were in daily decisions. The re- requiring supervision mobility and supervisi staff for transfers. On 10/31/2022 at app observation was made bar shaped bed rails i An additional observa 11/1/2022 at 8:28 a.m bar shaped bed rails i conducted with R58. the bed rails on the si when turning in the be not remember whether consent because they got it.	 plan. m., ASM #1, ASM #2, the od ASM #4, the regional ere informed of these was provided prior to exit. R58), the facility failed to or the use of bed rails. DS (minimum data set) rly assessment, with an e date of 8/8/2022, the t of 15 on the BIMS (brief tatus) assessment, noderately impaired to make esident was coded as of one person for bed on with setup help only from proximately 2:30 p.m., an e of R58 in bed with bilateral n place. tion of R58 was made on a fast of R58 in bed with bilateral n place. tion of R58 was made on a fast of the bed to grab onto bed on the bed to grab onto bed on the bed that they used des of the bed to grab onto bed on the bed when they 	F 700				
	The comprehensive c documented in part, " complications related	-					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		495394	B. WING _			_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	impaired mobility. Da Revision on: 04/13/20 The physician orders "Order Date: 4/13/202 Bilateral enabler bars mobility" A Physical Device Eva R58 documented and assist bars as an enal repositioning/support, mobility and to enhan Further review of R58 evidence consent for On 11/02/2022 at app request was made via (administrative staff m administrator, for evid bed rails for R58. On 11/03/2022 at 8:42 they did not have a co and they had complet On 11/3/2022 at 11:00 conducted with ASM (member) #2, the direct stated that residents v supposed to have an appropriateness. ASI were appropriate they educated the guest ar and obtained a conset that the consent was	t movement, guest has ate Initiated: 04/13/2021. 021." for R58 documented in part, 21 14:18 (2:18 p.m.). to assist with bed aluation dated 5/10/2022 for assessment for the use of bler for , to enable/increase bed ice mobility. 3's clinical record failed to the use of side rails. oroximately 8:00 a.m., a a written list to ASM member) #1, the lence of consent for use of 2 a.m., ASM #1 stated that onsent for R58's bed rails ted one on 11/2/2022. 0 a.m., an interview was (administrative staff ctor of nursing. ASM #2 who had bed rails were	F 7	'00				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 700 Continued From page 157 F 700 it was scanned into the medical record. ASM #2 stated that this process should be completed on admission or prior to putting rails on the bed. On 11/3/2022 at 4:00 p.m., ASM #1, the administrator. ASM #2. the director of nursing and ASM #4, the regional clinical coordinator were made aware of the above concern. No further information was provided prior to exit. F 730 Nurse Aide Peform Review-12 hr/yr In-Service F 730 12/18/22 CFR(s): 483.35(d)(7) SS=E §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review Criteria 1 and facility document review, it was determined The missing evaluations have now been the facility staff failed to provide performance completed. evaluations for four of five CNA's (certified nursing assistants). Criteria 2 An audit has been completed to ensure The findings include: annual performance evaluations have been completed for all CNAs. Corrections During the Sufficient and Competent Staffing were made as needed. facility task review on 11/2/22 at 2:00 PM there was no evidence of performance evaluations and Criteria 3 mandatory training for four of five CNA's (certified The Administrator/designee will provide nursing assistants) reviewed. in-service education to Administrative Nurses on the requirement for timely CNA On 11/2/22 at 9:00 AM, ASM (administrative staff evaluations. member) #1, the administrator was provided a list

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 730 Continued From page 158 F 730 of five CNA's with a request for evidence of Criteria 4 An audit of required CNA evaluations will performance reviews. be completed weekly x 4 weeks, then On 11/2/22 at 10:00 AM, ASM #2, the director of monthly for 1 month to assure timely nursing stated, "April is when I started. I do not completion. know if some of these performance reviews have been done." On-going compliance will be monitored through routine license audits. The 1. CNA #4 with a date of hire of 12/15/08, results of the audits will be reviewed at the evidenced no annual performance evaluation. quality assurance meeting. Additional 2. CNA #6 with a date of hire of 10/20/20, education and monitoring will be initiated evidenced no annual performance evaluation. for any identified concerns. 3. CNA #7 with a date of hire of 12/17/20, evidenced no annual performance evaluation. 4. CNA #8 with a date of hire of 9/3/21, evidenced no annual performance evaluation. On 11/02/22 at 5:06 PM, ASM #2, the director of nursing stated, "We do not have any more performance reviews." ASM #2 was informed that 4 out of 5 performance reviews were missina. On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. A review of the facility's policy "Staff Development" policy dated 4/2022, revealed, "A competency evaluation will be completed annually for certified nurse aides." No further information was provided prior to exit. F 732 Posted Nurse Staffing Information F 732 12/18/22 SS=D CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE LAUR	RELS OF BON AIR				101 BON AIR CROSSINGS DRIVE SON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 732	§483.35(g)(1) Data remust post the following basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categon unlicensed nursing stresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must post (A) Clear and readable (B) In a prominent plaresidents and visitors §483.35(g)(3) Public as staffing data. The fact written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fact posted daily nurse staffing nurse staffing and the postent of the public exceed the communit §483.35(g)(4) Facility requirements. The fact postent daily nurse staffing nurse staffing a months, or as required is greater. This REQUIREMENT by: Based on observation	equirements. The facility og information on a daily and the actual hours worked gories of licensed and aff directly responsible for t: s. I nurses or licensed defined under State law). des. g requirements. ost the nurse staffing data h (g)(1) of this section on a inning of each shift. ted as follows: le format. ace readily accessible to access to posted nurse cility must, upon oral or a nurse staffing data c for review at a cost not to ty standard. data retention cility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced n, staff interview, and facility	F	732	Criteria 1		
	document review, it w	as determined the facility			Nursing Staffing is now being posted of	Jaily	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 732 Continued From page 160 F 732 staff failed to post daily nurse staffing for two of as required. four days reviewed. Criteria 2 The findings include: Administrative Nurses, or designee will provide in-service education to the staffing During the Sufficient and Competent Staffing coordinator on the staff posting to include facility task review started on 10/31/22 and weekends. ending on 11/3/22, a review of the daily nurse staffing evidenced the following: The Weekend Manager will ensure that the staff posting is current on each weekend day. On 10/31/22 at approximately 11:00 AM the surveyors entered the facility. On the bulletin board in the main lobby was the staff posting with Criteria 3 a date of 10/27/22. The daily staff postings will be audited on weekdays x 4 weeks, weekly x 4 weeks, On 11/1/22 at 7:15 AM, the bulletin board in the and daily x 1 month. main lobby had the staff posting with a date of 10/27/22. Criteria 4 On-going compliance will be monitored On 11/2/22 at 8:15 AM the bulletin board in the through routine monitoring. The results of main lobby had the staff posting with a date of the monitoring will be reviewed at the 11/2/22 quality assurance meeting. Additional education and monitoring will be initiated On 11/3/22 at 8:15 AM the bulletin board in the for any identified concerns. main lobby there is staff posting with a date of 11/3/22 On 11/2/22 at 8:15 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked who was responsible for posting the daily staffing, ASM #2 stated, the staffing and scheduling coordinator is responsible for posting the daily staffing. ASM #2 stated, "I have not followed behind to make sure it is being done." On 11/2/22 at 10:15 AM an interview was conducted with CNA (certified nursing assistant) #2, the scheduling coordinator. When asked who

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CENTERS FOR MEDICARE & MEDICAID SERVICES		PRINTED: 01/19/2023 FORM APPROVED OMB NO. 0938-0391
	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495394 B. WING		11/03/2022
NAME OF PROVIDER OR SUPPLIER S	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE LAURELS OF BON AIR	101 BON AIR CROSSINGS DRIVE SON AIR, VA 23235	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 732 Continued From page 161 F 732 was responsible for posting the daily staffing, CNA #2 stated, "During the week, I am responsible, on the weekends it is the nursing supervisor." When asked the process to post staffing, CNA #2 stated, "It is posted by 7:00 AM when I am here. I get here at 6:30 AM during the week." On 11/3/22 at 3:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional clinical coordinator were made aware of the findings. According to the facility's "Required Regulatory Postings" policy, dated 4/19/22, included, "The following information will be posted on a daily basis by the facility: Data requirements: facility name, current date, total number and actual hours worked of the following categories of licensed and unlicensed nursing staff directly responsible for guest/resident care per shift (registered nurses, licensed practical nurses, certified nursing aides and medication aides) and resident census." F 757 No further information was provided prior to exit. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) F 757 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or		12/18/22

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 757 Continued From page 162 F 757 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, Criteria 1 and facility document review, it was determined The medication order for resident #15 was that the facility staff failed to ensure a resident corrected, and the resident is now was free of unnecessary medications for one of receiving medication according to the 52 residents in the survey sample, Resident #15 correct pain scale. (R15). Criteria 2 The findings include: Residents receiving PRN pain medications have the potential to be For (R15), the facility staff administered a prn (as affected by the alleged deficient practice. needed) pain medication Roxicodone (1) outside An audit has been completed of all PRN of the physician ordered pain level parameters. pain medications to ensure that the pain scale is correct. (R15) was admitted to the facility with a diagnosis that included but was not limited to: right leg Criteria 3 fracture. The DON/designee will provide in-service education to licensed nurses on On the most recent MDS (minimum data set), a transcription of pain medication scales significant change assessment with an ARD (assessment reference date) of 10/15/2022, the Criteria 4 resident scored 15 out of 15 on the BIMS (brief The DON/designee will conduct a random interview for mental status), indicating (R15) was 3 times per week x 4 weeks, weekly x 4 cognitively intact for making daily decisions. weeks, then monthly x 1 month of guests Section J0400 "Pain Frequency" coded (R15) as receiving pain medications according to a

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/19/2023 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495394	B. WING		11	/03/2022
NAME OF PR	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
	ELS OF BON AIR		9	101 BON AIR CROSSINGS DRIVE		
	CELS OF BON AIR		E	30N AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 757	Continued From page "Occasionally." Unde documented, "A. Nur (R15) was coded a "4 The physician's order part, "Roxicodone Tak Give 1 (one) tablet by as needed for pain. C Start Date: 09/30/202 The "(Name of Pharm Regimen Review Rep "September 30, 2022 documented in part, " tab (tablet) po (by mo needed for pain disch pain 6-10 (should be for pain 4-6)." Further regimen review revea nurse practitioner date 2022)." The eMAR (electronic record) for (R15) date documented the phys Further review of the or received five milligran level of five on 10/18/2 The comprehensive c 09/18/2022 document risk for pain and has p C2 fracture (fracture or vertebra) with fusion, with Odontaoid fractur projection at the back	e 163 r "J0600. Pain Intensity" it neric Rating Scale (00-10)." (four)." for (R15) documented in olet 5 (five) MG (milligram). mouth every 6 (six) hours Order Date: 09/30/2022. 2." nacy) Admission Medication ort" for (R15) dated through October 7, 2022" Roxicodone Tablet 5 mg 1 uth) every 6 hours as arge summary states for 7-10) since ibuprofen (2) is r review of the medication led the signature by the ed "10-10-22 (October 10, e medication administration ed October 2022 ician order as stated above. eMAR revealed that (R15) ns of roxicodone for a pain 2022. are plan for (R15) dated ted in part "Need: (R15) is at post concussion headache	F 757	DEFICIENCY)		
	(leg). Date Initiated: (-				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	
		495394	B. WING			11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZI	P CODE		
			9	101 BON AIR CROSSINGS DRIV	E		
THE LAUP	RELS OF BON AIR		1	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE		(X5) COMPLETION DATE
F 757	Continued From page medications as ordere 06/30/2021."		F 757				
	interview was conduct practical nurse) #4. A medication regimen re eMAR LPN # 4 stated received the roxicodo On 11/03/22 at approxiinterview was conduct staff member) #2, dire reviewing (R15's) meet the October 2022 eM medication was adminiparameters. When as	ximately 11:37 a.m., an ted with ASM (administrative ector of nursing. After dication regimen review, and AR ASM # 2 stated that the nistered outside of the pain sked if it was an ion ASM # 2 stated yes.					
	documented in part, " pain evaluation notify and implement new o On 11/03/2022 at app #1, administrator, ASI ASM #4, regional clin aware of the above fir No further information References: (1) Are an immediate- oxycodone hydrochlo management of mode the use of an opioid a This information was https://dailymed.nlm.r	Procedure: 8. Following the the physician if indicated rders as received." proximately 4:02 p.m., ASM M #2, director of nursing and ical coordinator, were made ndings.					

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES			FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION	(X3) DATE	
		495394	B. WING		11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	RELS OF BON AIR			9101 BON AIR CROSSINGS DRIVE		
THE LAUP	CELS OF BON AIR			BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 757	Continued From page	: 165	F 75	57		
F 773 SS=D	tenderness, swelling, osteoarthritis (arthritis the lining of the joints) (arthritis caused by sw joints). It is also used pain, including menstr before or during a me information was obtain https://medlineplus.go tml. Lab Srvcs Physician (C CFR(s): 483.50(a)(2)(§483.50(a)(2) The fac (i) Provide or obtain la ordered by a physicia practitioner or clinical accordance with State practice laws. (ii) Promptly notify the physician assistant, n nurse specialist of lab outside of clinical refe with facility policies ar notification of a practif physician's orders. This REQUIREMENT by: Based on staff intervir review, clinical record a complaint investigat notify the physician of	ned from the website: bv/druginfo/meds/a682159.h Order/Notify of Results (i)(ii) cility must- aboratory services only when n; physician assistant; nurse nurse specialist in e law, including scope of e ordering physician, urse practitioner, or clinical boratory results that fall erence ranges in accordance nd procedures for tioner or per the ordering is not met as evidenced iew, facility document I review and in the course of tion, the facility staff failed to f critical lab results in a e of 52 residents in the	F 7	73 Criteria 1 Resident #162 has been discharged the facility. Criteria 2 All residents have the potential to be affected by the alleged deficient prace		12/18/22

Event ID: 33UH11

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 773 Continued From page 166 F 773 The findings include: Criteria 3 For Resident #162 (R162), the facility staff failed The DON/designee will provide in-service to act upon critical lab results reported to the education to licensed nurses on timely facility on 7/8/2022; the facility staff did not report physician notification of critical lab results. the critical lab results to the physician until 7/9/2022 after R162's family member inquired Criteria 4 about them. The DON/designee will conduct lab result audits on weekdays x 4 weeks, monthly x On the most recent MDS (minimum data set), an 4 weeks, and monthly x 1 month. admission assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored On-going compliance will be monitored 4 out of 15 on the BIMS (brief interview for mental through routine monitoring. The results of status), indicating the resident was severely the monitoring will be reviewed at the impaired for making daily decisions. Section I quality assurance meeting. documented R162 having an active diagnosis of anemia. Section O documented R162 receiving transfusions while not a resident of the facility and within the last 14 days. The progress notes documented in part, - "6/24/2022 12:56 (12:56 a.m.) Physician Note. ...[R162] was admitted to [Name of hospital] on 6/18/2022 following ground-level fall. [R162] was found to have a left femoral neck fracture and underwent a left hip hemiarthroplasty. [R162] required 1 unit of packed red cells transfusion ... " - "7/7/2022 18:49 (6:49 p.m.) Nurses Notes. Note Text: Patient and family requesting labs due to patient's history of anemia. Practitioner notified and new order received. Husband, [Name of husband] made aware." - "7/9/2022 08:35 (8:35 a.m.) Nurses Notes. Note Text: daughter [Name of daughter] called looking for results on labs, ...HEMOGLOBIN 5.8 g/dL (grams per deciliter) (R162's test result); 12.0-16.0 (normal range); LL (Critical Low) Final... CALL TO PRIMARY : [Name of physician] reported results awaiting orders."

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495394	B. WING			_	11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773	 "7/9/2022 09:06 (9:0 Entry: Note Text: Gue (emergency room) du Hemoglobin was elev for [R162] to be sent to Patient was pale in co pain. Will continue to The physician orders part, "CBC (complete bloc (differential) and BMF the next 3 days one ti days. Order Date: 07 The laboratory report electronic medical rec metabolic panel and a differential collected or a.m.), received on 7/8/2 The report documente Hemoglobin of 5.8 g/o a red stop sign at the information/Flag. The the red stop sign mea critical results (results) On 11/2/2022 at 8:08 conducted with ASM is stated that critical lab facility by the lab to the that the nurses called practitioner on call reg stated that they did not them about critical lab facility of the stated that they did not them about critical lab 	 a.m.) Nurses Notes. Late ast is going to the ER e to critical labs, ated. Daughter requested to [Name of hospital]. blor did not complain of any monitor." for R162 documented in od count) with diff (basic metabolic panel) in me only for anemia for 3 (07/2022." included in R162's cord documented a basic a complete blood count with on 7/8/2022 at 01:46 (1:46 (2022 at 07:25 (7:25 a.m.)) 022 at 17:08 (5:08 p.m.). ed the critical low dl highlighted in red text and top of the report under lab e report legend documented a m., an interview was #7, medical doctor. ASM #7 results were called to the ne nurse. ASM #7 stated the physician or nurse garding the labs. ASM #7 ot recall staff contacting os but the documentation 	F	773				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 773 Continued From page 168 F 773 (administrative staff member) #2, the director of nursing stated that the LPN (licensed practical nurse) who obtained the lab results after the daughter called for them on 7/9/2022 no longer worked at the facility and could not be interviewed. ASM #2 stated that the LPN who sent R162 to the emergency room on 7/9/2022 was not working and provided a phone number to contact them. Attempts were made to reach the LPN with no answer and the voice mail full. On 11/2/2022 at 2:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated that they had spoken with R162's family member when they requested to have lab work done due to their history of anemia. RN #3 stated that they had contacted the physician and relayed the request from the family and received an order for routine lab work. RN #3 stated that the lab work was not ordered as stat (right away) but ordered to be done within the next 3 days. RN #3 stated that R162's lab work was ordered on 7/7/2022 and drawn the next day. RN #3 stated that they contracted an outside lab for blood work which sent a phlebotomist in early in the morning to draw the blood. RN #3 stated that the lab called the facility and spoke to the nurse with any critical lab results. RN #3 stated that when the nurse received critical lab results over the telephone from the lab they should verify the lab value with the lab, obtain their name, notify the physician or nurse practitioner, notify the responsible party and document everything in the medical record. On 11/3/2022 at 8:11 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that an outside lab came to the facility to draw the blood early on the night shift.

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RVICES					1 APPROVED 0. 0938-0391
	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
195394	B. WING		_	11/0	03/2022
	ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			S DRIVE		
	В	ON AIR, VA 23235			
DED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
hat lab work hember used. ed the lab hame and ted that lab ted that the t draw after d that if there lab called the alled the port it. view was r of nursing. ed a phone lay saying that there were been called to hey had been and advised hospital for practitioner. gated and en drawn the ay around had found out ADON critical lab n or nurse #2 stated that e units ion of critical audit of labs eview was ated that	F 773				
	ION NUMBER:	A. BUILDING	ION NUMBER: A. BUILDING 195394 B. WING STREET ADDRESS, CITY, ST 9101 BON AIR CROSSINGS BON AIR, VA 23235 CIENCIES ID PROVIDERS (EACH CORRENT NFORMATION) PREFIX CROSS-REFERENT (EACH CORRENT TAG CROSS-REFERENT CROSS-REFERENT TAG book kept at hat lab work nember used. ad the lab name and atted that the t draw after id that if there lab called the alled the sport it. F 773 view was r of nursing. ed a phone tay saying that there were boen called to hey had been and advised a hospital for practitioner. gated and en drawn the ay around had found out ADON critical lab n or nurse #2 stated that e units ion of critical audit of labs eviewed by ittioner. A. BUILDING	ION NUMBER: A BUILDING	ION NUMBER: A BUILDING

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 01/19/2023 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		11/	/03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	nurse. LPN #8 stated to be called to the phy On 11/3/2022 at 12:27 conducted with RN #2 called any critical resu- nurse. RN #2 stated be called to the physic On 11/3/2022 at 3:26 they were unable to fi education that they ha notification of critical I On 11/3/2022 at 4:00 administrator, ASM #2 ASM #4, the regional made aware of the ab No further information Complaint deficiency. Food Procurement,St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or considered state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr	d that any critical labs were ysician immediately. 7 p.m., an interview was 2. RN #2 stated that the lab ults to the facility to the that the critical labs should cian immediately. p.m., ASM #2 stated that ind evidence of the ad completed regarding the lab results. p.m., ASM #1, the 2, the director of nursing and clinical coordinator were bove concern. n was presented prior to exit. tore/Prepare/Serve-Sanitary 2) ty requirements. re food from sources ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility pompliance with applicable	F 773			12/18/22

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 812 Continued From page 171 F 812 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was Criteria 1 determined that the facility staff failed to serve No negative outcome was associated with food in a sanitary manner in one of one resident the deficient practice. dining rooms. Criteria 2 The findings include: All residents have the potential to be affected by this practice. The facility staff failed to keep their thumbs from touching the food surfaces of the resident's plates Criteria 3 while serving the resident's lunch in the The DON/designee will provide in-service second-floor dining room. education to the nursing staff on the procedure for serving meals in a sanitary On 10/31/2022 at approximately 12:30 p.m., an manner. observation of the second-floor dining room was conducted. CNA (certified nursing assistant) #1 Criteria 4 was observed with gloved hands sorting resident Dining room observations will be meal tickets on top of the ice chest, then placing completed 3 times per week x 4 weeks, the meal ticket on top of the steam table and weekly x 4 weeks, and monthly x 1 month. placing their open gloved hands on top of the Additional education and/or counseling steam table. CNA #1 was then observed placing will be provided as needed. their thumb on the surface edge resident lunch plates when serving them to eight residents. On-going compliance will be monitored through routine monitoring. The results of On 10/31/2022 at approximately 1:45 p.m., an the monitoring will be reviewed at the interview was conducted with CNA #1. When quality assurance meeting. asked why they wore gloves when serving the resident's lunch that day CNA #1 stated that they were told to wear them. After informed of the above observation CNA #1 stated that they should have not placed their hand on the ice chest and steam table surfaces and that they

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 01/19/2023 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		(X3) DATE SURVEY COMPLETED	
		495394	B. WING		11/	/03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812 F 839	should have placed th the resident's plate to touching the surface of On 11/02/2022 at app (administrative staff m ASM #2, director of m clinical coordinator we above findings. No further information Staff Qualifications	heir hands on the bottom of prevent their thumb from edge of the plates. roximately 5:00 p.m., ASM hember) #1, administrator, ursing and ASM #4, regional ere made aware of the	F 81			12/18/22
SS=D	§483.70(f) Staff qualif §483.70(f)(1) The faci full-time, part-time or professionals necessa provisions of these re	ications. lity must employ on a consultant basis those ary to carry out the quirements. ional staff must be licensed,				
	applicable State laws. This REQUIREMENT by: Based on staff intervi and employee record that the facility staff fa maintenance of requir five CNAs (certified no The findings include: The facility staff failed required certification f	is not met as evidenced ew, facility document review review, it was determined		Criteria 1 The identified Nurse Aide has a currel license on file. Criteria 2 All licensed staff have the potential to affected by this practice. An audit ha been completed to ensure that all lice are current, and the current license is file. Corrections were made as need Criteria 3 Administrative Nurses, or designee w	be s enses on ed.	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 839 Continued From page 173 F 839 During the Sufficient and Competent Staffing provide in-service education to Payroll facility task review on 11/2/22 at 2:00 PM, CNA staff on the requirement of maintaining #7's employee record contained a certification copies of current licenses on file. verification from the Virginia Department of Health Professions on 5/27/22. CNA #7 was hired on 12/17/20. There was no evidenced of Criteria 4 CNA certification verification prior to 5/27/22. The Payroll Department will provide monthly tracking of licenses expiration On 11/2/22 at 4:15 PM, an interview was dates to appropriate department conducted with ASM (administrative staff managers for license follow-up. The member) #2, the director of nursing. When tracking long will be 3 times per week x 4 asked who is responsible for pulling certifications, weeks, then weekly x 4 weeks, then ASM #2 stated, "The staffing and scheduling monthly x 1 month, with corrective action coordinator and unit managers are responsible taken when necessary. for pulling the certifications. I have not followed behind to make sure it is being done." On-going compliance will be monitored through routine license audits. The On 11/3/22 at 3:30 PM, ASM #1, the results of the audits will be reviewed at the administrator, ASM #2, the director of nursing and guality assurance meeting. Additional ASM #4, the regional clinical coordinator were education and monitoring will be initiated made aware of the findings. for any identified concerns. According to the ASM #1, the administrator, there is no facility policy regarding CNA certification verification. No further information was provided prior to exit. F 842 **Resident Records - Identifiable Information** F 842 12/18/22 SS=E CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	-	(X3) DATE	
		495394	B. WING			11/0	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUR	ELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page to do so.		F 842				
	-	dance with accepted s and practices, the facility al records on each resident ented; e; and					
	all information contain regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506; (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research pur medical examiners, fu a serious threat to heal by and in compliance §483.70(i)(3) The faci record information agai unauthorized use. §483.70(i)(4) Medical for-	r their resident permitted by applicable law; ment, or health care red by and in compliance activities, reporting of abuse, violence, health oversight administrative proceedings,					

Facility ID: VA0394

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 842 Continued From page 175 F 842 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-(i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Criteria 1 Based on staff interview, facility document review and clinical record review, it was determined the Fluid intake is now being recorded facility staff failed to maintain a complete and properly, with no negative impact to resident #6. accurate clinical record for two of 52 residents in the survey sample, Residents #6 and Resident #58. Resident #58 has been seen by the physician and has no additional concerns. The findings include: Criteria 2 1. For Resident #6 (R6) the facility failed to All residents receiving fluid restrictions document on the TAR (treatment administration have the potential to be affected by these record) the fluids provided to R6; and the CNAs practices. A physician visit audit has been (certified nursing assistants) failed to document completed, with needed visits completed. the fluids consumed during the meals. Criteria 3 The DON/administrative nurse will On the most recent MDS (minimum data set) assessment, a quarterly assessment with an conduct in-service education to nursing assessment reference date of 10/4/2022, coded staff on documentation of fluid-restricted the resident as scoring a 15 out of 15, indicating diets, and the Medical Records the resident is not cognitively impaired for making Coordinator will receive education on

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PRINTED: 01/19/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 842 Continued From page 176 F 842 daily decisions. R6 has a diagnosis of congestive required physician visits. heart failure (CHF). Criteria 4 The physician order dated, 9/27/2022, Administrative Nurses will audit the MAR documented, "Fluid restriction - 1800 ml for residents on a fluid-restricted diet daily (milliliters) - for nursing - 300 ml 7-3 (7:00 a.m. to and CNA intake records for 3:00 p.m. shift), 300 ml for 3-11 (3:00 p.m. to documentation of fluid intake, and 11:00 p.m.) and 120 ml for night (11:00 p.m. to corrections will be made as identified. 7:00 a.m.) every shift." The audits will be completed on weekdays Review of the TAR for September 2022 x 4 weeks, then weekly for 4 weeks, then documented the above physician order. On the monthly for one month. Additional training following days, the blocks to document the and/or corrective actions will be consumed fluids were blank: completed as needed. 9/28/2022 for 3-11 (3:00 p.m. to 11:00 p.m.) shift. Review of the TAR for October 2022 documented On-going compliance will be monitored the above physician order. On the following days, through routine monitoring. The results of the blocks to document the consumed fluids were the monitoring will be reviewed at the blank. guality assurance meeting. Additional 10/2/2022 for the 3-11 shift education and monitoring will be initiated 10/3/2022 for the 7-3 (7:00 a.m. to 3:00 p.m.) for any identified concerns. shift 10/11/2022 for the 3-11 shift 10/21/2022 for the 7-3 shift 10/30/2022 for the 3-11 shift. Review of the CNA documentation for October 2022, documented the fluids taken during a meal except on the following dates, the blocks were empty for meal consumption and fluid intake: 10/2/2022 - dinner 10/3/2022 - breakfast, lunch and dinner 10/4/2022 - dinner 10/5/2022 - breakfast and lunch 10/6/2022 - breakfast and lunch 10/7/2022 - dinner 10/9/2022 - breakfast and lunch 10/10/2022 - breakfast and lunch 10/11/2022 - breakfast and lunch

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495394	B. WING				11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
THE LAU	RELS OF BON AIR				9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD B		(X5) COMPLETION DATE
F 842	10/12/2022 - breakfast 10/13/2022 - breakfast 10/13/2022 - breakfast 10/15/2022 - breakfast 10/16/2022 - breakfast 10/20/2022 - breakfast 10/22/2022 - breakfast 10/22/2022 - breakfast 10/26/2022 - breakfast 10/26/2022 - breakfast 10/28/2022 - breakfast 10/28/2022 - breakfast 10/29/2022 - breakfast 10/30/2022 - breakfast 10/31/2022 - breakfast 10/31/2022 - breakfast 11/2/2022 - breakfast	st, lunch and dinner st and lunch st, lunch and dinner st and lunch st, lunch and dinner st and lunch st, lunch and dinner st, lunch and dinner st and lunch at and lunch at and lunch st, lunch and dinner st, lunch, and dinner addes, the blocks were imption and fluid intake: , lunch, and dinner. ation was shared with ASM nember) #2, the director of at 10:52 a.m. When asked e TAR and the CNA te, ASM #2 stated, nobody there be documentation, edical Records ented in part, "Policy: The medical records on each ordance with accepted is and practice and state lical records must be	F	842				

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						FORM): 01/19/2023 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	-	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495394	B. WING			11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING 30N AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	accessible, systemati maintained in a safe a ASM #1, the administ the regional clinical co aware of the above co p.m. No further information 2. For Resident #58 (maintain a complete a record. On the most recent M assessment, a quarter assessment, a quarter assessment reference resident scored 11 out interview for mental s indicating they were r daily decisions. On 11/1/2022 at 8:28 conducted with R58. see the physician offer them regarding their p they did not remember their doctor. Review of R58's clinic physician 60-day rece 7/20/2022. Further review of R58 evidence any physicia progress notes betwee On 11/3/2022 at 8:50 conducted with ASM	cally organized and and secure environment." rrator, ASM #2, and ASM #4 pordinator, were made oncern on 11/3/2022 at 4:30 and accurate prior to exit. R58), the facility failed to and accurate medical IDS (minimum data set) rrly assessment, with an e date of 8/8/2022, the it of 15 on the BIMS (brief tatus) assessment, moderately impaired to make a.m., an interview was R58 stated that they did not en and wanted to speak with prostate. R58 stated that er the last time they saw cal record documented a ertification note dated the stated to an or nurse practitioner en 7/21/2022-11/3/2022. a.m., an interview was	F 842				

Facility ID: VA0394

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	: 01/19/2023 APPROVED	
STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		495394	B. WING		_	11/03/2022		
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
			91	9101 BON AIR CROSSINGS DRIVE				
THE LAURELS OF BON AIR			В	BON AIR, VA 23235				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 842	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 842					

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUR	RELS OF BON AIR			01 BON AIR CROSSINGS DN AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842 F 880 SS=D	guest/resident, has ac provides sufficient evi provided" On 11/3/2022 at 4:00 administrator, ASM #2 ASM #4, the regional made aware of the ab No further information Infection Prevention &	dequate plans of care, and idence of the effects of care p.m., ASM #1, the 2, the director of nursing and clinical coordinator were pove concern. n was provided prior to exit. & Control (2)(4)(e)(f)	F 842 F 880				12/18/22
	The facility must estal infection prevention a designed to provide a comfortable environm development and tran- diseases and infection §483.80(a) Infection p program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visite providing services und arrangement based u conducted according accepted national sta §483.80(a)(2) Written	blish and maintain an nd control program a safe, sanitary and hent and to help prevent the asmission of communicable ns. brevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2023 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		495394	B. WING			_	11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran- to be followed to prev (iv)When and how iso resident; including but (A) The type and dura- depending upon the in involved, and (B) A requirement tha least restrictive possit circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syster identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu-	lance designed to identify le diseases or can spread to other in possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable in lesions from direct or their food, if direct ne disease; and procedures to be followed tect resident contact. m for recording incidents cility's IPCP and the en by the facility. le, store, process, and to prevent the spread of	F	880				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 880 Continued From page 182 F 880 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility Criteria 1 document review, it was determined that the There was no negative outcome from facility staff failed to maintain an effective these deficient practices. infection control program in 5 of 14 rooms: and one of ten staff members failed to wear PPE Criteria 2 (personal protective equipment) per facility Upon notification, facility rounds were protocol. completed to ensure that the proper mask was being used and that proper sanitation The findings included: was observed between residents on isolation precautions. 1. The facility staff failed to wash hands after doffing (removing) PPE (personal protective Criteria 3 equipment) in transmission-based precaution The DON/designee will provide in-service isolation rooms during meal tray delivery to 5 of education to all nursing staff on the 14 rooms in the survey sample. correct mask to utilize and the hand washing procedure to be used after doffing PPE. On 10/31/2022 at 12:23 p.m., an observation was made of staff delivering meal trays to residents in rooms on the first floor of the facility. Criteria 4 - At 12:34 p.m., CNA (certified nursing assistant) Facility rounds will be conducted 3 times #9 was observed outside of Room 112 wearing a per week x 4 weeks, weekly x 4 weeks, mask and donning a faceshield, gown, and then monthly for 1 month to ensure proper gloves. CNA #9 was observed to take a meal mask usage and hand washing. tray off of the cart in the hallway and take it into Room 112 to the resident. CNA #9 doffed the On-going compliance will be monitored gown and gloves at the door and disposed of through routine monitoring. The results of them in the trash can in the resident room. CNA the monitoring will be reviewed at the #9 then closed the door to the room and quality assurance meeting. Additional proceeded to the meal cart. CNA #9 failed to education and monitoring will be initiated wash or sanitize their hands. for any identified concerns. - At 12:37 p.m., CNA #9 was observed outside of Room 111 wearing a mask and a faceshield, and donning a gown, and gloves. CNA #9 was observed to take a meal tray off of the cart in the hallway and take it into Room 111 to the resident. CNA #9 doffed the gown and gloves at the door and disposed of them in the trash can in the

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Facility ID: VA0394

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 01/19/2023 APPROVED 0: 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			9	101 BON AIR CROSSING	S DRIVE		
THE LAUP	RELS OF BON AIR		E	30N AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	the room and proceed #9 failed to wash or se - At 12:40 p.m., CNA = Room 110 wearing a donning a gown, and observed to take a me hallway and take it int CNA #9 doffed the go and disposed of them resident room. CNA # meal cart. CNA #9 fa hands. - At 12:43 p.m., CNA = Room 113 wearing a donning a gown, and observed to take a me hallway and take it int CNA #9 doffed the go and disposed of them resident room. CNA # the room and proceed #9 failed to wash or se - At 12:46 p.m., CNA = Room 115 wearing a donning a gown, and observed to take a me hallway and take it int CNA #9 doffed the go and disposed of them resident room. CNA = the room and proceed #9 failed to take a me hallway and take it int CNA #9 doffed the go and disposed of them resident room. CNA = the room and proceed #9 failed to wash or se Observation of the do and 115 all document Precautions (1)." A si documented in part, "	#9 then closed the door to led to the meal cart. CNA anitize their hands. #9 was observed outside of mask and a faceshield, and gloves. CNA #9 was eal tray off of the cart in the o Room 110 to the resident. wn and gloves at the door in the trash can in the #9 then proceeded to the iled to wash or sanitize their #9 was observed outside of mask and a faceshield, and gloves. CNA #9 was eal tray off of the cart in the o Room 113 to the resident. wn and gloves at the door in the trash can in the #9 then closed the door to led to the meal cart. CNA anitize their hands. #9 was observed outside of mask and a faceshield, and gloves. CNA #9 was eal tray off of the cart in the o Room 113 to the resident. wn and gloves at the door in the trash can in the #9 was observed outside of mask and a faceshield, and gloves. CNA #9 was eal tray off of the cart in the o Room 115 to the resident. wn and gloves at the door in the trash can in the #9 then closed the door to led to the meal cart. CNA anitize their hands. wn and gloves at the door in the trash can in the #9 then closed the door to led to the meal cart. CNA anitize their hands. ors of rooms 112, 111, 113 ed "Droplet and Contact gn posted on the doors	F 880				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/19/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING		_	11/0	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			101 BON AIR CROSSING SON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	when leaving room, C Sanitizer or B) soap a On 10/31/2022 at 12:2 conducted with CNA # residents on droplet a required the mask, fac prior to going in the ro gown and gloves prior #9 stated that there w to dispose of the PPE #9 stated that there w to dispose of the PPE #9 stated that handwa every time they leave #9 stated that they no their pocket and did n On 11/2/2022 at 10:22 conducted with LPN (LPN #5 stated that has to entering and exiting removing gloves. LPI done to prevent the sp The facility policy, "Ha 9/9/2022 documented washing/hand hygiend most important single healthcare-associated should be performed: with the guest/resider protective equipment facemask);"	Clean hands with A) Hand ind water" 48 p.m., an interview was 49. CNA #9 stated that ind contact precautions ceshield, gown and gloves for and they removed the r to exiting the room. CNA erere trash cans in the rooms after they removed it. CNA ashing should be performed any residents room. CNA irmally kept hand sanitizer in ot have it with them. 2 a.m., an interview was licensed practical nurse) #5. indwashing was done prior g a residents room and after N #5 stated that this was pread of infection. and Hygiene" last revised I in part, "Hand e is generally considered the procedure for preventing d infectionsHand hygiene Before and after contact it;After removing personal (e.g., gloves, gown, it) and proximately 5:00 p.m., ASM hember) #1, the 2, the director of nursing and clinical coordinator were	F 880				

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TATEMANT O					(VO) 5 4	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		495394	B. WING		1	1/03/2022
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	
THE LAUR	ELS OF BON AIR			9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 185	F 88	0		
		n was provided prior to exit.				
	Reference:					
		ons are intended to prevent				
		ious agents, including ortant microorganisms,				
		direct or indirect contact with				
		ent ' s environment as				
		The specific agents and				
		ch Contact Precautions are				
	indicated are found in application of Contac	t Precautions for patients				
	• •	with MDROs is described in				
		C MDRO guideline.927				
	Contact Precautions					
		e wound drainage, fecal				
		r discharges from the body I potential for extensive				
	environmental contan	•				
		e-patient room is preferred				
		ire Contact Precautions.				
		t room is not available,				
		ction control personnel is				
	recommended to ass	ess the various risks				
		ing the patient with an				
		n multi-patient rooms, =3				
		n between beds is advised				
		inities for inadvertent sharing				
		infected/colonized patient				
		ealthcare personnel caring ct Precautions wear a gown				
	-	ractions that may involve				
	contact with the patie					
	contaminated areas in					
		g PPE upon room entry and				
	-	ting the patient room is done				
		, especially those that have				

Facility ID: VA0394

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2023 / APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	SURVEY LETED
		495394	B. WING			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS DRIVE 3ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	difficile, noroviruses a pathogens; RSV)." Th the website	nination (e.g., VRE, C. and other intestinal tract his information is taken from nfectioncontrol/guidelines/is	F	880			
	wear the appropriate protocol during medic 10/31/22 at 4:10 AM. Upon entry to the faci approximately 11:00 / staff member) #1, the are all wearing N95 fa the patient units. We residents and residen Observations on day 11/1/22, day/evening/ day/night shift on 11/3	ation administration on lity on 10/31/22 at AM, ASM (administrative administrator stated, "We ace masks when we are in have four COVID positive					
	nurse) #2 was observ medications. The roc identified as an enhar was observed wearing from room, LPN #2 w they were required to stated, it keeps chang positive residents so When asked if she ha	om LPN #2 was in was need isolation room. LPN #2 g a surgical mask. Upon exit as asked what face masks wear in patient areas, LPN ging. We have some Covid I believe it is a N95 mask. I believe it is a N95 mask. I believe it is a N95 mask.					

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DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					D: 01/19/2023
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		-	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUR	ELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
			I	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	187	F 88	o			
F 887 SS=D	AM with ASM #2, the asked what PPE is to room with enhanced p Enhanced precautions wound or other infecti precautions, if going t must wear complete F equipment). If it is jus wear the N95 mask." On 11/3/22 at 3:30 PM administrator, ASM #2 ASM #4, the regional made aware of the fin No further information COVID-19 Immunizat CFR(s): 483.80(d)(3)(§483.80(d) (3) COVIE LTC facility must deve and procedures to en- (i) When COVID-19 v facility, each resident is offered the COVID- immunization is media resident or staff memi immunized; (ii) Before offering CC members are provide regarding the benefits effects associated wit (iii) Before offering CC resident or the resident	2, the director of nursing and clinical coordinator were dings. a was provided prior to exit. ion i)-(vii) 0-19 immunizations. The elop and implement policies sure all the following: accine is available to the and staff member 19 vaccine unless the cally contraindicated or the ber has already been 0VID-19 vaccine, all staff d with education a and risks and potential side h the vaccine; 0VID-19 vaccine, each	F 88	7			12/18/22
	regarding the benefits effects associated wit (iii) Before offering CC resident or the residen receives education re	and risks and potential side h the vaccine; DVID-19 vaccine, each nt representative garding the benefits and					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		495394	B. WING			11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	101 BON AIR CROSSINGS DRIVE		
THE LAUF	RELS OF BON AIR			В	30N AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 887	requires multiple dose resident representative provided with current additional doses, inclu- benefits or risks and p associated with the C requesting consent for additional doses; (v) The resident, resident member has the oppor COVID-19 vaccine, and (vi) The resident's me documentation that in the following: (A) That the resident of was provided education benefits and potential COVID-19 vaccine; and (B) Each dose of COV to the resident; or (C) If the resident did vaccine due to medications or re (vii) The facility maintat to staff COVID-19 vac includes at a minimum (A) That staff were pro- the benefits and potential COVID for a staff were offered information on obtainii (C) The COVID-19 vac related information as Disease Control and I Healthcare Safety Ne	e; e COVID-19 vaccination as, the resident, re, or staff member is information regarding those uding any changes in the botential side effects OVID-19 vaccine, before r administration of any dent representative, or staff ortunity to accept or refuse a nd change their decision; dical record includes dicates, at a minimum, or resident representative on regarding the risks associated with nd /ID-19 vaccine administered not receive the COVID-19 al efusal; and ains documentation related ccination that n, the following: ovided education regarding ntial risks D-19 vaccine; the COVID-19 vaccine or ing COVID-19 vaccine; and occine status of staff and is indicated by the Centers for Prevention's National	F	887			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 887 Continued From page 189 F 887 Based on clinical record review, staff interview, Criteria 1 facility document review, and in the course of a Resident #162 was discharged from the complaint investigation, it was determined the facility. facility staff failed to offer and/or administer the COVID-19 vaccination to one of 9 residents Criteria 2 reviewed for immunizations in the survey sample, All residents have the potential to be Resident #162. impacted by this practice. An audit of immunization records for all residents has The findings include: been completed, and vaccines have been offered/given as indicated. For Resident #162 (R162), the facility staff failed to offer the COVID-19 (1) vaccination after Criteria 3 admission to the facility or document a The DON/designee will provide in-service contraindication for not offering the vaccination. education to the nursing staff on the procedure for offering vaccines on a On the most recent MDS (minimum data set), an timely basis. admission assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored Criteria 4 4 out of 15 on the BIMS (brief interview for mental An audit will be completed 3 times per status), indicating the resident was severely week x 4 weeks, weekly for 4 weeks, then impaired for making daily decisions. monthly x 1 month. Any omissions will be corrected at that time. The comprehensive care plan for R162 documented in part, "COVID-19, [R162] has the On-going compliance will be monitored potential for developing COVID-19 infection r/t through routine monitoring. The results of (related to) current pandemic, Has diagnosis of the monitoring will be reviewed at the dementia/Alzheimer's with decreased safety quality assurance meeting. Additional awareness and is unable to understand the need education and monitoring will be initiated for a mask. Date Initiated: 06/23/2022. Revision for any identified concerns. on: 07/20/2022." The nursing comprehensive evaluation for R162 dated 6/22/2022 on admission to the facility documented in part, "...Resident/Guest COVID-19 Vaccine Status: Partially vaccinated, received only 1 of 2 doses. Type of COVID-19 vaccine (i.e. Moderna, Pfizer-BioNTech, Janssen) and dates received: Pfizer 1.17.22..." The assessment was completed by the former

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 01/ FORM APP MB NO. 093	ROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		X3) DATE SURVE COMPLETED	ΞY
		495394	B. WING			11/03/20	22
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
	ELS OF BON AIR			9101 BON AIR CROSSINGS DRIVE			
	TELS OF BON AIR			BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COM	(X5) PLETION DATE
F 887	copy of the Virginia In System dated 6/22/22 documented the resid the Pfizer COVID-19 of further documented R date of 2/3/2022 and 3 3/14/2022 for the COV The clinical record fai documentation of the offered during R162's contraindication for no them. On 11/2/2022 at appro- request was made via (administrative staff m administrator for evide vaccine being offered R162. On 11/2/2022 at 10:40 they did not have evid facility offering or adm vaccine to R162 and/of Conducted with ASM a ASM #2 stated that the responsible for reside	ursing (ADON). ther documented a printed munization Information 2 for R162 which lent receiving dose 1 of 2 of Vaccine (2) on 1/17/2022. It R162 with a recommended a past due date of VID-19 Vaccine. led to evidence COVID-19 vaccine being stay at the facility or a bt offering the vaccine to oximately 8:00 a.m., a a written list to ASM hember) #1, the ence of the COVID-19 and/or administered to 0 a.m., ASM #1 stated that dence to provide of the hinistering the COVID-19 or their responsible party. 0 a.m., an interview was #2, the director of nursing. le former ADON was nt COVID-19 vaccination t the facility and no longer	F 88		Y)		
	and offered the vaccir stated that R162 shou	essed for vaccination status ne if it was due. ASM #2 uld have been offered the nen they were admitted to					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/19/2023 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMP	SURVEY
		495394	B. WING			11/0	03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSING BON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 887	Continued From page the facility.	191	F 88	7			
	older, especially those myocarditis associate vaccines, may receive of the COVID-19 vacco weeks after the first p dose should not be re after the first dose. P older who recently ha may receive a second deferral period of 3 m or positive test (if infer (3) The facility policy, "Gu Vaccination" dated "et documented in part, " re-admissions will be and/or physician for p will be offered the vac available." The policy The vaccine admini- guests/residents that additional dose or boo Vaccine. This can be of medical record for o immunization report o administrator, ASM #2 ASM #4, the regional made aware of the ab	People ages 12 years and e at higher risk of d with mRNA COVID-19 e the second primary dose sine by Pfizer BioNTech 3-8 rimary dose. The second ceived earlier than 3 weeks eople ages 12 years and d SARS-CoV-2 infection I primary dose after a onths from symptom onset ction was asymptomatic). Uests/Resident COVID-19 ffective 9/12/2022" All new and evaluated by the nurse revious immunization and scine if appropriate and further documented, " strator will identify would qualify to receive the oster dose of COVID-19 accomplished by: Review copy of vaccine card, state r documentation of /ID-19 Vaccine" p.m., ASM #1, the 2, the director of nursing and clinical coordinator were					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 887 Continued From page 192 F 887 Complaint deficiency. Reference: (1) COVID-19 COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/fag.ht ml#How-COVID-19-Spreads (2) Pfizer COVID-19 vaccine On August 23, 2021, FDA announced the first approval of a COVID-19 vaccine. The vaccine has been known as the Pfizer-BioNTech COVID-19 Vaccine, and the approved vaccine is marketed as Comirnaty, for the prevention of COVID-19 in individuals 12 years of age and older. Comirnaty is a monovalent COVID-19 vaccine that is approved for use as a two-dose primary series for the prevention of COVID-19 in individuals 12 years of age and older. It is also authorized for emergency use to provide a third primary series dose to individuals 12 years of age and older with certain kinds of

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2023 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		495394	B. WING		_	11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAUF	RELS OF BON AIR		_	101 BON AIR CROSSING ON AIR, VA 23235	S DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 887	d-response/coronaviri izer-biontech-covid-19 (3) This information w website: https://www.cdc.gov/v oads/Pfizer-Caregiver	This information was osite: mergency-preparedness-an us-disease-2019-covid-19/pf 9-vaccines vas obtained from the vaccines/covid-19/eui/downl	F 887				
F 947 SS=D	CFR(s): 483.95(g)(1)- §483.95(g) Required aides. In-service training mu §483.95(g)(1) Be suff continuing competend be no less than 12 ho §483.95(g)(2) Include training and resident a §483.95(g)(3) Address determined in nurse a and facility assessme address the special no determined by the fact §483.95(g)(4) For nur to individuals with cog address the care of the This REQUIREMENT by: Based on staff intervia and employee record	in-service training for nurse st- icient to ensure the ce of nurse aides, but must urs per year. dementia management abuse prevention training. s areas of weakness as nides' performance reviews nt at § 483.70(e) and may eeds of residents as	F 947	Criteria 1 The identified asso completed the requ			12/18/22

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 495394 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE THE LAURELS OF BON AIR BON AIR, VA 23235 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 947 Continued From page 194 F 947 required training for one of five CNAs (certified Criteria 2 nursing assistants). All Nurse Aides have the potential to be The findings include: affected by this practice. An audit has been completed on the required The facility staff failed to provide the required dementia/abuse training for CNAs. All mandatory training for abuse, neglect and associates are now current in this dementia training for one of five CNAs that were required training. employed for greater than one year, CNA #6. Criteria 3 During the Sufficient and Competent Staffing The DON/RCC will provide in-service facility task review conducted on 11/2/22 at 2:00 education to the ADON on the monitoring PM, there was no evidence of mandatory training of staff training to ensure requirements for CNA #6. CNA #6 had a date of hire of are met. 10/20/20, there was no evidence of dementia or abuse training. Criteria 4 An audit will be completed monthly x 3 An interview was conducted on 11/2/22 at 4:00 months to ensure that required in-service PM with ASM #1, the administrator. When asked education is completed. Any variances for the education record for CNA #6, ASM #1 will be corrected with additional training stated, we do our training in the Relias system but and/or corrective action provided. evidently this CNA did not complete their education this year. On-going compliance will be monitored through routine monitoring. The results of On 11/3/22 at 3:30 PM, ASM #1, the the monitoring will be reviewed at the administrator, ASM #2, the director of nursing and quality assurance meeting. Additional ASM #4, the regional clinical coordinator were education and monitoring will be initiated made aware of the findings. for any identified concerns. A review of the facility's policy "Staff Development" policy dated 4/2022, revealed, "The annual training schedule should include programs relating to but not limited to: fire prevention and safety, emergency disaster procedures and drills, infection prevention, chemical hazards, quality assessment performance improvement, compliance program, resident rights and responsibilities, care program, abuse prohibition, areas of weakness identified

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/19/2023 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE	
		495394	B. WING			-	11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS SON AIR, VA 23235	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 947	Continued From page inn nurse aide perforr guest/resident needs, of care problems."	· · · · · · · · · · · · · · · · · · ·		947				

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