STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 7/26/23 through 7/27/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey (VA00057144-substantiated with deficiency). The census in this 120 bed certified facility was 118 at the time of the survey. The survey sample consisted of five current resident reviews and one closed record review.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice for medication management for one of six residents in the survey sample; Resident #1. The findings include: For Resident #1, the facility staff failed to reconcile hospital discharge orders for insulin, resulting in two missed doses. Resident #1 was admitted to the facility on 11/23/22 and discharged on 12/8/22. The	F 658	1) The resident discharged from the facility on 12/8/22 2) Medication reconciliations have been completed for all admissions for the past 30 days with changes made as needed. 3)The DON/designee will provide in-service education to Licensed Nurses on Physician Orders to include order transcription. 4)Medication reconciliation audits will be completed daily x 2 weeks, then weekly x 4 weeks. Corrections will be made when	8/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/11/2023

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F 658	Continued From page 1 resident had the diagnoses of but not limited to diabetes, chronic kidney disease, and high blood pressure. On the admission MDS (Minimum Data Set) dated 11/29/22, the resident coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status). The resident was coded as having received insulin on 5 of the last 7 days. A review of the clinical record revealed the hospital discharge summary dated 11/23/22 that documented the resident was on Insulin Glargine (1) 25 units every night at bedtime. A review of the facility admission orders for 11/23/22 failed to reveal that the insulin was transcribed and ordered. A review of the November 2022 (Medication Administration Record) revealed that the resident was not administered any doses of insulin on 11/23/22 or 11/24/22. A pharmacy recommendation dated 11/25/22 documented that the hospital discharge orders differed from the facility orders in that Insulin Glargine had not been ordered. The insulin Lantus (same as glargine) was ordered on 11/25/22 after this recommendation. On 7/26/23 at 4:42 PM, an interview was conducted with LPN #1 (Licensed Practical Nurse). She stated that the nurse who admitted the resident missed this medication. She stated that normally she would have reviewed the new admission record the next day to ensure all the orders were in. She stated that because the next day was a holiday and she was off, it did not get	F 658	needed with additional education provided when necessary. Continued compliance will be monitored through random audits and reported to the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 658	Continued From page 2 done and the order for the insulin was missed until the day after the holiday [11/25/22], resulting in the resident missing two doses. A review was conducted of the facility policy, "Physician's Order." This policy documented, "...Transcribing the written order: Once the order is verified, the receiving licensed nurse documents the word "noted" next to the order along with his or her signature, title, and the date the order is noted...Immediately after noting an order, the receiving licensed nurse transcribes it..." On 7/27/23 at 11:09 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey. (1) Insulin Glargine is used to treat diabetes. Brand names include Lantus. Information obtained from https://medlineplus.gov/druginfo/meds/a600027.html	F 658		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's	F 710		8/17/23

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F 710	Continued From page 3	F 710		

immediate care and needs.

§483.30(a) Physician Supervision.
The facility must ensure that-

§483.30(a)(1) The medical care of each resident is supervised by a physician;

§483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide practitioner supervision of the resident's medications for one of six residents in the survey sample; Resident #1.

The findings include:

The nurse practitioner documented on 11/24/22 to continue with lantus (insulin), but failed to recognize that the facility failed to transcribe the hospital order and failed to write an order for the medication, thus, the resident did not get the medication on 11/23/22 and 11/24/22. The order was not written until 11/25/22 after a pharmacy review.

Resident #1 was admitted to the facility on 11/23/22 and discharged on 12/8/22. The resident had the diagnoses of but not limited to diabetes, chronic kidney disease, and high blood pressure.

A review of the clinical record revealed on the hospital discharge summary dated 11/23/22 that

1)The resident discharged from the facility on 12/8/22

2) Medication reconciliations have been completed for all admissions for the past 30 days with changes made as needed and communicated to the medical practitioner.

3)Medical Practitioners will receive in-service education on Physician Services, to include medical evaluations of the resident and review of orders for care and treatment.

4) Medication reconciliation audits will be completed daily x 2 weeks, then weekly x 4 weeks, including verification of medical practitioner documentation. Corrections will be made when needed with additional education provided when necessary. Continued compliance will be monitored through random audits and reported to the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

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F 710	Continued From page 4	F 710		

documented the resident was on Insulin Glargine (1) 25 units every night at bedtime.

A review of the facility admission orders for 11/23/22 failed to reveal that the insulin was transcribed and ordered.

A review of the November 2022 (Medication Administration Record) revealed that the resident was not administered any doses of insulin on 11/23/22 or 11/24/22.

Review of the clinical record also revealed a nurse practitioner note dated 11/24/22 and it documented ".... DM (diabetes mellitus)-ongoing-continue lantus..." However, the nurse practitioner did not recognize that the insulin had not been ordered and that the resident was not getting it, and therefore, did not write an order for it on 11/24/22.

A pharmacy recommendation dated 11/25/22 documented that the hospital discharge orders differed from the facility orders in that Insulin Glargine had not been ordered. The insulin Lantus (same as glargine) was ordered on 11/25/22 after this recommendation.

On 7/26/23 at 4:42 PM, an interview was conducted with LPN #1 (Licensed Practical Nurse). She stated that the nurse who admitted the resident missed this medication. She stated that normally she would have reviewed the new admission record the next day to ensure all the orders were in. She stated that because the next day was a holiday and she was off, it did not get done and the order for the insulin was missed until the day after the holiday (11/25/22).

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F 710	Continued From page 5 On 7/27/23 at 11:09 AM, ASM #2 (Administrative Staff Member) the Director of Nursing, contacted the nurse practitioner, who was on the road out of town, and asked about the order. She relayed that the nurse practitioner stated that she recalled seeing the resident on Thanksgiving Day (11/24/22) but most likely reviewed the hospital discharge orders instead of the facility orders and so she did not pick up on the missed insulin order. The order being missed at the time of admission on 11/23/22 and the nurse practitioner not verifying the orders on 11/24/22 resulted in the resident missing two bedtime doses of the insulin. A review was conducted of the facility policy, "Physician Services." This policy documented, "...2. Physician services include but are not limited to:...b. A medical evaluation of the guest/resident and review of orders for care and treatment..." On 7/27/23 at 11:09 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey. (1) Insulin Glargine is used to treat diabetes. Brand names include Lantus. Information obtained from https://medlineplus.gov/druginfo/meds/a600027.html	F 710		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		8/17/23

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F 760	Continued From page 6 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure that one of six residents in the survey sample, Resident #1, was free of a significant medication error. The findings include: For Resident #1, the facility staff failed to transcribe and order the resident's hospital discharge orders for Insulin Glargine on 11/23/22; and the nurse practitioner failed to review the admission medications and thus did not identify that the order was missed, on 11/24/22. This error resulted in the resident missing two doses of insulin, on 11/23/22 and 11/24/22, which constitutes a significant medication error. Resident #1 was admitted to the facility on 11/23/22 and discharged on 12/8/22. The resident had the diagnoses of but not limited to diabetes, chronic kidney disease, and high blood pressure. A review of the clinical record revealed on the hospital discharge summary dated 11/23/22 that documented the resident was on Insulin Glargine (1) 25 units every night at bedtime. A review of the facility admission orders for 11/23/22 failed to reveal that the insulin was transcribed and ordered.	F 760	1) The resident discharged from the facility on 12/8/22 2) Medication reconciliations have been completed for all admissions for the past 30 days with changes made as needed. 3) The DON/designee will provide in-service education to Licensed Nurses on Physician Orders to include order transcription. 4)Medication reconciliation audits will be completed daily x 2 weeks, then weekly x 4 weeks. Corrections will be made when needed with additional education provided when necessary. Continued compliance will be monitored through random audits and reported to the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 760	Continued From page 7	F 760		

A review of the November 2022 (Medication Administration Record) revealed that the resident was not administered any doses of insulin on 11/23/22 or 11/24/22.

Review of the clinical record also revealed a nurse practitioner note dated 11/24/22 and it documented ".... DM (diabetes mellitus)-ongoing-continue lantus..." However, the nurse practitioner did not recognize that the insulin had not been ordered and that the resident was not getting it, and therefore, did not write an order for it on 11/24/22.

The order being missed at the time of admission on 11/23/22 and the nurse practitioner not verifying the orders on 11/24/22 resulted in the resident missing two bedtime doses of the insulin.

A pharmacy recommendation dated 11/25/22 documented that the hospital discharge orders differed from the facility orders in that Insulin Glargine had not been ordered. The insulin Lantus (same as glargine) was ordered on 11/25/22 after this recommendation.

On 7/26/23 at 4:42 PM, an interview was conducted with LPN #1 (Licensed Practical Nurse). She stated that the nurse who admitted the resident missed this medication. She stated that normally she would have reviewed the new admission record the next day to ensure all the orders were in. She stated that because the next day was a holiday and she was off, it did not get done and the order for the insulin was missed until the day after the holiday [11/25/22].

On 7/27/23 at 11:09 AM, ASM #2 (Administrative

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F 760	Continued From page 8 Staff Member) the Director of Nursing, contacted the nurse practitioner. She relayed that the nurse practitioner stated that she recalled seeing the resident on Thanksgiving Day [11/24/22] but most likely reviewed the hospital discharge orders instead of the facility orders and so she did not pick up on the missed insulin order. A review was conducted of the facility policy, "Medication Administration." This policy did not address new admission orders, however it did document, "...Medications are administered in accordance with written orders....Begin new medication orders timely..." On 7/27/23 at 11:09 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey. (1) Insulin Glargine is used to treat diabetes. Brand names include Lantus. Information obtained from https://medlineplus.gov/druginfo/meds/a600027.html	F 760		
F 842 SS=D	Resident Records - Identifiable Information 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	F 842		8/17/23

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agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 10 for- (i) The period of time required by State law; or (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: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for two of six residents in the survey sample; Residents #2 and #3. The findings include: 1. For Resident #2, the facility staff failed to document ADL care across multiple shifts, multiple days, and in multiple categories of ADL care. Resident #2 was admitted to the facility on 7/14/23 and readmitted on 7/20/23. An admission MDS had not been completed as of the time of the survey. The admission nursing	F 842	1)ADL care is now being documented daily for residents #2 and #3. 2)All residents have the potential to be affected by this deficient practice. 3)The DON/designee will provide in-service education to all nursing staff on documentation of ADL care to include, the Certified Nurse Aid who is assigned to the resident will be responsible for completing the ADL flowsheet or POC prior to the end of their shift. 4) ADL documentation will be audited. The audits will be completed on weekdays x 4 weeks, then weekly for 4 weeks, then monthly for one month. Additional training	

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F 842	Continued From page 11 assessment dated 7/14/23 documented the resident as independent with ADL care and the admission nursing assessment dated 7/20/23 documented the resident as requiring assistance with ADL care. A review of the July 2023 ADL record revealed the following missing documentation. The resident was in the facility from 7/14/23 through 7/18/23 and 7/20/23 through 7/26/23 (date of survey review). ADL Care Statement was not documented for day shift on 7/15/23 and 7/24/23; evening shift on 7/16/23; and night shift on 7/14/23, 7/15/23, 7/18/23, 7/20/23, 7/22/23, 7/23/23, and 7/25/23. Bed mobility was not documented for day shift on 7/15/23 and 7/24/23; evening shift on 7/16/23; and night shift on 7/14/23, 7/15/23, 7/18/23, 7/20/23, 7/22/23, 7/23/23, and 7/25/23. Behavior monitoring (CNA documentation) was not documented for day shift on 7/15/23 and 7/24/23; evening shift on 7/16/23; and night shift on 7/14/23, 7/15/23, 7/18/23, 7/20/23, 7/22/23, 7/23/23, and 7/25/23. Personal Hygiene was not documented for day shift on 7/15/23 and 7/24/23; evening shift on 7/16/23; and night shift on 7/14/23, 7/15/23, 7/18/23, 7/20/23, 7/22/23, 7/23/23, and 7/25/23. Toilet Use and Continence was not documented was not documented on day shift for 7/15/23 and 7/24/23; evening shift on 7/16/23; and night shift on 7/14/23, 7/15/23, 7/18/23, 7/20/23, 7/22/23, 7/23/23, and 7/25/23.	F 842	and/or corrective actions will be completed as needed. On-going compliance will be monitored through routine monitoring. The results of the monitoring will be reviewed at the quality assurance meeting. Additional education and monitoring will be initiated for any identified concerns.	

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F 842	Continued From page 12	F 842		

Transferring was not documented on day shift for 7/15/23/22 and 7/24/23; evening shift on 7/15/23; and night shift on 7/14/23, 7/15/23, 7/18/23, 7/20/23, 7/22/23, 7/23/23, and 7/25/23.

Weekly weights was not documented for day, evening, or night shift for 7/17/23 and 7/24/23.

Eating / Food Acceptance was not documented for breakfast or lunch for 7/15/23 and 7/24/23; and dinner was not documented for on 7/16/23 and 7/21/23.

Resident Snack was not documented for evening shift on 7/16/23, 7/21/23 and 7/23/23. There was no schedule for day or night shift snacks.

On 7/26/23 at 2:04 PM, an interview was conducted with CNA #1 (Certified Nursing Assistant). She stated that ADL care should be documented every shift.

On 7/27/23 at 10:38 AM, an interview was conducted with OSM #2, activities assistant, who was previously a temporary nurse aide. She stated that ADL care should be documented, and that there are ways to document if something was not applicable or if the resident refused. She stated there should not be blanks on the ADL record.

On 7/27/23 at 10:58 AM, an interview was conducted with CNA #2. She stated that ADL documentation should be done on every shift, regardless of if the care was done, refused, or not applicable, even if the resident was independent to do their own, it should be documented.

A review was conducted of the facility policy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 07/27/2023

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

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F 842	Continued From page 13	F 842		

"Daily Nurse Aide Documentation." This policy documented, "Daily documentation of the resident's/guest's care and status is a requirement...Supportive documentation is the responsibility of the entire care team, including the Certified Nurse Aide....The Certified Nurse Aide who is assigned to the resident will be responsible for completing the ADL Flow Record or POC (point of care) prior to the end of their shift..."

On 7/27/23 at 11:09 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Clinical Coordinator were made aware of the findings.

No further information was provided by the end of the survey.

2. For Resident #3, the facility staff failed to document ADL care across multiple shifts, multiple days, and in multiple categories of ADL care.

Resident #3 was admitted to the facility on 7/18/23. An admission MDS had not been completed as of the time of the survey. The admission nursing assessment dated 7/18/23 documented the resident required assistance with ADL care.

A review of the July 2023 ADL record revealed the following missing documentation. The resident was admitted 7/18/23 and the below review is through 7/26/23 (date of survey).

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F 842	Continued From page 14	F 842		

ADL Care Statement was not documented for day shift on 7/19/23 and 7/20/23; evening shift on 7/20/23 and 7/26/23; and night shift on 7/18/23, 7/20/23, 7/21/23, 7/24/23, and 7/25/23.

Bed mobility was not documented for day shift on 7/19/23 and 7/20/23; evening shift on 7/20/23 and 7/26/23; and night shift on 7/18/23, 7/20/23, 7/21/23, 7/24/23, and 7/25/23.

Behavior monitoring (CNA documentation) was not documented for day shift on 7/19/23 and 7/20/23; evening shift on 7/20/23 and 7/26/23; and night shift on 7/18/23, 7/20/23, 7/21/23, 7/24/23, and 7/25/23.

Personal Hygiene was not documented for day shift on 7/19/23 and 7/20/23; evening shift on 7/20/23 and 7/26/23; and night shift on 7/18/23, 7/20/23, 7/21/23, 7/24/23, and 7/25/23.

Shower / Bath was not documented for day shift for 7/20/23.

Toilet Use and Continence was not documented for day shift on 7/19/23 and 7/20/23; evening shift on 7/20/23 and 7/26/23; and night shift on 7/18/23, 7/20/23, 7/21/23, 7/24/23, and 7/25/23.

Transferring was not documented for day shift on 7/19/23 and 7/20/23; evening shift on 7/20/23 and 7/26/23; and night shift on 7/18/23, 7/20/23, 7/21/23, 7/24/23, and 7/25/23.

Weekly weights were not documented for day, evening, or night shift for 7/24/23.

Resident Snack was not documented for evening shift on 7/20/23. There was no schedule for day

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F 842	Continued From page 15	F 842		

or night shift snacks.

On 7/26/23 at 2:04 PM, an interview was conducted with CNA #1 (Certified Nursing Assistant). She stated that ADL care should be documented every shift.

On 7/27/23 at 10:38 AM, an interview was conducted with OSM #2, activities assistant, who was previously a temporary nurse aide. She stated that ADL care should be documented, and that there are ways to document if something was not applicable or if the resident refused. She stated there should not be blanks on the ADL record.

On 7/27/23 at 10:58 AM, an interview was conducted with CNA #2. She stated that ADL documentation should be done on every shift, regardless of if the care was done, refused, or not applicable, even if the resident was independent to do their own, it should be documented.

A review was conducted of the facility policy, "Daily Nurse Aide Documentation." This policy documented, "Daily documentation of the resident's/guest's care and status is a requirement...Supportive documentation is the responsibility of the entire care team, including the Certified Nurse Aide....The Certified Nurse Aide who is assigned to the resident will be responsible for completing the ADL Flow Record or POC (point of care) prior to the end of their shift..."

On 7/27/23 at 11:09 AM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Clinical Coordinator were made aware of the

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F 842	Continued From page 16 findings. No further information was provided by the end of the survey.	F 842		