STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER: The Laurels of Bon Air		STREET ADDRESS, CITY, STATE, ZIP CODE: 9101 Bon Air Crossings Drive Bon Air, VA 23235	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services to maintain residents' high level of well-being for three of 14 residents in the survey sample, Residents #4, #11, and #9. The findings include: 1. For Resident #4 (R4), the facility staff failed to verify and transcribe physician's orders in a timely manner upon admission. This resulted in a failure to initiate ceftriaxone (an antibiotic), insulin (used to treat diabetes), and blood sugar monitoring in a timely manner. A review of R4's clinical record revealed the resident was admitted to the facility on [DATE] at 5:14 p.m., with diagnoses that included but were not limited to bacterial meningitis and diabetes. A review of R4's hospital discharge medication list dated 11/18/24 revealed the following orders: -ceftriaxone 2 g (grams) IV (intravenous) every 12 hours through 11/23/24. -insulin glargine (used to treat diabetes) 100 units/ml- inject 8 units into the skin nightly. -insulin lispro (used to treat diabetes) 100 units/ml- inject 0-4 units into the skin four times daily (before meals and nightly). A review of facility physician's orders revealed the following orders: 11/19/24 ceftriaxone 2 g IV every 12 hours. 11/19/24 insulin glargine 100 units/ml- eight units at bedtime. 11/20/24 accuchecks (blood sugar checks) before meals and at bedtime. A review of R4's November 2024 MAR (medication administration record) revealed the resident did not receive ceftriaxone, insulin, or blood sugar monitoring. (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 11/20/24 at 9:47 p.m. documented, Patient husband approached RN (registered nurse) and stated that his wife (patient) had not been given her antibiotic during dayshift. Husband was concerned and stated 'She seems different today and I think its [sic] because of her infection and not receiving the antibiotic.' This RN investigated and found that patient had not been given her morning dose as it was rescheduled. Patient assessed and VSS (vital signs stable), but patient was very confused, notable to be reoriented and unable to follow directions. This RN spoke with husband and husband stated 'I want her to get her antibiotic and then we will see how she dose [sic]. Pm dose given at 7pm and family educated. Husband stated 'I don't feel comfortable with her staying here. Im [sic] so worried about her. I want her to go to (name of hospital) Ed. Provider notified at 8pm after speaking with husband. EMS (Emergency Medical Services) arrived at 2030 (8:30 p.m.) and patient and husband left unit at 2100 (9:00 p.m.). A note signed by the nurse practitioner on 11/19/24 at 11:59 p.m. documented, #Assessment and Plan# DM2 (type two diabetes) FBG (fasting blood glucose [blood sugar check]) not recorded in patient chart. per MAR patient has not received ordered insulin. accuchecks (blood sugar checks) AC/HS (before meals and at night). discharged on glargine 8u (units) sc (subcutaneous) qHS (every night). SSI (sliding scale insulin) orders incomplete thus not transcribed. monitor FBG as ordered and add SSI if warranted. A note signed by the physician on 11/20/24 documented, Discussed at clinical mtg this am- did not receive ceftriaxone- order not entered initially, then when entered not here from pharmacy. Discussed w/admin, nurse and UM. We have 1 gr in stock but not 2 gr- can order for future- was established that I should have been called re issue. On 12/19/24 at 9:15 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated the admitting nurse needs to make sure the medication list provided from the hospital is actually the discharge medications (not a home medication list). She stated the nurse should call the provider for the purpose of reconciling the medications, and to make certain that the facility provider wants all the medications on the discharge list. She stated the facility nurses enter the medication orders in the computer, and the provider reviews the orders the next day. She stated sometimes the admitting nurses are extremely busy and cannot reach the provider right away. She stated any order clarifications are listed in a book which the provider reviews on their next visit. She stated medication reconciliation with the facility provider should happen as soon as the resident gets to the building. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 11:59 a.m., ASM (administrative staff member) #3, an attending physician, was interviewed. She stated when a resident is admitted , a facility nurse is responsible for entering the orders into the facility's electronic medical record software. She stated a second nurse (the unit manager or someone else) is responsible for reviewing the orders for accuracy. She stated the facility nurses use the discharge medication list sent with each resident from the hospital. She stated the facility nurses do not call her to verify orders for each resident prior to entering them into the computer and implementing them. She stated she is in the facility Mondays, Wednesdays, and Fridays to see residents, and she reviews medications and signs the orders at that time. She stated it is not a standard for the facility nurses to call her for the purpose of reconciling medications on admission. She stated she was not aware R4 did not receive ceftriaxone until after the resident was discharged , she was not aware R4 did not receive insulin glargine, and anyone receiving insulin should have his or her blood sugar monitored at least twice a day. On 12/20/24 at approximately 9:00 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing, and ASM #5, the regional director of clinical services, were informed of these concerns. The facility policy titled, Physician's Order documented, Physician orders are obtained to provide a clear direction in the care of the resident .A physician or state permitted health care professional must write orders on a Physician Order Sheet and/or prescription pad. If the facility is using an electronic medical record the order will be entered into the EMR (electronic medical record) system .Once the order is verified, the receiving nurse documents the word 'noted' next to the order along with his or her signature, title, and the date the order is noted at the bottom of the interim order sheet as applicable in the facility. Immediately after noting an order, the receiving nurse transcribes it in permanent ink on the MAR . The facility policy titled, Diabetic Management documented, Upon admission the interdisciplinary team evaluates the diabetic resident and implements a plan of care to ensure: Orders are received and are accurate related to blood glucose monitoring and anti-diabetic agents. Blood glucose orders should include parameters to follow and when to notify the physician. No additional information was provided prior to exit. 32642 2. For Resident #11 (R11), the facility failed to initiate Coumadin (a blood thinner) in a timely manner. A review of R11's clinical record revealed she was admitted to the facility on [DATE] at 5:33 p.m. R11's admitting diagnoses included a history of a heart valve replacement and atrial fibrillation (1). A review of R11's hospital discharge records revealed the following as part of a list of the resident's discharge medications: Warfarin (Coumadin) 5 mg (milligram) tab (tablet) .Daily dosage based on INR (2). A review of R11's provider's orders revealed no order for R11's Coumadin until 12/15/24, a delay of approximately 48 hours since the resident's previous dose. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 11:59 a.m., ASM (administrative staff member) #3, an attending physician, was interviewed. She stated when a resident is admitted , a facility nurse is responsible for entering the orders into the facility's electronic medical record software. She stated a second nurse (the unit manager or someone else) is responsible for reviewing the orders for accuracy. She stated the facility nurses use the discharge medication list sent with each resident from the hospital. She stated the facility nurses do not call her to verify orders for each resident prior to entering them into the computer and implementing them. She stated she is in the facility Mondays, Wednesdays, and Fridays to see residents, and she reviews medications and signs the orders at that time. She stated it is not a standard for the facility nurses to call her for the purpose of reconciling medications on admission. She stated she was aware that R11 was admitted on Friday, 12/13/24, but did not receive orders for Coumadin until 12/15/24. She stated this resident had just had heart surgery, and that without the daily Coumadin, the resident was at high risk of developing a blood clot. On 12/20/24 at 9:00 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing, and ASM #5, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. References (1) Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes your heart to beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications. This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation. (2) Prothrombin time (PT) and the associated international normalized ratio (INR) are routinely tested to assess the risk of bleeding or thrombosis and to monitor response to anticoagulant therapy in patients. This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569083/. 3. For Resident #9 (R9), the facility staff failed to initiate the monitoring of blood glucose or administration of insulin in a timely manner. A review of R9's clinical record revealed she was admitted [DATE] at 5:17 p.m. The resident was admitted with a diagnosis of diabetes. A review of R11's hospital discharge records revealed an order for short acting insulin to be given on a sliding scale, according to blood glucose monitoring levels. A review of R11's provider's orders revealed no order for R9's glucose monitoring or insulin administration until 12/15/24 at 7:30 a.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 9:15 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated the admitting nurse needs to make sure the medication list provided from the hospital is actually the discharge medications (not a home medication list). She stated the nurse should call the provider for the purpose of reconciling the medications, and to make certain that the facility provider wants all the medications on the discharge list. She stated the facility nurses enter the medication orders in the computer, and the provider reviews the orders the next day. She stated sometimes the admitting nurses are extremely busy and cannot reach the provider right away. She stated any order clarifications are listed in a book which the provider reviews on their next visit. She stated medication reconciliation with the facility provider should happen as soon as the resident gets to the building. On 12/19/24 at 11:59 a.m., ASM (administrative staff member) #3, an attending physician, was interviewed. She stated when a resident is admitted , a facility nurse is responsible for entering the orders into the facility's electronic medical record software. She stated a second nurse (the unit manager or someone else) is responsible for reviewing the orders for accuracy. She stated the facility nurses use the discharge medication list sent with each resident from the hospital. She stated the facility nurses do not call her to verify orders for each resident prior to entering them into the computer and implementing them. She stated she is in the facility Mondays, Wednesdays, and Fridays to see residents, and she reviews medications and signs the orders at that time. She stated it is not a standard for the facility nurses to call her for the purpose of reconciling medications on admission. She stated if a resident has been getting insulin in the hospital, they should have blood glucose levels checked at least twice a day, and as much as four times a day, depending on the resident's condition. No additional information was provided prior to exit.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to obtain a physician-order laboratory test for one of 14 residents in the survey sample, Resident #12. The findings include: For Resident #12 (R12), the facility staff failed to perform a PT/INR (1) blood test on 12/12/24. A review of R12's clinical record revealed she was admitted to the facility on [DATE] at 5:33 p.m. R11's admitting diagnoses included a history of a heart valve replacement and atrial fibrillation (2). A review of R12's hospital discharge records revealed the following as part of a list of the resident's discharge medications: Warfarin (Coumadin, a blood thinner) 5 mg (milligram) tab (tablet) .Daily dosage based on INR. A review of R12's provider's orders revealed the following order dated 12/2/24: PT/INR one time only for anticoagulant monitoring .Start dated 12/12/24. Further review of R12's clinical record failed to reveal evidence that the laboratory test was completed on 12/12/24. On 12/20/24 at 8:38 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated night shift nurses check to make sure laboratory orders have been entered correctly by the day and evening nurses, based on interactions with providers. She stated each morning, she does a secondary check to make sure all of the lab tests have been completed. She added: I am the last check. She stated on the date R12's PT/INR was due, circumstances prevented her from checking to make sure it had been completed as ordered. She stated the lab was not done as originally ordered by the provider. On 12/20/24 at 9:00 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing, and ASM #5, the regional director of clinical services, were informed of these concerns. A review of the facility policy, Anticoagulant Therapy, revealed, in part: Confirm with the physician the desired INR and/or PT testing schedule and therapeutic range .Initiate and order anticoagulant therapy labs per physician's order. No additional information was provided prior to exit. REFERENCE (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Prothrombin time (PT) and the associated international normalized ratio (INR) are routinely tested to assess the risk of bleeding or thrombosis and to monitor response to anticoagulant therapy in patients. This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569083/. (2) Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes your heart to beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications. This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation.