

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 01/07/2026
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, it was determined the facility staff failed to administer medications per the physician orders for three of five residents in the survey sample, Residents # 4, #5, and #2. The findings include: 1. For Resident #4 (R4), the facility staff failed to administer Calcium Carbonate Chewable Tablets on two occasions in December 2025. The physician order dated, 3/22/2025, documented, Calcium Carbonate Chewable Tablets (used to treat heartburn, upset stomach) (1) 500 MG (milligrams); Give 1 Tablet by mouth in the morning. The MAR (medication administration record) for December 2025, documented the above order. On 12/5/2025 and 12/26/2025, a blank was on the MAR where there should be documentation of the administration of the medication. An interview was conducted with LPN (licensed practical nurse #1, on 1/6/2026 at 4:45 p.m. LPN #1, LPN #1 stated a nurse evidence they've given medication by checking it off on the MAR. The above MAR was reviewed with LPN #1. LPN #1 stated if it's not documented it wasn't done. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical nurse consultant, were made aware of the above findings on 1/7/2026 at approximately 1:05 p.m. No further information was obtained prior to exit. 1. This information was obtained from the following website: https://medlineplus.gov/druginfo/med/s/a601032.html 2. For Resident #5 (R5), the facility staff failed to administer Ciprofloxacin (an antibiotic) (1) per the physician orders. The physician order dated, 12/18/2025, documented, Ciprofloxacin HCL (hydrochloride) 500 MG; Give 1 tablet by mouth every 12 hours for UTI (urinary tract infection) for 7 days. The December MAR documented the above order with a start date of 12/19/2025. On 12/19/2025 for the 9:00 a.m. dose and the 9:00 p.m. dose, the boxes were blank. Review of the list of medications in the emergency drug storage system documented the Ciprofloxacin in the emergency back up box. An interview was conducted with LPN (licensed practical nurse #1, on 1/6/2026 at 4:45 p.m. LPN #1, LPN #1 stated a nurse evidence they've given medication by checking it off on the MAR. The above MAR was reviewed with LPN #1. LPN #1 stated if it's not documented it wasn't done. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical nurse consultant, were made aware of the above findings on 1/7/2026 at approximately 1:05 p.m. No further information was obtained prior to exit. 1. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a688016.html 3. For Resident # 2 (R2) the facility staff failed to administer Lorazepam per the physician order. R2 was admitted to the facility on [DATE] for respite care. The physician order dated, 12/4/2025, documented, Lorazepam Oral Concentrate (used to treat anxiety and agitation) (1), 2 (two) MG/ML (milligrams per milliliter; Give 0.25 ml by mouth every 2 hours for anxiety. The December MAR documented the above order. For 12/4/2025, the medication was scheduled for 4:00 p.m., 6:00 p.m., 8:00 p.m. and 10:00 p.m. The nurse documented that she had given the medication as prescribed at those times. On 12/5/2025 at 4:00 a.m. and 6:00 a.m. doses, it was documented as administered. Review of the Narcotic sign out sheet, for the Lorazepam, documented the</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 495394	Facility ID: 495394 If continuation sheet Page 1 of 4

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>nurse only gave two doses on 12/4/2025 at 5:30 p.m. and 7:00p.m. There was no documentation that the medication had been administered at the other scheduled times. On 12/5/2025, it was documented on the narcotic sheet that the resident received the Lorazepam at 12:00 a.m., 2:00 a.m. and what appears to be 6:00 a.m. There is no documented dose at 4:00 a.m.The comprehensive care plan dated, 12/6/2026, documented lin part, Need: (R2) is at risk for adverse reactions and side effects from antianxiety medications. Interventions: Administer anti-anxiety medications per orders.An interview was conducted with LPN #1 on 1/6/2026 at 4:45 p.m. LPN #1 stated the process to administer a narcotic it to take it out of the narcotic box, sign what you are giving in the narcotic sign out book and then document the dose on the MAR. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical nurse consultant, were made aware of the above findings on 1/7/2026 at approximately 1:05 p.m.No further information was obtained prior to exit.1. This information was obtained from the following website: https://medlineplus.gov/druginfo/med s/a682053.html.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on staff interview and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for two of five residents in the survey sample, Residents #1 and #2. The findings include: 1. For Resident #1 (R1), the facility staff failed to document the administration of narcotic medications on the medication administration record (MAR). The physician order dated 12/4/2025, documented, Morphine Sulfate Oral Solution (used to treat pain) (1) 100 MG/5ML (milligrams per 5 milliliters); Give 0.5 ml by mouth every 4 hours as needed for SOB (shortness of breath) or discomfort. The December MAR documented the above order. The MAR documented the medication was only administered on 12/5/2025 at 9:33 a.m. Review of the narcotic sign out sheet, that is not a part of the clinical record, documented the resident had received Morphine on 12/4/2025 at 5:00 p.m. and 9:00 p.m. and again on 12/5/25 at 9:00 a.m. Only the 12/5/2025 at 9:00 a.m. dose was documented in the clinical record. The physician order dated 12/4/2025 documented, Lorazepam Oral Tablet (used to treat anxiety and agitation) (2) 0.5 MG (milligram); Give 1 tablet by mouth every 4 hours as needed for anxiety, restlessness or agitation for 14 days. The December MAR documented the above order. The MAR failed to evidence any documentation that the medication had been administered. Review of the narcotic sign out sheet, that is not a part of the clinical record, documented the resident had received Lorazepam on 12/4/2025 at 5:00 p.m. and 9:00 p.m. and on 12/5/2025 at 1:00 a.m. An interview was conducted with LPN #1 on 1/6/2026 at 4:45 p.m. LPN #1 stated the process to administer a narcotic it to take it out of the narcotic box, sign what you are giving in the narcotic sign out book and then document the dose administered on the MAR. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical nurse consultant, were made aware of the above findings on 1/7/2026 at approximately 1:05 p.m. No further information was obtained prior to exit. 1. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682133.html 2. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html. 2. For Resident #2 that facility staff failed to document or documented when medications were given when not given. The physician order dated 12/4/2025 documented, Morphine Sulfate Solution 20 MG/ML (milligrams per milliliter); Give 0.5 ml by mouth every 2 hours for pain. The December MAR documented the above order. On 12/4/2025 it was documented the nurse administered the Morphine at 4:00 p.m., 8:00 p.m. and 10:00 p.m. Review of the narcotic sign off sheet, failed to evidence the nurse administered the medication at that time. The only Morphine administered was documented on the narcotic sign off sheet was on 12/4/2025 at 6:00 p.m. On 12/5/2025 at 6:00 a.m. and on 12/5/2025 at 2:00 a.m., it was documented that the Morphine was administered. Review of the narcotic sign off sheet, failed to evidence a dose being administered at 6:00 a.m. on 12/5/2025 or 2:00 a.m. on 12/6/2025. On 12/6/2025 at 2:00 a.m. it was documented on the MAR that the Morphine was given. Review of the narcotic sign off sheet failed to evidence documentation that the dose was administered. On 12/6/2025 at 6:00 a.m. the nurse documented on the MAR that the resident was sleeping and did not administer the dose at that time. Review of the MAR documented the nurse did indeed administer the dose at 6:00 a.m. The physician order dated 12/4/2025 documented, Lorazepam Oral Concentrate 2 MG/ML; Give 0.25 ml by mouth every 2 hours for anxiety. The December MAR documented the above order. On 12/6/2025 at 2:00 a.m. the nurse signed off the administration of the Lorazepam. Review of the narcotic sign off sheet failed to evidence the administration of the Lorazepam at 2:00 a.m. On 12/6/2025 at 6:00 a.m. the nurse documented the resident was sleeping and did not administer the medication. Review of the narcotic sign off sheet documented the nurse did give the medication at 6:00 a.m. An interview was conducted with LPN #1</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>on 1/6/2026 at 4:45 p.m. LPN #1 stated the process to administer a narcotic it to take it out of the narcotic box, sign what you are giving in the narcotic sign out book and then document the dose administered on the MAR. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the clinical nurse consultant, were made aware of the above findings on 1/7/2026 at approximately 1:05 p.m.No further information was obtained prior to exit.</p>		