DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES



PRINTED: 03/02/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495346	B. WING		02/24/2017
,	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	,	STREET ADDRESS, CITY. STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENT	-s	F 000		
	conducted 2/22/17 are required for con Federal Long Term Safety Code survey The census in this 2 at the time of the surconsisted of 7 curre (Residents #1 throur record review (Residents - READIII) (g)(10) The resident (i) Examine the resofthe facility conducts are surveyors and any prespect to the facility (g)(11) The facility members residents, the results the facility. (ii) Have reports with certifications, and corespecting the facility years, and any plan respect to the facility to review upon requirements.	24 certified bed facility was 15 arvey. The survey sample and Resident reviews gh #7) and three closed dents #8 through #10). RIGHT TO SURVEY ACCESSIBLE thas the right to- ults of the most recent survey cited by Federal or State clan of correction in effect with y; and the most recent survey of so of the most recent survey of t	F 167	F167 1. All residents, family members and legal representatives were affected by this deficient practice. 2. The Medical Director was notified of these findings. 3. To ensure this deficient practice is corrected, a poster, a 8"x10", will be placed on the wall near the survey binder. T poster will have 1" lettering to indicate the location of the st bender. 4. Additionally, the three preceding years of survey results made available in a separate section of the survey binder. poster will also indicate that these survey results are availa and the location. 5. The poster and the binder will be monitored monthly by the Administrator and/or designee to ensure compliance. 6. Compliance will be reports at the quarterly Quality Assur and Performance Improvement Committee.	4/9/2017 t least 4/9/2017 his urvey will be 4/9/2017 The ble he 4/9/2017
	areas of the facility t	hat are prominent and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

caren M. Aolden (RN, LNHA

march 30, 2017

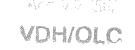
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

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

Event ID:7CR911

Facility ID: VA0295

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED



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CENTE	RS FOR MEDICARE	& MEDID SERVICES			OMB NO. 0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495346	B. WING	A AND AND AND AND AND AND AND AND AND AN	02/24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	
BON SE	COURS DEPAUL,TCC		description of the second of t	150 KINGSLEY LANE NORFOLK, VA 23505	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 167	Continued From pa	ge 1	F 16	37	
	accessible to the pu	ublic.			
	information about c This REQUIREMEN by: Based on observat facility staff failed to the location of the s residents and visitor	I not make available identifying omplainants or residents. It is not met as evidenced ion and staff interview, the provide a posting to indicate urvey results for review by the rs; and, failed to make the years of survey results readily ents and visitors.			
	The findings include	ed:			
	conducted with the allower observation, a copy a white binder was for located at the entrare contained a copy of completed on 4/28/2 that the survey resulting years were located in posting observed.	am, a facility tour was Administrator. Based on of the facility survey result in ound on a wall file organizer nce to the unit. The binder the facility survey result 16. The Administrator stated lts for the three preceding n her office. There was also it that directed the residents cation of the survey results.			
	interviewed in her of provide the three pre She pulled the previ- file cabinet in her off (1). These had not b residents and visitor	om, the Administrator was fice and was asked to eceding years survey results. ous three years results from a fice where she kept the 2567s een readily accessible for s. She stated, "I have not I just did it now.""When I'm			

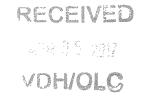
FORM CMS-2567(02-99) Previous Versions Obsolete

On 2/23/17 at 1:35 pm, during a meeting with the

Event ID: 7CR911

Facility ID: VA0295

If continuation sheet Page 2 of 17





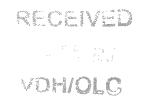
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495346	B. WING	manufacture and annual action as a second	02/24/2017
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	N (X5) BE COMPLETION
F 309 SS=E	Administrator, she sasked me about this got by me about the changes. But it's the copies of the survey preceding years in the entrance to the unit. A copy of the facility and accessibility of the requested and the facility. (1) 2567 - is a form deficiencies cited by (SA) or Regional Officorrections. (Source: https://www.cms.govForms/Downloads/0483.24, 483.25(k)(l) FOR HIGHEST WEI 483.24 Quality of life is a fur applies to all care ar residents. Each resifacility must provide services to attain or practicable physical, well-being, consister comprehensive asset 483.25 (k) Pain Managemer The facility must ens	stated that "No one had ever is, or is it new?" "That one is three years with the new ere now". She had added a results for the three he binder located at the he binder located at the policy that addressed posting the survey results was acility did not have a policy on was presented by the he surveying State Agency fice (RO) as requiring the surveying State Agency fice (RO) as requiring he will be a policy. The surveying State Agency fice (RO) as requiring he will be a policy. The surveying State Agency fice (RO) as requiring he will be a policy of the surveying State Agency fice (RO) as requiring he will be survey in the survey in th	F 30	67	4/9/2017 ior to 4/9/2017 ithe se DON 4/9/2017 Vand/or 4/9/2017 Quality

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

Event ID: 7CR911

Facility ID: VA0295

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAD SERVICES		on and and often party and a second party pass		OMB NO	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION		ATE SURVEY IMPLETED
		495346	B. WING	CONT. C. MAN CANADAM	address of the Addres	0:	2/24/2017
NAME OF F	PROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
DONEE	COUDS DEDAIL TOS		l	150 KI	NGSLEY LANE		
BON SEC	COURS DEPAUL,TCC			NORF	OLK, VA 23505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	the comprehensive and the residents' g (I) Dialysis. The fact residents who requiservices, consistent of practice, the comparties, and the repreferences. This REQUIREMENT by: Based on observation staff and resident in documentation, the care was provided to practicable physical	essional standards of practice, person-centered care plan, loals and preferences. cility must ensure that re dialysis receive such with professional standards prehensive person-centered esidents' goals and IT is not met as evidenced ions, clinical record review,	F 30)9			
	pain medications (H for Resident #1. 2. The facility staff for non-pharmacological	al approaches prior to offering ydrocodone/Acetaminophen)					
		admitted to the nursing facility noses that included surgical					
							1

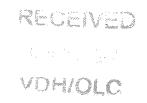
FORM CMS-2567(02-99) Previous Versions Obsolete

The most recent Minimum Data Set (MDS) was a 30 day dated 2/20/17 and coded the resident with

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDI



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CENTERS FOR MEDICARE	& MEDIL ID SERVICES				0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE	
	495346	B. WING	W 2017 - M 1000 M 1	02/2	4/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	The control of the co	5 17 May 43 1 7
BON SECOURS DEPAUL,TCC			150 KINGSLEY LANE NORFOLK, VA 23505		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
indicated the reside the skills needed for Resident #1 was as assistance of one station (ADL) excep with set up of one states assessed to have properties (PRN) pain medical non-medication into the Care Plan date resident had anxiety set by the staff would verbalize or gesture control was adequated the staff listed they included evaluate for interventions for incompositioning/music/T bath/shower, etc). The facility's Admissionated the nursing facility Resident #1 had physical for Hydrocodone/Acting/325 by mouth in necessary.	a possible score of 15 which ent was moderately impaired in or daily decision making. Seessed to require extensive staff for all Activities of Daily teating where she was coded staff only. The resident was eain, was on a 'as needed' tion, as well as erventions for pain. In 1/24/17 identified the y due to pain and that the goal lid be that the resident would be to communicate her pain te. Some of the interventions used to accomplish this goal or non-pharmacological reased comfort. Told Triangle of the interventions used to accomplish this goal or non-pharmacological reased comfort. Told Triangle of the interventions used to accomplish this goal or non-pharmacological reased comfort.	F 3	09		

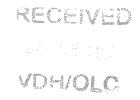
FORM CMS-2567(02-99) Previous Versions Obsolete

no forms of documentation in the clinical record that indicated other interventions were tried or attempted prior to administration of the

Event ID: 7CR911

Facility ID: VA0295

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CENTE	RS FOR MEDICARE	& MEDI D SERVICES			OMB NO. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495346	B. WING		02/24/2017
	PROVIDER OR SUPPLIER COURS DEPAUL,TCC		1	TREET ADDRESS, CITY, STATE, ZIP CODE 50 KINGSLEY LANE IORFOLK, VA 23505	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 309	Continued From pa Hydrocodone/Aceta		F 309		i
	DON on 2/23/17 are about what non-pha staff try prior to adm or pain medication, Certified Nursing As and use pillows for during this interview determine or evaluation.	with the Administrator and the bund 2:30 p.m. when asked irmacological measures would inistering a PRN anti-anxiety the Administrator stated the sistants (CNA) turn residents comfort. It was determined to the CNAs would not te for the need for an medication after trying other			
	at 2:45 p.m., she sta	with Resident #1 on 2/23/17 ated she was not aware of ould do besides give her a sked for it.			
	pass and pour obsel Practical Nurse (LPN anti-pain medication	o.m., during a medication rvation, the Licensed N) #1 administered a PRN to another resident without pproaches to alleviate the			
	policy or procedure t	I approaches prior to use of a			
	medication is used to pain. It contains an o (Hydrocodone) and a	etaminophen combination o relieve moderate to severe pioid (narcotic) pain reliever a non-opioid pain reliever rdrocodone works in the			

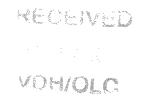
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brain to change how your body feels and responds to pain. Acetaminophen can also

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDI



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CENTER	RS FOR MEDICARE	& MEDID SERVICES				OMB NO. 09	38-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SU COMPLE	
		495346	B. WING		MANAGEMENT PR. A. V. C.	02/24/	2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BON SE	COURS DEPAUL,TCC				50 KINGSLEY LANE ORFOLK, VA 23505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CC	(X5) DMPLETION DATE
F 309	Continued From pa	ge 6	F 3	09			
	reduce a fever (http://www.webmd odone-acetaminoph	.com/drugs/2/drug-251/Hydroc nen-oral/details).					
	on 2/13/17 with diag aftercare and spina. The most recent Mi an Admission dated resident with a scoro of 15 which indicate problems in the skill making. Resident #: extensive assistanc of Daily Living (ADL was coded with set resident was assess	nimum Data Set (MDS) was 2/20/17 and coded the e of 14 out of a possible score of the resident had no ls needed for daily decision 2 was assessed to require e of one staff for all Activities) except eating where she up of one staff only. The sed to have pain, was on a 'as medication, as well as					
	resident had alterati surgical status (lumb that the goal set by the resident would verbat communicate her pa Some of the interver used to accomplish non-pharmacological comfort (positioning/ or bath/shower, etc)	ain control was adequate. Intions the staff listed they this goal included evaluate for al interventions for increased //music/TV/reading/warm drink					
	Resident #2 had phy	vsician's orders dated 2/13/17					1

for Oxycodone (1) 10 milligrams

(mg)/Acetaminophen 325 mg 1-2 tablets every 6 hours by mouth (PO) as needed (PRN) for pain.

DEPARTMENT OF HEALTH AND HUNN SERVICES



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CENTER	RS FOR MEDICARE	& MEDIC D SERVICES				OME	3 NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X:	3) DATE SURVEY COMPLETED
		495346	B. WING			LDDGCS4LCCHID0+4467860;ht0:0000480000000000000000000000000000000	02/24/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP	, CODE	
BON SEC	COURS DEPAUL,TCC				KINGSLEY LANE RFOLK, VA 23505		
Martiner programme to the second				NON	PROVIDER'S PLAN OF C	ODDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT	
F 309	Continued From pa	ige 7	F3	309			
	Administration Recadministered Oxycomg 2 tablets 33 time documentation in the other interventions	ebruary 2017 Medication ords (MAR), Resident #2 was odone/Acetaminophen 10/325 es. There were no forms of ne clinical record that indicated were tried or attempted prior the pain medication.					
	DON on 2/23/17 are what non-pharmace nursing staff try price anti-anxiety or pain Administrator states. Assistants (CNA) to for comfort. It was conterview, the CNAs evaluate for the needs	with the Administrator and the ound 2:30 p.m. when asked blogical measures would the or to administering a PRN medications, the d the Certified Nursing arn residents and use pillows determined during this is would not determine or ed for an anti-anxiety or pain ing other interventions.					
	she asked for Oxyc nursing staff brings her. She said she w	p.m., Resident #2 stated once odone/Acetaminophen, the the medication and gives it to vas not offered any other prior to administration of hinophen.					
	pass and pour obse Practical Nurse (LP anti-pain medication	p.m., during a medication ervation, the Licensed N) #1 administered a PRN n to another resident without pproaches to alleviate the tate.					

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The Administrator stated they did not have a

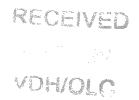
non-pharmacological approaches prior to use of a

policy or procedure to address

Event ID: 7CR911

Facility ID: VA0295

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495346	B. WING	2 II . M. 17 Million of Million and American and Conference of the	02/24/2017
BON SE	PROVIDER OR SUPPLIER COURS DEPAUL,TCC		asse a standard de mario in grando in cognida de posições programas com su mario de standard de mario in cognida de posições por cognida de standard de mario in cognida de posições programas com su mario de standard de mario in cognida de posições por cognida de posições por cognidad de posições	STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 309	PRN psychotropic r (1) Oxycodone/Ace		F 309		
F 329 SS=D	severe pain. Oxycodrugs known as opi works in the brain to and responds to pai (http://www.webmd. Oxycodone-oral/Ox	done belongs to a class of oid (narcotic) analgesics. It o change how your body feels n com/drugs/2/drug-1025-5278/ycodone oral/details). EGIMEN IS FREE FROM	F 329	F 329 1. There were no adverse signs and/or symptoms for the ide residents and there were no other residents who were adversaffected by this deficient practice.	
	drug regimen must	ugs-General. Each resident's be free from unnecessary sary drug is any drug when		The Medical Director was notified of all findings. A policy for non-pharmacological interventions prior to off anti- anxiety medications will be developed and presented to Quality Assurance Performance Improvement Committee for and approval. All licensed staff will be in-serviced on the new policy by the and/or designee. Monthly random chart audits will be completed by the DON.	o the review ne DON 4/9/2017
	therapy); or	e (including duplicate drug		designee and the results of the audits will be reported to the Assurance Performance Improvement Committee on a quar 6. All psychotropic medications will be reviewed by the DON designee on a monthly basis to ensure that the drug regimen form unnecessary drugs and these findings will be reviewed	Quality terly basis. and/or 4/9/2017 is free
	(2) For excessive du(3) Without adequate			Pharmacist and the Medical Director on a monthly basis and to the Quality Assurance and Performance Improvement Coron a quarterly basis.	
	(4) Without adequate	e indications for its use; or			
	()	of adverse consequences ose should be reduced or			
	paragraphs (d)(1) the This REQUIREMEN' by: Based on observation staff and resident into	s of the reasons stated in rough (5) of this section. T is not met as evidenced ons, clinical record review, erview, the facility staff failed idents (Resident #1 and #2)			



CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495346	B. WING _	17 TH 12 - F IN NOVEMBER CONSISTENCE CONTROL OF THE	02/24/2017
	PROVIDER OR SUPPLIER COURS DEPAUL,TCC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 329	Continued From pa	**	F 32	9	
	non-pharmacologic	ailed to offer Resident #1 al interventions prior the ti-anxiety medication, Ativan			
	non-pharmacologic	ailed to offer Resident #2 al interventions prior the ti-anxiety medication, Xanax			
	The findings include); ;			
	1. Resident #1 was on 1/23/17 with diag aftercare (left hip fra	admitted to the nursing facility noses that included surgical acture).			
	30 day dated 2/20/1 a score of 11 out of a indicated the resider the skills needed for Resident #1 was assistance of one station (ADL) except with set up of one stated for an anxiety resident was assess needed (PRN) pain non-medication interresident was coded to	nimum Data Set (MDS) was a 7 and coded the resident with a possible score of 15 which at was moderately impaired in daily decision making. Sessed to require extensive aff for all Activities of Daily eating where she was coded aff only. The resident was not disorder diagnosis. The ed to have pain, was on a 'as medication, as well as ventions for pain. The to have received antianxiety upporting diagnoses for the			
	The Care Plan dated	1/24/17 identified the			

resident had anxiety due to pain and that the goal set by the staff would be that the resident would verbalize or gesture to communicate her pain

DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES



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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495346	B. WING	and some some and boundaries appear on some has appear suggests a set of	02/24/2017
	PROVIDER OR SUPPLIER COURS DEPAUL,TCC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
	the staff listed they included evaluate for interventions for incompositioning/music/1 bath/shower, etc.). The also indicated the reand was on a psychiate the disorder. The resident was that shoping skills related exhibit behaviors the over the next 30 day the staff listed to imencourage resident feelings, help find where evaluate mood and the facility's Admissionated 1/24/17 did not for the resident nor the resident mood. The facility is administration revery 6 hours as new According to the Jar Administration Recomposition administered Ativan February, thirteen (1 forms of documental indicated other intervattempted prior to according to the Jar Administration recomposition of	te. Some of the interventions used to accomplish this goal or non-pharmacological reased comfort [V/reading/warm drink or The care plan dated 1/23/17 esident had a anxiety disorder notropic medication used to the goal the staff set for the ne would demonstrate good to anxiety symptoms and at will promote her well-being ys. Some of the interventions plement this goal included to express and identify mays to cope with feeling, behaviors and document. Sion History and Physical of address anxiety situations list a diagnosis of anxiety. Sysician's orders dated 1/23/17 ams (mg) by mouth (PO) cessary. The provided the intervention of the Clinical record that wentions were tried or diministration of the Ativan.	F 329		
	During a interview w	ith the Administrator and the			

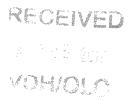
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DON on 2/23/17 around 2:30 p.m. when asked what non-pharmacological measures would the

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DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES



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CENTE	KS FUR MEDICARE	A MEDIORID SERVICES		wa swishipinanji kwaji kwi		CINIR IA	J. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY OMPLETED
		495346	B. WING	********	8 Al 3 A 4 4 4 more contrasted a red years and parameter proper features are contrasted a displacement from P 1 Al 1	0:	2/24/2017
NAME OF	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	Andrew Street Constitution Constitution (Street Constitution (Street Constitution (Street Constitution (Street	CONTRACTOR OF THE PROPERTY OF
BON SE	COURS DEPAUL,TCC	;			O KINGSLEY LANE		
				IAC	DRFOLK, VA 23505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	Continued From pa nursing staff try pric anti-anxiety or pain	or to administering a PRN	F3	129			
	Administrator state Assistants (CNA) to	d the Certified Nursing urn residents and use pillows					
	interview, the CNAs evaluate for the nee	determined during this s would not determine or ed for an anti-anxiety or pain ing other interventions.					
	at 2:45 p.m., she st	with Resident #1 on 2/23/17 ated she was not aware of rould do besides give her the ne asked for it.					•
	pass and pour obse Practical Nurse (LP antianxiety medicat	p.m., during a medication ervation, the Licensed N) #1 administered a PRN ion to another resident without pproaches to alleviate the tate.					
	policy or procedure	al approaches prior to use of a					
	anxiety. Lorazepam known as benzodia and nerves (central calming effect. This effects of a certain in (GABA)	m medication is used to treat belongs to a class of drugs zepines which act on the brain nervous system) to produce a drug works by enhancing the natural chemical in the body com/drugs/2/drug-6685/ativan					
	2. Resident #2 was on 2/13/17 with diag	admitted to the nursing facility gnoses that included surgical					TO THE PROPERTY OF THE PROPERT

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aftercare and spinal stenosis.

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DEPARTMENT OF HEALTH AND HUNN SERVICES.



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	RS FOR MEDICARE	& MEDICALD SERVICES			OM	FORM APPROVED 1B NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495346	B. WING	Belleville and State Commission of the State Commissio		02/24/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
BON SE	COURS DEPAUL,TCC			150 KINGSLEY LANE			
				NORFOLK, VA 2350	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRI IEFICIENCY)		
F 329	Continued From pa	ge 12	F 3	29			
	an Admission dated resident with a scor of 15 which indicate problems in the skill making. Resident ## extensive assistanc of Daily Living (ADL was coded with set resident was not codiagnosis. The resident was on a 'as n medication, as well interventions for pain have received antian supporting diagnose. The Care Plan dated resident had alterative surgical status (lumb that the goal set by the resident would verbacommunicate her passident would verbacommunicate her passome of the interver used to accomplish non-pharmacological comfort (positioning/or bath/shower, etc.) also indicated the reand was on a psychotreat the disorder. The resident was that she coping skills related exhibit behaviors that	as non-medication n. The resident was coded to exiety medication, but no es for the use of it. d 2/14/17 identified the on in comfort related to post par fusion) and stenosis and the staff would be that the					

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the staff listed to implement this goal included encourage resident to express and identify feelings, help find ways to cope with feeling,

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARE & SERVICES

PRINTED: 03/02/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	42 LOK MEDICAKE	& MEDIONAD SERVICES				MD 140. 0330-0331	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495346	B. WING		182.3.7.8.8.8.	02/24/2017	
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
BON SEC	COURS DEPAUL,TCC				INGSLEY LANE FOLK, VA 23505		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 COMPLETION	
F 329	2329 Continued From page 13 evaluate mood and behaviors and document			329			
		ysician's orders dated 2/13/17 nouth (PO) three times a day or anxiety.					
	Administration Recadministered Xanax were no forms of do record that indicate	bruary 2017 Medication ords (MAR), Resident #2 was a PO seven (7) times. There ocumentation in the clinical d other interventions were rior to administration of the					
	DON on 2/23/17 are what non-pharmace nursing staff try price anti-anxiety or pain Administrator states Assistants (CNA) tu for comfort. It was conterview, the CNAs evaluate for the needs	with the Administrator and the bund 2:30 p.m. when asked blogical measures would the or to administering a PRN medications, the difference that the Certified Nursing rn residents and use pillows letermined during this awould not determine or ed for an anti-anxiety or paining other interventions.					
	she asked for Xana medication and give not offered any othe administration of Xa	p.m., Resident #2 stated once x, the nursing staff brings the as it to her. She said she was a comfort measures prior to anax.					
		rvation the Licensed				and a second	

Practical Nurse (LPN) #1 administered a PRN antianxiety medication to another resident without offering any other approaches to alleviate the



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495346	B. WING	***************************************	02	2/24/2017
	PROVIDER OR SUPPLIER COURS DEPAUL,TCC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505	Standardinessocienzisticka distribución	PP And PP One WE SERVE AND A CONTROL OF THE SERVE AND A CONTROL OF T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From paresident's anxiety st	ate.	F 32	29		
	policy or procedure	al approaches prior to use of a				
	panic disorders. It be medications called to the brain and nerves produce a calming of the effects of a certal body (GABA) (http://www.webmd.o- oral/details).	penzodiazepines which act on s (central nervous system) to effect. It works by enhancing ain natural chemical in the com/drugs/2/drug-9824/xanax		F371		
F 371 SS=F	considered satisfacte authorities. (i) This may include	from sources approved or or by federal, state or local food items obtained directly subject to applicable State	F 37	 There were no residents identified as having been aff this deficient practice. All residents had the potential to be affected by this depractice. The Medical Director was notified of these findings. The Director of Food and Nutrition Services has deverocedure to ensure the deficient practice will not occur. The Manager on Duty is responsible to verify by direct that each person responsible for this task is correctly petask and documenting the results. All staff involved has been in serviced and documente will be audited on a random basis and the results will be to the Quality Assurance and Performance Improvement on a quarterly basis. 	eficient loped a again. t observation erforming the ed results presented	4/9/2017 4/9/2017 4/9/2017 4/9/2017 4/9/2017
	facilities from using p gardens, subject to o	es not prohibit or prevent produce grown in facility compliance with applicable ad-handling practices.				
	(iii) This provision do from consuming food	es not preclude residents ts not procured by the facility.				
		e, distribute and serve food in essional standards for food				decimality of the second secon

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CENTER	RS FOR MEDICARE	E & MEDIČ) SERVICES				<u>omb nc</u>). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		495346	B. WING			02	2/24/2017
NAME OF F	PROVIDER OR SUPPLIER	Representation of the second s		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				150	KINGSLEY LANE		
BON SEC	COURS DEPAUL,TCC	,		NOF	RFOLK, VA 23505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	Continued From pa	ige 15	F:	371			
	foods brought to results visitors to ensure satisfication and constitutions. This REQUIREMENT by: Based on inspection interviews and facilities staff failed to ensure were followed in the The Food Service To thermometer between ach food item on the The findings included During observation 11:30 a.m., the Food obtained the temperitems without sanitize between obtaining the awipe cloth that was preparation surface. Afterwards the FST surveyor wanted her I can do it again using Chef was present as stated afterwards, "sanitized bucket or achecking those temperitems to ensure the I can do it again using the I can do	on of the kitchen, staff lity policy review, the facility re safe and sanitary practices e kitchen. Technician failed to sanitize the een acquiring temperatures for the tray line. Technician failed to sanitize the een acquiring temperatures for the tray line. Technician failed to sanitize the een acquiring temperatures for the tray line on 2/23/17 at od Service Technician (FST) eratures of seven (7) food zing the thermometer in those temperatures. She used as used to wipe food as to clean the thermometer. Testated she thought this er to "Hurry and get it done, but ing alcohol wipes." The Lead and did not stop the FST, but "She did not use either the an alcohol wipe in between aperatures."					
	She stated she was	3/17 at approximately 4:45 p.m. s very upset and she expected he thermometer using either					

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the sanitizing agent in the prepared bucket or with alcohol pads. The Director stated she did not

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

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CENTER	RS FOR MEDICARE	& MEDIN D SERVICES	-	000A004000X240A0004		<u>)MB NO. 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495346	B. WING			02/24/2017
NAME OF F	PROVIDER OR SUPPLIER			\$1	REET ADDRESS, CITY, STATE, ZIP CODE	
BON SEC	COURS DEPAUL,TCC			15	60 KINGSLEY LANE	
DON OL	SOUND DEL AGE, 100			N	ORFOLK, VA 23505	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 371	Continued From pa	ge 16 pecifically addressed	F 3	371		
	sanitizing the therm	ometer between taking ch food item, she expected				
		nd it is what she routinely				
		p.m., the Administrator was				
		aforementioned issue in the information was provided prior				
	,					

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