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:		is conducted 3/12/18 th					1
i i		was not in compliance v	vilh	· Ł			
<u> </u> ;	the Virginia Rules an			1	<u> </u> :		<u>}</u>
1	Licensure of Nursing	raciilies.];	· .		1
J	i The census in this 12	20 certified bed facility v	vas] :	<u> </u>		
-	1	survey. The survey sa		,	The statements made on	this plan	4-25-18
	consisted of 41 reside	ent reviews; 35 current		}	of correction are not an a	dmission	:
	residents and 6 close	ed.			to and do not constitute a	ın	.
	į:				agreement with the alleg	⊇d	1 1
FODT	Non Compliance			F001	deficiencies herein. To re	main th	
					compliance with all state	and	1 1
	•	f compliance with the		1	federal regulations, the co	enter has	1
:	following state licens	nue tedaliettietus:		; }	laken the autions sot forti	h in the	
,	This RULE: is not me	et as evidenced by:		.}	following plan of correctly	on. The	
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3	12VAC5-371 - 250 K	o F657 Care Plan Revis	noie) :			!
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X Patricia Bailey signing for Kathayo Kright Adminion tractor

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EXPENSION OF SERVICES OF REPORT OF TREASURE ASSOCIATION AND SERVICES OF TREASURE PRODUCTION AND SERVIC	State of Vir	ginis				77.111.	FORMAPPROVE
NAME OF PROVIDER OR SUPPLIES BON SECOURS-MARRY/VEW NURSING STATE AND STATE			IDENTIFICATION NUME		A. BUILOING _	CONSTRUCTION	COMPLETED
SINGLE ROAD SINGLE	· NAME OF PRO	White Or groppies	1 495206	CTOUL CARD		Tub and	03/15/2018
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PRETAL TORY OR LISC DETITIVING INFORMATION) 12/NC-5: 12/NC-5: 12/NC-5: 13/1-180* 1-18		O MANAGO OT	AZEN MENTAL PARENTAL PROPERTY AND ADDRESS OF THE PARENTY AND ADDRESS OF THE	SUFFOLK,	VA 23435		
1. Resident # 103 and #96 have had no ill -effects from his practice. Residents #103 and #96's respiratory devices will be stored according to policy and appropriate infection control practiceEducation was completed for staff members #3#2#26 regarding infection Control Practices. 2. Those residents who have respiratory devices or that reside within the facility could potentially be affected by lhese practices. 3.A) The infection Control Coordinator will complete monthly fracking /trending and reporting on infections and infection provention within he facility. This report will be provided to the DON/Administrator monthly for their miview. B) Education was provided to nursing care staff on Infection control policy and practices. This education included the following: -Hand washing policy including practices followed during the dining and meat timesPractice of glucometer checks and protection barriers during this practiceNobulizar/respiratory device storage C) The Infection Control Coordinator will conduct monthly reviews/audits of the Infection control practices in Findings of these audits and action items; shandwashing, glucometer infection control practices and respiratory device storage. The findings of these audits and action items will be provided to the Don monthly for	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FE		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE COMPLETE
	1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-					1. Resident # 103 and #96 had no ill -effects from this practiceResidents #103 and #96's respiratory devices will be according to policy and appropriate infection control practiceEducation was completed members #5#2#26 regardle infection Control PracticesEducation was completed members #5#2#26 regardle infection Control Practices. 2. Those residents who have respiratory devices or that within the facility could pote be affected by linese practice. 3.A) The Infection Control Coordinator will complete miracking /trending and repoinfections and infection provided to the DON/Administrator monthly their mire. B) Education was provided nursing care staff on Infectice control policy and practices education included the follo-Hand washing policy including and meat timesPractice of glucometer che and protection barriers duminativeNebulizer/respiratory devices torage C) The Infection Control Coordinator will conduct moreview/audits of the Infection control tracking numbers, handwashing, glucometer in control practices and respirately device storage. The findings theso audits and action items and respirately audits and action items.	have 4-23-18 stored of for staff ng ve reside entially cos. monthly rting on vention it will for to on This wing: ting e cks ng this e entially
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			- 1	12VAC5-	4) The DON will report Quality Assurance and Performance Improvem Committee monthly for the findings and action these audits to assure practice/policy complianinfection control practice policy. 5) Date of Compliance of Compl	nent 6 months items of nce with e and	4,25-18
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IAME OF PROVIDER OR SUPPLIER		STREET	ADDRESS, CITÝ, STATE,	ZIP COOE		<u> </u>
BON SECOURS-MARYVIEW NURSING C		SUFFO	RIDGE ROAD LK, VA 23435			
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			12VAC 5-	12VAC5-371-250/F 1) Rosident # 34 is a rosident. Resident # plan has been review revised as needed. 2) Those residents with facility with individual that require their care reviewed and revised potentially be affected practice. 3) Process review an include the following: a) An Enhanced process initiated at the am clirithat will include those are reported and need updates or revisions with the will include those are reported and need that is identified outside meeting. b) The required need that is identified outside meeting will be directed mds/unit manager for update in between as c) A monthly random appropriate updates be manager and will be pushed by monthly. 4) The DON will report findings and care plan to Quality Assurance aperformance Improver Committee (QAPI) momonths to ensure compare plan update process.	discharged 263's care ved and ho reside in dual needs e plans to be could d by this d revisions ass has been alcat meeting items that d care plan will be dit managers for update de the am ed to the ongoing sessments audit will and y the unit rovided to audit compliance ind nent nthty for 3 pliance with se/policy.	4125/10

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STATEMEN (:OF CO AND PLAN OF CO		(X1) PROVIDEN/SUPPLIER/ IDENTIFICATION NUMB	CLIA IER;	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SII COMPLET	
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	IDER OR SUPPLIER RS-MARYVIEW NURS	ING C	STREET AND 4775 BRID SUFFOLK,		ATE, PIP CODE	•	
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				12 VAC 5- 37 - 220 C	12 VACS-371-220C-/F 684 1) Resident (207) Is a discharg resident: - Education provided to slaff member identified (425) 2) Those residents who receive Insulin could potentially be at ris 3) a) Education was provided to nurses on: -following physicians order and sliding scale for insulin coverage b) The nurse managers will conduct weekly audits of the following and report findings to the following and report findings coverage, glucometer checks an sliding scale physician orders coverage and provide feedback the DON monthly. 4) The DON will report to Quality Assurance and Performance Improvement Committee (QAPI)monthly for 3 months, the findings of the audits related to inedication provided for sliding scale and the follow up to sustain compliance with insulin coverage, glucometer checks and documentation. 5) Date of Compilance 4/25/16	ed sk sk	4/25/18
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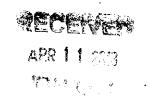
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		495206		B. WING		03	/15/2018
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			- 1	12 VAC 5 - 3'71-2200	12VACS-371-220D/F 667 1) Resident #263 was senn outside godattist. Residents plan was reviewed and updaneeded. 2) Those residents with podineeded. 3) A) The Nurse managers will residents who have been assessed or receives an ord podiatry care to an outside podiatrist. B) Facility will actively seek to a qualified Internal contractor podiatry care that could visit facility. C) A facility list will be established for those residents who need podiatry care and follow up appointments as needed. This will be kept by the Unit Manager This list will be provided to the DON monthly. D) Education to the nurses we provided on assessment /evaluation/observation of foo care needs during showers or care. 4) The DON will submit the podiatry need/ appointment list Quality Assurance and Performance Improvement Committee (QAPI)monthly for months to assure compliance foot/podiatry appointments/os 5) Date of Compliance 4/25/18	care ated as latry refer er for find for the shed s list gers. e as t/nait	4125118
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					2 y Ac 5- 3 71 - 300 A	1. Resident #5 s medical care needs have been revaluated and care plant as needed. The medication is new delivered labeled and revender with the facilities external vendor. 2. Those residents who is medications brought in froutside source or need recould potentially be affect this practice; 3. A) A review of the policy medications provided by an outside source was computed by an outside source was computed by the Don/Administrator B) Education was provided by an outside source was provided by the Don/Administrator B) Education was provided the following: If medication is requested brought in from an outside it will be communicated to DON for review and considered the policy. C) A review and audit will be completed weakly of those residents who may have medications requested or reby an outside source. This and action items will be proton the Don weekly. 4) The Don will report to the Quality Assurance and Performance Improvement Committee (QAPI) monthly menths the findings and neaction items regarding	ations and elections and elections and elections and elections are promised to the promised election at may side election the election the election the election and election the election the election and election the election the election and election the election the election the election and election the election the election and election the election the election and election the election and elections are electronic	4/2511
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				12 VAC5- 871-2204	t. Plan of Correction/Abe provided with immediate for oxygen use and safet residents #25 and #4. A) Residents #25 and #4's needs including oxygen is reviewed and their care rupdated as needed. Thoso residents who roxygen and utilize tanks potentially be affected by practice. A) Education was providenting care staff on: -tho oxygen administratistorage, safety and documpracilice per the oxygen pounding the cally by the Nurse Manage Environmental services to related to oxygen storage safety. C) The results and any neaction items of the safety will be provided to the Administrator dally as need weekly by report. The Administrator will in Quality Assurance Committed (GAPI) monthly for 6 monthindings of the safety/oxygrounding and audits and a action items to assure con with the oxygon Date of Compliance 4/25/18	stement follow up y for care use were plans eceivo could this ed to on, nentation olicy. briducted ers and am and cessary audils ded and aport to ittee en ny	4/25/18
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ratement of ND PLAN OF C	LAN OF CORRECTION NUMBER: 495206		MER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION	<u>}</u>	SURVET PLETED
	MIDER OR SUPPLIER VRS-MARYVIEW NURS	ING C	STREE FAGD 4775 BRID SUFFOLK,		ZIP CODE		, , , , , , , , , , , , , , , , , , , ,
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Improvement Committee (QAPI) monthly for 3 months the finding of the baseline care plan audit and any follow up actions items to maintain compliance with the baseline care plan policy. 5) Date of Compliance 4/25/18				1.	1	1. Residents #25 164,213,103,51,57 we offered the opportunity to retheir current care plan and progress since admissionEducation and policy requiprovided to Identified team members: #4,#5,#2, DON, I 2. Those residents residing facility could potentially be a for this practice. 3. A) The current practice was reviewed and modified to interdisciplinary meeting and according the required timel requirementThe Signature page will be maintained as a record of the baseline care plans being of and accepted or refused. B) The MDS Coordinator with newly admitted residents and compile a log. The log will in that a baseline care plan was offered and documented to residents per required timeling this log will be provided to It DON Monthly. 4) The DON will report to Quality and follow up actions items to maintain compliance with the baseline care plan audit any follow up actions items to maintain compliance with the baseline care plan policy.	rement MDS In the at risk clude; d I audit d dicale s new ne. alily API) ling of and	4 (25)18



DEPARTMENT OF HEAL'TH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	IX1) PROVICER/SUPPLIER/CUA IDENTIFICATION NUMBER.	(X2) MIJI A_BUILD		FRONSTRUCTION	(XG) DATE	SURVAY LETEO
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€ 000	Initiat Comments An unannounced Errsurvey was conducte Corrections are required. CFR Part 483.73, RecCare Facilities. Five (investigated during the Policies/Procedures-CFR(s): 483.73(b)(6) [(b) Policies and procedure policies and procedure policies and procedure plan set forth in paragrand the communication in the policies address the following (6) [or (4), (5), or (7) a volunteers in an emore staffing strategies, incommended for integration of State health care profession during an emergency *(For RNHCIs at §403 procedures. (6) The unemergency and other	nergency Preparedness d 3/12/18 Ihrough 3/19/18. red for compliance with 42 quirement for Long-Term 5) complaints were the survey. Volunteers and Staffing edures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of these and procedures must be d at least annually. At a a and procedures must i:] as noted above] The use of regoncy or other emergency cluding the process and role the and Federally designated hals to address surge needs 3.748(b):] Policies and the emergency staffing	E	000	The stalements made on this plan of corare not an admission to and do not consagreement with the alleged deficiencies of the cereating of the center has taken actions set forth in the following plan of correction. The following plan of correctionstitutes the centors allegations of compliance. All alleged doficiencies have or will be corrected by the date indicated E024 1) No residents alfected at time of surversely potentiat for all residents to be affected at the procedure was revisupdated to reflect the following tlems: The use of volunteers and other emerges staffing strategies including the process of state and federatly designated horither professionals in the event of an emerger. To include and ensure process review table-top exercises as needed and requiregulation. Also, to include and ensure documentated Outcome and Actions in the After -Action Improvement Plan. b) Education was provided to staff, residing items: The policy and process for the use and incorporation finvolvement of volunteers other staff during emergencies and table exercises/drills. 4) The Administrator will provide updates Quality Assurance and Performance Improvement (QAPI) committee monthly emergency drills, exercises, policy changes, contact information changes,	rection titule an herein. hd the on e been y d. sed and ency and role care hcy. after the red per ion of ents and top s to the on any ges, role	47/3/1X
	emergency. This REQUIREMENT	surge needs during an is not met as evidenced			documentation and required after action 5) Date of compliance 4/25/18	aoma.	
	by: Based on review of the	he facilily's emergency					
		nd staff interview, the facility	1				
		the policies were in place for	[
ABORATORY	DIRECTOR'S OR PROVIDER/S	UPPCIER REPRESENTATIVE'S SIGNATURE			דווו ר	, <u></u>	(X6) DATF

Any deficiency statement ending with an asterisk (*) defictes a deficiency which the institution may be excused from correcting providing it is determined that other sategrands provide sufficient protection to the patients. (See instructions | Except for nursing fromos, the findings stated above are disclosable 90 days fellowing the date of servey whether or not a plan of correction is provided. For dursing fromes, the anniverring 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 requirate to continued program participation.

Facility IO: VA0040

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DEPARTMENT OF LIEALTHAND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

AND DUAN OF CORRECTION MORREST		(X2) MULTIPL A BUILDING	E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		495206	B. WING	<u></u>	C 03/19/2018
NAME OF P	KOVIDER OR SUPPLIER	<u> </u>	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP GOOE	
DOM OF O	DUBO MADAUACIA MUDI	01110 C		4775 BRIDGE ROAD	
BÛN ŞEC	DURS-MARYVIEW NUR	SINGC		SUFFOLK, VA 23435	
(X4) ID PREHX TAG	[EACH DEFICIENC	ATEMENI OF DEFICIENCIES Y MURT BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION [FACH CORRECTIVE ACTION SHOULD B CROSS-REFFRENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
E 024	Conlinued From page volunteers.	⊒ 1 	E 024	4.	
	The findings included	t :			
	conducted with the D Project Administrator During the interview of persons, the facility s	m. and interview was iroctor of Long Term Care and the Clinical Analyst. with the aforementioned laft-failed to provide			
	for the use of volunte	ers and other staff strategies by preparedness plan.			
E Q26 SS=C		er Declared by Secretary	E .02	e <u>E026</u>	4/25/18
	develop and impleme policies and procedu plan set forth in para-assessment at paragand the communicall this section. The policie reviewed and update minimum, the policie address the following (8) [(6), (6)(C)(iv), (7) [facility] under a waity), or (9)] The role of the or declared by the Secretary,		 No residents affected at time of survey. Potential for all residents to be affected. The policy and procedures were revised as needed for providing care an treatment at Atternate Care Siles undorwaiver. The Planned current and future Table exercises will be evaluated and docume determine effectiveness of this policy & procedure in practice. The Administrator will provide updat Quality Assurance and Performance Improvement (QAPI) committee monthle emergency drills, exercises, policy charchanges, contact information changes, 	ed. ewed and id the 1135 e Top ented to es to the y on any nges, rote
	provision of care and	eclion 1135 of the Act, in the I trealment at an allernate y emergency management		documontation and required after action 5) Date of Compliance 4/25/18	n items
	procedures, (8) The waiver declared by the with section 1135 of a	3.748(b):] Policies and role of the RNHCI under a ne Secretary, in accordance AcI, in the provision of care site identified by emergency			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB_NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDEN/SUPPLIERICLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI ILTIPLE CONSTRUCTION A. BUILDING			SURVEY LETEO	
		495206	ย. W ING	в. WING			19/2018
	HOVIOER OR SLIPPLIER OURS-MARYVIEW NUR	SING C	STREET AOORESS, CITY, STATE, ZII* COOE 4775 TRIOGE ROAD SUFFOLK, VA 23435				
(X1) IU PREFIX TAG	FIX TEACH DEFICIENCY MUST BE PRECEDED BY FULL			ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE AMPROPRI DEFICIENCY)		IX5) COMPLETION DATE
E 026	TAG TAG			PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		ed. /as	4/25/18
					information. b) State licensing or certification agency of the state long term care ombudsman other sources of assistance as appropriatis contact information. c) This information will be vatidated as rand at a minimum of monthly for accura Administrator/designee. 4) The Administrator will provide update Quality Assurance and Performance Improvement (QAPI) committee monthly emergency drilts, exercises, policy chan	and ate for seeded cy by the s to lile	
<u> </u>		Suppl IO: 13/9			changes, contact information changes,		Page 3 of 101

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	MENT OF HEALTH AND HUMAN SERVICES	FOR	M ΛΡΡΠΟVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES	OMB NO	0, 0938-0391
		documentation and required after action items. 5. Date of compliance 4/25/18	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event to: TYYX t1

Facility (D: VA0040

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

		(XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, RUILOING			(X3) DATE SURVEY COMPLETED		
		495206	B. WING	9 MANG			С	
NAME OF D	ROVIDER OR SUPPLIER	435206	Er admara -		REET ADDRESS, CITY, STATE, 7IP CODE	03/	19/2018	
147102 CJ F1	COMPANY OIL SOLL FER		1		75 BRIDGE ROAD			
Bon Sec	DURS-MARYVIEW NUR:	BING C			UFFOLK, VA 23435			
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E 031	Continued From page	3	E	031			;	
	(ii) The State Licensin	ng and Certification Agency. State Long-Term Care assista⊓ce,			·			
	information for the fol (i) Federal, State, trib omergoncy prepared	lowing: al, regional, andlocal ness staff.						
	(iv) The State Protoct	issistance, ng and Certification Agency. ion and Advocacy Agency. is not mot as evidenced						
	preparedness plan ar	he facility's emergency nd staff interview, the facility y contact information was in t least annually.						
	The findings include:				•			
	Project/Administrator During the interview of persons, the facility s	irector of Long Term Care and the Clinical Analyst, vith the aforementioned taff failed to provide						
	plan required facility communication, and	ne omergency preparedness contacts were included in the documentation that all ontact information had been d at least annually.						
E 032 SS=C	Primary/Alternate Me CFR(s): 483.73(c)(3)	ans for Communication	E		<u>E032</u>		4/25/18	
	emergency prepared that complies with Fe	t develop and maintain an ness communication plan deral, State and local laws d and updated at least			No residents affected at time of surve Potential for all rosidents to be affecte The Policy and Procedure was update include all required information pertaining primary/alternate communication include all Federal, State, Local laws related to I	ed, ed to g to ng:		

	RTMENT OF HEALTH LAND HUMAN SERVICES	FÖRMA	: 03/30/2018 APPROVED
CENT	ERS FOR MEDICARE & MEDICAID SERVICES	primary and alternate means for communication with facility staff, federal, state, tribal, regional, and local emergency staff. b) This information will be validated as needed and at a minimum of monthly for accuracy by the Administrator/designee. 4) The Administrator will provide updates to the Quality Assurance and Performance improvement (QAPI) committee monthly on any emergency drills, exercises, policy changes, role changes, contact information changes, documentation and required after action items. 5) Date of compliance 4/25/18	<u>0936-<u>03</u>91</u>

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		49520B	e, wing		03/19/	/2018
	ROVINER OR SUPPLIER OURS-MARYVIEW NUR	SING C	4	TREET ADDRESS, CITY, STATE, ZIP CODE 775 BRIDGE ROAO SUPPOLK, VA 23435	<u> </u>	
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E 032	annually.] The commall of the following: (3) Primary and alter communicating with (i) [Facility] staff. (ii) Federal, State, triomergency manager '[For ICF/IIDs at §48 alternate means for ICF/IID's staff, Federal emergency manager of the REQUIREMEN' by: Bused on roview of plan and staff intervinclude in the plan of Federal, State, Tribal emergency agencies. The findings include On 3/19/18 at 2110 project Administrato During the interview.	nate meansfor the following: bal, regional, and local ment agencies. 3.475(c):] (3) Primary and communicating with the ral, State, tribal, regional, and nagentent agencies. T is not met as evidenced einergency preparedness ew, the facility staff failed to ommunication with staff, it, regional and local is.	E 032			
E 039 SS=C	documentation that communication plan means for communi Federal, State, triba emergency agencies EP Testing Requires	the einergency preperedness Included and alternato calling with facility staff, I, regional and local s. ments	E 03	9 <u>E039</u>	4/	/25/18
33-0	(2) Testing. The [fed	r bility, except fur LTC facilities, must conduct exercises to		1) No residents affected at time of survey) 2) Potential for all residents to be affected. 3) The Ernergency Preparedness policiprocedures were reviewed and update.	ted. by and d to	
E - E	NUMBER OF STREET	Pubol (D. 1997)	II F	actile IL: VA0040 II continu	iation sheet Pag	je 7 of 194



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												2 4	nctude the revie analysis of emeral a) The planned exercises (sche- will be evaluated effectiveness of practico. b) This informati	igency procurrent a duted as duted as this police this police to will be	reparedno ind future required cumentoc cy & proc e validato	ess ex table and no to de odure ed as r	ercises. lop eedod) termine in		.	
							ū		_				and at a minimu Administrator/de 4) The Administ Quality Assuran Improvement (C emergency dritt changes, contac documentation	esigned rator will ace and P (APt) cons s, exercis at informated	provide t Performan mmiltee m ees, potic ation chai incd after	ipdale ico nonthly chan nges,	s to the y on any iges, role			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINCED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEPICITNCIES (X1) PROVIDER/SUPPLIERIGIAN AND PLAN OF CONFECTION IDENTIFICATION NUMBER:		(X2) MI II.	TIPLE ((X3) DATE SURVEY COMPLETED				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING			C	
		495206	B. WING				19/2018	
	ROVIDER OR SUPPLIFR	SING C		477	REET AUURESS, CITY, STATE, ZIP CODE 75 BRIOCE ROAD JFFOLK, VA 23435			
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€ 039	[facility, except for Ri all of the following: *[For LTC Facilities a The LTC facility must the emergency plan a unannounced staff di procedures. The LTC following:] (i) Participate in a full community-based or exercise is not acces facility-based. If the [actual natural or mar requires activation of [facility] is exempt from community-based or full-scale exercise for the actual ovent. (ii) Conduct an additional include, but is not him [A) A second full-scale exercise of the actual ovent. (iii) Conduct an additional participation of Edinically-relevant emore problem statement of problem statement of problem statement prepared questions of emergency plan. [iii) Analyze the [facilimaintain documental exercises, and emerging facility's] emergency *[For RNHCIs at §40]	olan at least annually. The NHCIs and OPOs] must do NHCIs and OPOs] must do NHCIs and OPOs] must do NHCIs and OPOs] must do NHCIs and oxercises to test at least annually, including fills using the emergency of facility must do all of the NHCIS and individual, facility-based and individual, facility-based and individual, facility-based at 1 year following the onset of the exercise that may have a careful to the following: Scale exercise that may have a careful to the following: Scale exercise that is includes a group facilitator, using a narraled, hergency scenario, and a set als, directed messages, or designed to challenge an lity's] response to and tion of all drills, tabletop gency events, and revise the y ptan, as needed.	F	ПЗ9				
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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 i CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIFR/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUII DING Ċ 495206 B. WING 03/19/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER DR SUPPLIER 4775 BRIDGE ROAD BON SECOURS-MARYVIEW NURSING C SUFFOLK, VA 23435 PROVIDER'S I*LAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLESSON DATE (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREHIX GROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TΛG DEFICIENCY) E 039 E 039 Continued From page 6 must conduct exercises to test the emergency nian, Ihn, Inn HALand, OPOLorust do dig. discussion led by a facilitator, using a narraled, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emorgency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the (RNHCl's and OPO's) emergency plan, as needed. This REQUIREMEN'T is not met as evidenced by: Based on review of the facility's emergency preparedness plan and slaff interview, the facility staff failed to ensure documentation and analysis of their emergency exercises. The findings include: On 3/19/18 at 2:10 p.m. and interview was conducted with the Director of Long Term Care Project Administrator and the Clinical Analyst. During the interview with the aforementioned persons, the facility staff failed to provide documentation of the facility's emergency preparedness program exercise analysis and response, and how the facility updated its emergency preparedness program based on the exercise analysis. E 042 Integrated EP Program E 042 CFR(s); 483.73(f) ss=c1

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(e) [or (f)]Integrated healthcare systems. If a

DEPARTMENT OF HEALTH AND HUMAN SERVICES GENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

		496206	n Wing		03/19/2018
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□ 042	[facility] is part of a hof multiple separately that elects to have a emergency prepared may choose to partic system's coordinated program. If elected, the unified following:] (1) Demonstrate that active within the system development of the emergency prepared (2) Be developed at that takes into accordacility's unique circulations, and so integrated emergency propulations, and so integrated emergency is in compliance [with (4) Include a unified plan that moets the (a)(2), (3), and (4) or integrated emergency on and include the facility is capable of integrated emergency in compliance [with (4) Include a unified plan that moets the (a)(2), (3), and (4) or integrated emergency on and include the facility is capable of integrated emergency in and include the facility is capable of integrated emergency in and include the facility is capable of integrated emergency in and include the facility is capable of integrated emergency in and include the facility is capable of integrated emergency in an and include the facility is capable of integrated emergency in an and include the facility is capable of integrated emergency in an an an an an an an an an an an an an	ealthcare system consisting y certified healthcare facilities unified and integrated liness program, the [facility] sipate in the healthcare is emergency preparedness. I and integrated omergency and integrated omergency paradipated in the unified and integrated in a manner and each separatelycertified amstances, patient revices offered. The leach separately certified and continuity as a manner and each separatelycertified and actively using the unified and cypreparedness program and the program. It and integrated emergency requirements of paragraphs of this section. The unified and cyplan must also be based	E	1) No residents affected at time of surv 2) Potential for all residents to be affected. A review and revision to the facilities of unified Emergency Preparedness we completed by the Maryview Administration at This review included documentation facility choice/option was to not participated, unified EP program. Ly The Emergency Preparedness were reviewed and update current requirements. c) The planned current and future table with the evaluated and documented to defectiveness of current policy & process practice. d) This information will be validated as and at a minimum of monthly for accurated and at a minimum of monthly for accurated and Performance (QAPI) committee monthly emergency drills, exercises, policy changes, contact information changes documentation and required after action to the process of compliance 4/25/18	ted. s practice as as as ation team. I that the pale in an ar and ad per e lop apedical) determine dure in s needed racy by the attes to the hly on any anges, role

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MILTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SHRVEY COMPLETED	
495206		495206	B. WING.		C 03/19/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	03/13/2010	
}	WHO ELL ON GOT EJETS			4775 BRIOGE ROAO	1	
BON SEC	OURS-MARYVIEW NUR	SING C		SUFFOLK, VA 23435		
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, ,	Continued From page approach. (5) Include integrated that meet the require (b) of this section, a complan, and training and the requirements of page approach. This REQUIREMENT by: Based on review of the preparedness (EP) page failed to a place on their unified. The finding include: On 3/19/18 at 2:10 page conducted with the Daring the interview of preparedness, the facility sevidence of the follower of the	I policies and procedures ments set forth in paragraph coordinated communication ditesting programs that meet paragraphs (c) and (d) of this programs that meet paragraphs (c) and (d) of this paragraphs (e) and (d) of this paragraphs (e) and (d) of this paragraphs (e) and (d) of this paragraphs (e) and (d) of this paragraphs (e) and (d) of this paragraphs (e) and (d) of this paragraphs (e) and staff interview was preciously and integrated EP program (e)		UROSS-REFERENCED TO THE APPRODE DEFICIENCY)		
		unified and integrated EP involved in the development				
	system, was actively	he facility, within the unified and integrated EP involved in the annual un requirements and any				

FORM CMS-2507 (07-99) Previous Versions Obsolete

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If continuation sheet Page 16 of 104



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		495206	B. WING	STREET ADORESS, CITY, STATE, ZIP CODE	03/19/2018
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BONSEC	OURS-MARYVIEW NU	RSING C	l l	SUFFOLK, VA 23435	
					
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E 042	Continued From pa	ing Q	E 042		
L O'III	program updates.	ge v	L 072		
	program apaates.				
	Evidence of the ent	tire integrated and unified EP			
	program and all red				
		olicies and procedures,			
	· ·	n, training and testing			
F 000	program). INITIAL COMMENT	ı.e	F 000		
1, 000	INTERESTAL	13	1 00,	J.	
	An upganouscod N	Medicare/Medicaid standard			
		ed survey was conducted			
		3/19/18, Immodiate Jeopardy			
1		g area of Quality of Care at a			
		aled which constituted	1		
		ty of care. Significant uired for compliance with 42			
		eral Lorig Term Caro	1		
	requirements. The				
	survey/report will fo	allow. Five complaints were			
	investigated during	the survey.			
	The consus in this	120 certified bed facility was			
		he survey. The survey sample			
		ident reviows; 35 current			
	residents and 6 cm				
1	Right to Participate		F 55	3 <u>F553</u>	4/25/1 X
SS=D	CFR(s): 483.10(c)(2)(3)			177.4
	\$483.10(c)(2) The	right to participate in the		1) 2 residents in resident sample, resident #10 and resident #75, were no	tified
		mplementation of his or her		of his or her right to participate in the ca	
		an of care, including but not		planning process/meeting	
	limited to:	er e la discale de		 Current and potential residents could be affected 	1
		cipate in the planning process,		3) A review and revision to the current p	piocess
		o identify individuals or roles to planning process, the right to	1	was initiated as follows:	
		and the right to request		a) The care plan invitations will be issue	ad to
ĺ		rson-centered plan of care.		each resident and/or representative. The resident will be invited to their care plan	116 1
		ticipate in establishing the		conference. The family/ responsible par	rty will be

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	DEPART	MENT OF HEALTH AND HUMAN SERVICES		FORM APPROVED
		S FOR MEDICARE & MEDICAID SERVICES	(OMB NO. 0938-0391
			invited according to the resident choice and residents choice or designee according to capacity. b) Documentation of acceptance or decling will be documented on the invitation log maintained by the social service department care plan designee. c) Monthly audits will be completed by the Service department to review resident's invitation to care plan conference and documentation of invitation process. 4) The Social Service Director will provide report to the Quality Assurance and Performance Improvement Committee (Committee)	nd/or hation ent or e Social
	-		monthly for a minimum of 6 months on the results and any action items of the Care Conference Invitation Audits. 5) Date of compliance 4/25/18	
-				

Facility ID; VAU040

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATF SURVEY COMPLETED	
			. A. BOILOI	NG	C		
		495206	B. WING	- <u></u> ,.	03/19/20	18	
	ROVIDER OR SUPPLIET	ISING C		STREET ADDRESS, CITY, STATE, ZIP C 4775 BRIDGE ROAD SUFFOLK, VA 23435	חחב		
(X4) ID PRFFIX TAG	(EACH DEFICIENC	NATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL CGC IDENTIFYING INFORMATIONS	ID PREFI TAG		ON GLIOULU BE COM BE APPROPRIATE	IXSI PLEBON DATE	
f 553	amount, frequency, other factors related plan of care. (iii) The right to be in changes to the plan (iv) The right to rece included in the plan (v) The right to see the right to sign after sign of care. §483.10(c)(3) The factor of the right to particle and shall support the planning process multiplanning the cultural preferonces. This REQUIREMENT by: Based on resident cultural preferonces and the sumperson centered called and the sumperson centered called the full multiplanning multiplann	outcomes of care, the type, and duration of care, and any to the effectiveness of the formed, in advance, of of care. ive the services and/or Items of care. he care plan, including the nificant changes to the plan acility shall inform the resident pate in his or her treatment e resident in this right. The cust-usion of the resident and/or tive. It is not met as evidenced in developing goals of care. It is not met as evidenced interview, staff interview, when and facility documentation taff failed to invite 2 of 41 very sample, to attend their replan meeting (Resident #10 ed: Is originally admitted to the Diagnosis for Resident #10 ited to Heart Failure and		553			
Ĺ	The current Minimu	m Data Set (MDS), a quartorly			Magnification sheet Page 1	5 -/ 204	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO, 0938-0391

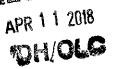
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) OATE SURVIY COMPLETED	
		495206	B. WING	B. WING		C 03/19/2018	
	ROVIDER OR SUPPLIER DURS-MARYVIEW NUR	SING C		4	TREET ADDRESS, CITY, STATE, ZIP CODE 1775 BRIOGE ROAO UFFOLK, VA 23435	<u> </u>	
(X4) IO PREPIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	STIBE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				IX5) COMPLETION DATE
F 553	(ARD) of 2/26/18 cool out of a possible scort Interview for Mental Simoderate cognitive in MDS. coded Resident of two with bathing, the hygiene, and total deextensive assistance dressing. During the initial tour 3:19 p.m., an interviex Resident #75 who stateter to attend a care An interview was con Worker (SW) on 3/14 p.m., who stated, "The care plan tetters the representative." An interview was condominated, "I gave the care plan tetters the representative." An interview was condominated, "I gave the care ident's representative was condiminated in the care interview was condiminated include the date the care interview was condiminated to the resident was invited the meeting. The above information.	Assessment Reference Date led the resident with an 11 re of 15 on the Brief Status (BtMS), indicating apairment. In addition, the 175 with total dependence aransfer, and personal pendence of one with toilet, of two with bed mobility and on 3/12/18 at approximately we was conducted with atod, "I never received a plan meeting." Iduated with the Social (18 at approximately 1:45 re receptionist issues out all to the residents and their ducted with the receptionist mately 2:00 p.m., who are plan lotter to the tive and not the resident." Imately 2:07 p.m., a second thed with the SW. The SW the care plan invitation tetter the resident was issued the addent's representative but as unable to show that the oratlend her care plan in was shared with the share or altered with the care plan.	F	553			
	Administration staff d	uring a pre-exit meeting on					<u></u>

FORM CMS-2507(02-99) Providus Vereions Obsolele

EvenUO: TYYX11

Facility IO: VAD01D

Incommunation sheet Page 20 of 104



CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 בורווניםממת אוויורים OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		UPLETER MPLETER C	
		495206	B. WING		0	3/19/2018
NAME OF PROVIDER OR SUPPLIER BON SECOURS-MARYVIEW NURSING C			477	FFT ADDRESS, CITY, STATH, ZIP CODE 5 BRIDGE ROAD FFOLK, VA 23435		
JX4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ICI PREHIX TAG	I'KÜVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 553	ស្សាប្រុស្ស 11 មុខប្រ. mm	nitamatini intermetian	₹ 553			
i	1/11/18. Diagnosis fo	admitted to the facility on or Resident #75 included but Diabetes and Hypertension .				
	assessment with an (ARD) of 2/9/18 code of a possible score of Mental Status (BIMS impairment. In additing #75 with extensive a bed mobility, dressing hygiene and bathing	n Data Set (MDS), a quarterly Assessment Reference Date ed the resident with a 15 oul f 15 on the Brief Interview for) indicating no cognitive on, the MDS coded Resident ssistance of one transfers, g, toilot use, personal on 3/12/18 at approximately				
		ew was conducted with ated, "I have nover been are plan meeting."				
	Worker (SW) on 3/14 p.m., who stated, "Ti	nducted with the Social 1/18 at approximately 1:45 ne receptionist issues out all to the residents and their				
	on 3/14/18 at approx stated, "I gave the re	nducted with the receptionist simately 2:00 p.m., who esident as well the resident's by of the care plan letter but the documentation."			·	
	interview was condu said moving forward will include the date	ximately 2:07 p.m., a second cted with the SW. The SW the care plan invitation lotter the resident was issued the the date the care plan letter				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X.I) PROVIDEN/SUPPLIER/CLIA AND PLAN OF CORRECTION UDBERT IDENTIFICATION NUMBER:			(X2) MULTII'L A BUII DING	(X3) LIATE SURVEY CUMPLETED	
					С
		495206	B. WING		03/19/2018
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIF CORF	
BON SEC	OURS-MARYVIEW NUR	SING C	l l	1775 TIRIOGE ROAO SUFFOLK, VA 23435	
(84)101		ATT.MENT OF DEFICIENCIES	, ii '	PHOVINER & PERIODE CORES (COME	10-11
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR	Y MUST DE PRECEDEO BY FIILL LSC IOENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	
1763				DEFICIENCY)	
	· · · · · · · · · · · · · · · · · · ·				
F 553	Continued From page		F 553	3	
		sident's representative but as unabio to show lhal tho			
		to attend their care plan			
	meeting.	,	}		
[The above information	on was phared with			
,]	7.7.2 4.4.2	luring a pre-exit meeting on			
	3/19/18 at 4:00 p.m.	No additional information			
	was provided.		! ———		
	The facility's policy: [Patient Contered Care plan			
	(⊏ffective November	2017)			
		e necessary care planning			
		nd services to attain or practicable physical, mental			
		ell-being consistent with the			
	resident comprehens	sive assessment and plan of			
	care and based on re 2016 Final Rule.	egulations as outlined in the			
	2010 Final Nois.				
	Procedure:				
		resident's representative will are planning process. This			
		through interactions with			
}	resident and/or resid	lent's representative prior to			
		ne care plan. Social Services			!
		ember will document in the cord if it is determined that a			
		esident and/or resident			
	representativo was r	not practicable or necessary			
		of the resident's care plan.	E 60		
F 580 \$S=D	Notify of Changes (II CFR(s): 483.10(g)(t	njury/Decline/Room, etc.) 4)(i)-(iv)(15)	150	0 <u>F580</u>	1/25/18
\$5=1)				1)Resident # 75's family and physician	were
-	§483.10(g)(14) Notif			notified of changes.	{
		mediatoly inform the resident; dent's physician; and nolify,		Education regarding change in condition reporting on policy/practice was provide)n ed to staff
	consult with the residence consistent with his o	nent's physician; and notify, or her authority, line resident		identified #1 and #2.	
		,. ,		Current residents could potentially be	affected

PRINTLD: 03/30/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES	FORM	APPROVED
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	by this practice. 3) a) Re-Education was provided on the change in condition process/policy and notifications. The re-education was provided for the following team members: - Nurses, contracted nurses and new nursing staff during orientation. b) A revised process was initiated to occur in each morning cfinical meeting. The process will include the following steps; - Review of resident's reported changes in conditions by the clinical team for appropriate.	
	actions per policy. -A log will be utilized by the unit managers to ensure that the appropriate actions have occurred as required per policy / time requirements. c) The unit managers will provide the results of the tool to the DON daily if needed or weekly by report, for review of appropriate follow up and any further action needed. 4) The DON will report findings of the Change in Condition log/actions to the Quality Assurance and Performance Improvement committee monthly (QAPI) for a minimum of 3 months to ensure appropriate follow up and compliance. 5) Date of Compliance 4/25/18	

FORM CMS-2507(02-99) Previous Versions Obsolute

Facility ID: VARIO46

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

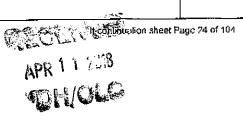
PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0301_

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI,II TIPLE CONSTRUCTION A. BUILDING			COMPLETED	
BON SEC	UURS-IMAKTVIEW NU	Z DING C	 \$l	JFFOLK, VA 23435	ì	٢
(X4) ID PREHX I AG	(EACH DEFICIEN	STATEMENT OF OEHICIENCIES CY MUST BE PRICCOED BY FULL R LSC IDEN TIFYING INFORMATION)	IO PRFFIX IAG	PROVICER'S PLAN OF (FACH CONRECTIVE ACT CROSS-REFERENCEO TO T DEHICIENC	ION SHOULD DE LIC APPROPRIATE	(A5) COMPLETION DATE
	Continued From parepresentative(s) with (A) An accident involve results in injury and physician intervention. The intervention in heat status in either life clinical complication (C) A need to alternate a need to discontinuit reatment duo to accommence a new from the fast status in either the intervention in heat status in either life clinical complication (C) A need to alternate to alternate the intervention of the interv	ge 14 hen there is- blying the resident which has the potential for requiring on; ange in the resident's physical, becal-status (that is, a lith, mental, or psychosocial threatening conditions or hs); treatment significantly (that is, a an existing form of liverse consequences, or to form of treatment); or ansfer or discharge the ficility as specified in biffication under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) byided upon request to the stalso promptly notify the sident representative, if any, im or roommate assignment 3.10(e)(6); or sident rights under Federal or	F 580			PATE
	State law or regular (e)(10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a conthat is a composite	tions as specified in paragraph on. st record and periodically s (mailing and email) and				
					2 ************************************	<u></u>

FORM CMS-2567(42-99) Previous Versions Obsolele

Eyent ID: TYYXTI

Facility IO: VA0040



DEPARTMENT OF HEALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF REPORTED		(X.1) PROVIDER/SUPPLIER/CITA IDEN HEICATION NUMBER:	1 ' '	HIPLE CONSTRUCTION		(X3) OATE SHRVEY COMPLETED	
AND PLAN OF CORRI	FOTION	IDENTIFICATION NONDEN.	A. FUII.OING		ļ	c	
		495206	B. WING	 .		3/19/2018	
NAME OF PROVIDE	R OR SHPPLIER -MARYVIEW NUR:	SING ¢		STREET ADDRESS, CITY, STATE 4775 BRIDGE ROAD SUFFOLK, VA 23435	., ∠श [,] CO∏		
(X4) IO PREFIX TAG	(EACH REFICIENC	ATTMENT OF DEFICITNCIES Y MOST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	III I'REF TAG	TX (FACITOGRECTIVE) CROSS-REFERÊNCES	IN OF CORRECTION E ACTION STITLED BE TO THE APPROPRIATE DIFNCY)	(X5) COMPLETION DATE	
its plicate part, room under This by: Bas facility faile representation of the control of the co	tions that compri, and must specifin changes betweer §483.15(c)(9). REQUIREMENT seed on staff intendity documentation of notify the physics estative of an one (1) of 41 resizes sample. Infinding included sident #75 was as 1/18. Diagnosis followed in the total to Type II current Minimur essment with an 1/18. Diagnosis followed in the total status (BIMS) arment. In additional to the total section of 2/9/18 code in the total status (BIMS) with extensive at I mobility, dressing the end behaviors directly assessing the total section of 2/9/18 compensions assessing the total section of 2/9/18 compensions assessing the total section of 2/9/18 compensions assessing the total section of 2/9/18 compensions assessing the total section of 2/9/18 compensions assessing the total sections as the total section of 2/9/18 compensions as the total	tion, including the various set the composite distinct by the policies that apply to cen its different locations. It is not met as evidenced wick, resident interview, and meriew, the facility staffician and resident abuse allegation with injury dents (Resident #75) in the continuous allegation with injury dents (Resident #75) in the continuous and it is included but Diabetes and Hypertension on Data Set (MDS), a quarterly Assessment Reference Date and the resident with a 15 out of 15 on the Brief Interview for so indicating no cognitive from the MDS coded Resident insistance of one transfers, and the resident was coded to me directed at others, and coted	580	II conjugation she			

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DEPARTMENT OF LIFALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SHPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IX2) MHILTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495206	B. WING		_	G 03/19/2018
NAME OF PROVIDER OR SUPPLIER BON SECOURS-MARYVIEW NUR		STREET ADURESS, CITY, 8 1775 BRIDGE ROAD SUFFOLK, VA 23435	rate, zip code		
in ADL care needs. intervention/approace included but not timit one with transfers, decreased but not timit one with transfers, decreased but not timit one with transfers, decreased but not a line of the caught under the with the wheel chair hards skin tear and bruising is nothing but abuse nurso." The surveyor skin tear to the top of the caught under the with the wheel chair hards skin tear and bruising is nothing but abuse nurso." The surveyor skin tear to the top of the caught under the wind as the caught under the wind as the caught under the wind abuse nurso." The surveyor asked if single the wall; the wall; the wall; the wall; the wall; the conty after, she returns of the point and the Reconty after, she returns on the process of the returns of the process of the returns of the process of the returns of the process of the returns of the process of the returns of the proces	thes to manage the goal and to extensive assistance of iressing and toilet use. If on 3/12/18 at approximately ew was conducted with tated, "On the night shift a sistant (CNA) was being one; I'm scared of her and the but she's gone now." The hat do you mean by CNA was to you?" The resident replied, to the battiroom, my leg got neol chair, the CNA pushed it hitting my hand causing a ng." The resident stated, "That is and I reported her to the or observed a large bruise and of Resident #/5's right hand. Inducted with License N) #1 on 3/15/18 at p.m., who stated, "CNA #1 ked if she would come into m because she will not allow to LPN went into Resident ed, "What is wrong" the last night (on 3/7/18), CNA #1 is battiroom, hit my hand al's abuse isn't it, she abused at she reported the abuse egistered Nurse (RN) #1 but med to work on 3/9/18. The lie had notified the MID or tative of the allegation of				

STATEMENT OF DEFICIENCIES AND PLAN OF GORRECTION		(X1) PROVIDER/SUPPLIER/CLM IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X5) DATE SURVEY COMPLETED	
					 "	(3
		495206	B. WING		· —	03/	19/2018
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET AODRESS, CHY, STATE, ZIP COOF.		
504.555	0			4775	BRIDGE ROAD		
BON SEC	OURS-MARYVIEW NUF	ISING C		SUF	FOLK, VA 23435		
(X4) ID FREFIX TAG	[FACH OEFICIENC	TATEMENT OF OEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	IU PRES TAG		PROVIDER'S PLAN OF CORRECTIO (FACIT CORRECTIVE ACTION SHOULD CROSS-REFERENCEUTO THE APPROP DEFICIENCY)	5E	(KS) COMPLETION DATE
F 580	Continued From pag	ne 17		580			
1 000				000			
		nducted with RN #1 on					
		ately 3:10 p.m. She said on					
		sting Resident #75 to the					
		getting her ready for bed					
		a large foam dressing to the . When the nurse asked the					
		ned to her hand, she replied,		- {			
		ne into the bathroom while io					
		hit my hand on the bathroom					
		d she removed the dressing					
		ight hand and observed her					
	1	gash (open area). The nurse			•		
		opon area to residents hand		l			
		Cleanser, applied Bacitracin		Ì			
	l .	ed it with a dressing. The RN					
		working on another unit, she					
	1	w anything about the alleged					
		etween Resident #75 and			•		
	_	iid, "Yes". The surveyor		1			
		is an attegation of abuse					
		olied, "Within 2 hours but no					
		' I should have reported the					
		d out - I dropped the batt on			4		
	that one." The surve	y asked when was the					
	Administrator or Dire	ector of Nursing (DON)	'	1			
	informed about the a	allegation of abuse; she					
	replied, "I told the D	ON on the morning of				•	
	3/12/18. Linformed I	ner that I was doing an					
	investigation on Res	sident #75 because the					
	resident told me tha	t CNA #1 abused her on		1			
	3/8/17." The surveyo	or asked if the physician or		-			
		ative was notified of the					
		abuse with injury. The RN					Į
		an was not mado aware until					
		-ray of resident right hand on					
		denl's representative wasn't]
	notified until today.	Doing the record review did					
	1	Resident #75's representative					
	was every notified."						

STATEMENT OF AND PLAN OF	OF OEHICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	NG		COMPLETED
		495206	R WING	<u> </u>		C 03/19/2018
	OVIDER OR SUPPLIER	RSING C		SIREET ADDRESS, CITY, STATE 4775 BRIOGE RCIAD SUFFOLK, VA 23435	E, ZII ¹ CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF OEFICIENCIES CY MUST DE PRÉCEDEO DY FULL R LSC IOENTIFYING INFORMATION)	IO PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULO III ID TO THE APPROPRIA ICIENCY}	
F 580	Continued From pa	ge 18	F	580		•
	3/16/18 at approxime was orienting with Considert #75's.roor assisting Resident in interpret CNA #1 trained to the whoelch roommate get read Resident #75 into the she pulled the curtar Resident #75 say the foot and you did it and not hear CNA #1 to Resident #75. Chapter with the corning oing to take her to checked out her fooleft the room 10 get she completed Resident #75. The chapter was a considerable with the complete the complete of the bathroom, puget dressed for like On 3/16/18 at apprinterview was considerable was considerable.	oximately 10:23 a.m., a phone lucted with CNA #1 who said				
	she worked the (7p stated she cared for p.m., with CNA #2 She said she and (Resident #75's rooresident from the brolled Resident #75' passed the first too bathroom, the resident abused me. The	or7a) shift on 3/7/18. The CNA or Resident #75 starting at 7 who I was training at that time. CNA #2 together went in m, they both transferred the led to the wheel chair then I 5 into the bathroom. We wel rack as you enter the dent yelled oul, you hurt me, he CNA said she asked the wrong"; the resident said you				
]]	TI II FINALUL TYY	Y 11	Fertility ID: YAAAAA	lf collinati	ion shee) Page 28 of 104

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IOENTIFICATION NUMBER:	(X2) MUL	HPLE CONSTRUCTION		(X3) EIATE COMIT	SURVEY LETEN
		495206	n. WING	•		C 03/19/2018	
-	ROVIDER OR SUPPLIER OURS-MARYVIEW NUR	SING C		STREET AUDRESS, CITY, ST 4775 BRIDGE ROAD SUFFOLK, VA 23435	ATE, ZII ¹ CODE		
(X4) IO PRELIX TAG	(EACH DEFICIENC	ATEMENT OF DETICIENCIES Y MUST BE PRESENTED TO FEBRUARY LSC IDENTIFYING INFORMATION)	ID PASTAG	A (LACH CORFIC CROSS-REFEREN	PLAN OF CORRECTION OTIVE ADYIDM CHOULD B ICED TO THE APPROPRI PEFICIENCY)	r	DAZE CUMU ELIUM IXM
F 580	the resident reptied, 'said the trainee finish resident that night. Chad Resident #75 all resident staled, "You taking care of me, I resident staled, "You taking care of me, I reshe immediately left I I I I I I I I I I I I I I I I I I I	A asked how did I hurt you, You hurt me." The CNA led providing care for the NA #1 said, the next night I night but that morning, the are not supposed to be exported you." The CNA said the room to go get LPN #1 I I I I I I I I I I IN was shared with I a pre-exit meeting on No additional information Change in Condition 18) I Suremy I Dentated Street I's Attending Physician or an there has been: ent involving the resident is of an Unknown source tructed by the resident, the arge Nurse will notify the expresentalive (sponsor) I wed in any accident or y in an injury including	F	580			
- ОНМ СМЯ-250	injuries of an unknov ภูดิร ของ คายพอนิธ งอกอเดาร ดาว		LITAL	tradately (cr. vovvcto	# CONDITION	(114) 6	P84 T + + 1



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED 03/30/2018

FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		<i>J</i> r =	OMB NO	<u>. 0</u> 938 <u>-0391</u>
STATEMEN).	OF DEHICIENCIES CORRECTION	(X1) PROVINER/SUPPLIER/CLIA IOENTHICATION NUMBER:	(X2) MUL) I A. 8UII DIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495206	8. WING _	· · · · · · · · · · · · · · · · · · ·	03/	; 19/2018
NAME OF P	ROVIDER OR SHIPPLIER		` I	STREET AOORESS, CITY, STATE, ZIP CODE	- '	
BON SEC	OURS-MARYVIEW NUF	RSING C		4775 BRIDGE ROAD SUFFOLK, VA 23435		
(X1) IÚ PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DIFFICIENCIES BY MUST BE PRECEDED BY FILL R LSC IDENTIFYING INFORMATION)	IU PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	BE	(XS) COMPLETION DATE
TAG	§483.10(g)(17) The (i) Inform each Medicaid of- (ii) The items and senursing facility services and for charged, and the anservices; and (ii) Inform each Medicaid in §483.10 section. §483.10(g)(18) The resident before, or a poriodically during the available in the facility services, including a covered under Medicaid State plan notice to residents or reasonably possible (ii) Where changes items and services facility must inform 60 days prior to imp	facility must- icaid-eligible resident, in of admission to the nursing e resident becomes eligible for ervices that are included in ces under the State plan and nt may not be charged; ns and services that the which the resident may be nount of charges for those licaid-eligible resident when to the items and services ligh(17)(i)(A) and (L) of this facility must inform each at the time of admission, and he resident's stay, of services lity and of charges for those any charges for services not icare/ Medicaid or by the in coverage are made to items and by Medicare and/or by the in, the facility must provide of the change as soon as is	JAG		ng their eled by the ial worker, following be us prior to se in or required d ABN empleted. ekty pending ng to od 10123 cont onths to me, date of forms	
	Transferred and doe	es not return to the lacility, the to the resident, resident				

	OF DEFICIENCIES CORRECTION	IX1 PROVIDERISUPPI IFRICLIA IDENTIFICATION NUMBER:	1	[X2] MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BURDING				
		49520G	B. WING				C 19/2018	
NAME OF P	ROVINER OR SUPPLIER	<u> </u>	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 001	10/2010	
				4	4775 BRIDGE ROAD			
BON SEC	OURS-MARYVIEW NUR	SINGC		;	SUFFOLK, VA 23435			
[X4] ID		ATEMENT OF DEFICIENCIES	CII		I FROVIDER'S PLAN OF CORRECTION		(X5 ₁	
PRCCIX TAG	-	Y MUST BE PRECEDED BY FOLL USC IDENTIFYING INFORMATION	TAG		[EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED FO THE APPROPRI DEFICIENCY]	U I'O THE APPROPRIATE DATE		
					DE RELEVIT			
F 582	Continued From page		F	582	 			
		late, as applicable, any						
		ready paid, less the facility's						
		days the resident actually						
	facility, regardless of	or retained a bed in the	1					
	discharge notice requ							
		refund to the resident or						
		ve arry and all refunds due						
	the resident within 30	days from the resident's						
	date of discharge from							
		dmission contract by or on						
		al seeking admission to the						
	-	ict with the requirements of						
	these regulations.	is not met as evidenced	-					
	by:	ia noi mei as evidenced						
	-	ord review, staff interviews,						
		ation, the facility staff failed					<u> </u>	
i		leneficiary Notices were	1					
		dents (Residents #75 and						
	#94) in the survey sai	mple.						
	The findings included	ı:	•			;		
	1. Resident #75 was	admitted to the nursing						
		h a diagnosis of congestive						
	heart failure (CHF), n	europathy and difficully						
	walking.		}					
	The Minimom Data S	el (MDS) Admission						
ļ		17/18 coded the resident						
		sible score of 15 on tho						
	Brief Interview for Me	ntal Status (BIMS) which						
		t was intact in the skills			}			
i	needed for daily deci-	sion making.			•			
1	On review of the Ben-	afiniary Notification	1					
		eliciary Notification by the facility to surveyors it						
		ent #75 was not listed for						
					<u>l</u>		<u> </u>	

STATEMENT OF DEFICIENCIES IX1) PROVIDER/SUPPLEMENTAL (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF-						
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A BUILDING	,		ti l
		495206	R WING		03	/19/2018
	ROVIDER OR SUPI-LIER OURS-MARYVIEW NU	RSING C	4775	ET ADDRESS, CITY, STATE, ZIF CON BRIDGE ROAD FOLK, VA 23435	<u> </u>	
(X4) ID PREFIX I'AG	(EACH DEFICIEN	STATEMENT OF OBJICIENCIES CYMILS I BE PRECEDED BY FILL R LSC IDEN NEYING INFORMATION)	PREFIX IAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OFFICIENCY)	SHOHLO HE	(XS) COMPLETION DATE
F 582	Continued From pathaving been issued Nursing Facility-Adform CMS-10055). NOMNC (Notice of Non-Coverage- for copies of the SNF provided. Resident #75 starts 2/15/18. Resident # Medicare Part A so not exhausted and SNF ABN(CMS-101 used 36 days of he Only an NOMNC will not fication to the resident #94 was facility on 9/22/17 post operative left. The Minimum Data 2/19/18 coded the	ge 22 I the SNF ABN (Skilled vanced Beneficiary Notice, The resident had received a Medicare Provider of CMS-10123), however no ABN(CMS-10135) were sed a Medicare Part A stay on strovered day of this stay was 475 was discharged from evices when benefit days were should have been issued a 055) and an 23). Resident #75 had only or Medicare Part A services. Vas issued, with verbal esident on 2/13/18. The sadmitted to the nursing with a diagnosis of falling and hip fracture. The Set (MIDS) assessment dated resident with an 11 out of a	F 582	CTFICIENCY		
	Mental Status (BIA	(5 on the Brief Interview for AS) which indicated the resident apaired in the skills needed for ing.				
	Checklists provide was noted that Re having been issue Nursing Facility-A form CMS-10055) NOMNC (Notice of Non-Coverage- form Coverage- form	deneficiary Notification and by the facility to surveyors it esident #94 was not listed for ad the SNF ABN (Skilled dvanced Beneficiary Notice, . The resident hact roceived a af Medicare Provider arm CMS-10123), however no ABN(CMS-10055) were			_	

STATEMENT OF CORRECTION IXI) PROVIDER/SUI PLIER/CHA IX2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED	
		495206	B. WING		03/19/2018
	ROVIDER OR SUPPLIER DURS-MARYVIEW NU	R\$ING C		STREET ADDRESS, CITY, STATE, ZIP CODE 4776 BRIDGE ROAO SUFFOLK, VA 23435	
(K4) IO PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DIFFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	lu PREHIX TAG	PROMOER'S PLAN OF CORRECTIVE ACTION SHOU EACH CORRECTIVE ACTION SHOU BE CROSS-REHENENCED TO THE APPROPRIATE DÉFICIENCY)	JLO COMPLETION DATE
F 583 \$\$=D	Resident #94 starte 9/23/17, and the last 11/22/17. Resident Medicare Part A se not exhausted and SNF ABN(CMS-101: 61 days of his Med NOMNC was issue the resident on 11/2 Orr 3/16/18 at 10:3/ Administrator and twere not aware of when Medicare Part Provider. They only residents. No additional informatic facility's policy Advanced Benefici indicated a a skilled CMS-10055 is issue resident or resident Medicare Part A codenied for service appeal the deriial of Personal Privacy/C CFR(s): 483.10(h)/stitles/1005/15 (c) 1005/16/16/16/16/16/16/16/16/16/16/16/16/16/	and a Medicare Part A stay on st covered day of this stay was #94 was discharged from revices when benefit days were should have been issued a 255) and an 23). Resident #94 only used care Part A services. Only an d, with verbal notification to 20/17. Dia.m., The facility he social worker stated they he issuance of a SNF ABN at A is discontinued by the issued the NOMNC to the matter was provided prior to and procedures tilled SNF ary Notice dated 2/2018 at ABN of non-coverage form and the second state of the second		583 F. 583. 1) The monitor was removed from id.	4/25/1¥ entified
	The resident has a	and Confidentiality. right to personal privacy and s or ther personal and medical		roons. Residents # 34 and #163 are residents. 2) Residents residing in the facility contentially be affected by this practice. 3) The review of policy and practices.	ould ce.

DEPARTMENT OF TRANSPORTATION OF THE PARTMENT O					
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	resident privacy and confidentiality including camera/monitor use, was completed and revisions were made to the current practices. a) Revisions to the current practice include: -review request per policy prior to initiation of any device (camera, monitor, recording) -obtain crussents prior to use per policy any requests for use of such devices as cameras, recording or monitors will be reviewed by the Administrator and Risk Manager prior to implementation and according to policy. 4) The Administrator will report any requests for devices or requests that would impact residents privacy or confidentiality (such as recording or monitoring) to the Quality Assurance and Performance Improvement Committee (QAPI) monthly for a minimum-of 6 months for review and policy compliance. 5) Date of Compliance 4/25/18				

	STATEMENT C ANO PLAN OF	OF OEFICIENCIES CORRECTION	(X1) PROVIDERIGUI PLIERICLIA IOENTIFICATION NUMBER:	(X2) MILTIPLE CONSTRUCTION A. BUILDING			ESURVEY PLETEO C
BON SECURIS MARYVIEW NURSING C DATE DESCRIPTION SUMMARY STATISHEN OF DEROCKNESS CAUCHESCENCY NUST TO PRESEDENCY PUBL PREPRY TAS PREPRY TAS CONTINUES NUST TO PRESEDENCY PUBL PREPRY TAS F 583 CONTINUES NUST TO PRESEDENCY PUBL PREPRY TAS F 583 CONTINUES NUMBER OF PROPRIATE PROPRIATE S483.1D(h)(f) Porsonal privacy includes accommodations, medical freatment, written and telephone communications, personal care, visits, and meetings of family and rosident groups, but this does not require the facility to provide a private room for each resident. §483.1D(h)(g) The facility must respect the rosidents right to personal privacy, including the right to send and promptly receive unopened mail and other lettors, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.1D(h)(g) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to return the release of personal and medical records except as provided at §483.70(0)(g) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudaman to oxamine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on ecord review, staff and resident interview, and the investigation of a Facility Reported Indiction (FR). The facility staff failed to ensure privacy and confidentially was maintained for two residents (Resident #44 and #163) in the			495206	B. WING	·	03	/19/2018
PRETAL TAS SUBMEMBERS OF THE PRECEDENT PULL PROPERTIES OF THE PROP		-	JRSING C	4775	BRIDGE ROAD FOLK, VA 23435		
§483.10(h)(f) Personal privacy includes accommodations, medical freatment, written and telephone communications, personal care, visits, and meetings of family and rosident groups, but this does not require the facility to provide a private room for onch resident. §483.10(h)(2) The facility must respect the rosidents right to personal privacy, including the right to privacy in his or her ous (flat is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other lettors, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical rocords. (i) The resident has the right to reture the release of personal and medical records except as provided at §483.70(f)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to oxamine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, staff and rosident interview, and the investigation of a Facility Reported Incident (FRI). The facility staff failed to ensure privacy and confidentiality was maintained for two residents (Resident #34 and #163) in the	PREFIX	(CACH DEFICIE)	NOY MUST DE PRECEDED DY PULL	PREFIX	(EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(XS) PAMPLETION OATE
accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for onch resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to personal privacy, including the right to privacy in his or hor oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other lettors, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to retuse the release of personal and medical records except as provided at §483.70(f)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to oxamine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview, and the investigation of a Facility Reported Incidont (FRI). The facility was maintained for two residents (Resident #34 and #163) in the	F 583	Continued From pa	age 24	F 583			
1 Superior of A to continue		accommodations, telephone commutand moetings of fathis does not requipervate room for or \$483.10(h)(2) The residents right to pright to privacy in lawritten, and electrothe right to send a mail and other lett materials delivered including those do than a postal serv. §483.10(h)(3) The and confidential polyimetric privacy at federal or state lawriting the facility multiple of the State to examine a residential polyimetric privacy at for two residents.	medical treatment, written and nications, personal care, visits, amity and resident groups, but ire the facility to provide a nich resident. facility must respect the personal privacy, including the his or her oral (lhat is, spoken), onic communications, including and promptly receive unopened ors, packages and other do to the facility for the resident, alivered through a means other ice. Personal and medical records, as the right to refuse the release nedical records except as 70(i)(2) or other applicable ws. Personal and medical records in accordance with State endicals accordance with State endicals and medical, social, and cords in accordance with State envestigation of a Facility of the facility staff failed to and confidentiality was maintained (Resident #34 and #163) in the				
The findings included:					<u> </u>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIERIELIA IDEN 11FICATION NUMBER.		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) OATE SURVEY COMPLETED		
		495206	G. WING		·		C /19/2018
NAME OF IS	ROVIDER OR SUPPLIER			[]	STREET ADDRESS, CITY, STATE, 7IP CODE		10/2010
BON SEC	OURS-MARYVIEW NUR	SING C			4775 BRIBGE ROAD SUFFOLK, VA 23435		
(K4) IU PREFIK TAG	(EACH DEFICIENC	ATEMENT OF BEMCIENCIES Y MUST BE PRECEDED BY MULL LSC IDENTIFYING INFORMATION)	ID PREF 1 AC		PHOVIDER'S PLAN OF CORRECTION (FACH CONTRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPE DEFICIENCY)	DE:	IX6I COMPI FTIKIN DATE
F 583	2/7/18 with diagnose quadriparesis due to with advanced cord of C3-4. This resident his pine DJD and neck type 2 diabetes, hype No Minimum Data Sedue to the resident's During the investigation Resident #163's roor treating him roughly. nursing staff, "You ar #163 was discharged During an interview of the Director of Nursin Administrator, the DO purchased a Digital Niplaced it in the room who was complaining not providing timely a month of the Director of Nursin Name of the Director of Nursin Administrator, the DO purchased a Digital Niplaced it in the room who was complaining not providing timely and was very anxious manufacturer guide to capable of having auso nurses could mon viewing devices were placed on the nursing then be able to monitimes.	s admitted to the facility on a which included severe spinal canal stenosis compression at C2-3 and ad diagnoses of Corvical pain, prerenal azotemia, intension, thrombocytopenia. In the facility of a FRI dated 2/14/18 mate complained of staff. The roommate stated to the re on camera." Resident if from the facility on 2/12/18. In 3/16/18 at 2:15 P.M. with reg (DON) and the DN stated, sho had fideo Baby Monitor and to appease Resident #163 g of staff ignoring him and resistance. It purchased the Video Baby sident #163 was not resting as According to the fines, the Video Monitor was dio whon the screen was off itor resident. The camera or a given to nursing staff and g cart. The nurses would tor Resident #163 at all	[-	583			
	I.	lministrator wore asked if Representative had given					

STATEMENT OF DEFICIENCES IX1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION TO STATE TO STATE OF THE STATE OF		1 ' '	(X2) MULTIPLE CONSTRUCTION A, RUII OING			(X1) NATE SURVEY COMPLITED		
		495206	B. WING				C 03/19/2	018
	ROVIDER OR SUIPPLIER OURS-MARYVIEW NUR	SING C		4775	ET ADDHESS, CITY, STATE, ZII [,] COOE BRIOGE ROAO FOLK, VA 23435			
(X4) ID PREFIX IAG	(EACH DEFICIENC	ATTMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD DE		(XS) MPLETIÓN DATE
F 583	verbal or written considered Baby Monitor. 2. Resident #34 was 12/19/17. This reside diagnoses which inclinyperplasia with lower Type 2 Diabetes Moldialysis, chronic obstisevere protein - calcembolism and thromic disease, and cognitis. An Initial Minimum Diassessed this reside Speech and Vision a area of Cognitive Palassessed as having Status (BIMS) as having Status (BIMS) as having area of Cognitive Palassessed as having the concerns. In the area was coded as having Resident #34 was the #163 during the time During this time period investigation of a FR Resident #34 complewas being treated ro Nursing Assistant). If invostigation a staff incameral investigation the CNA during the line CNA during the line CNA during the CNA during the line CNA during the line CNA during the CNA during the CNA during the CNA during the Line CNA during t	sent for the use of the Digital They both stated, "No". admitted to the facility on and was admitted with used benign prostatic or urinary tract symptoms, litus, dependence on renal articlive pulmonary disease, nie malnutrition, acute bosis, r.hronic kidney we communication deficit. ata Set (MDS) dated 1/12/18 and in the area of Hearing, is having no concerns. In the atterns this resident was a Brief Interview for Mental wing a score of (13). In the titems this resident was concerns. In the area of was coded as having no a of Behaviors this resident in an oconcerns. The resident was concerns. F	583					

STATEMENT OF DEFICIENCIES (XT) PROVIDER SUPPLIET OF LAND PLAN OF CORRECTION TO MINDER		V BRITO		(X3) DATE SURVITY COMPLETED			
		495206	B. WINC	B. WINC			C (19/2018
	ROVIDER OR SUPPLIER OURS-MARYVIEW NUR	SING C		477	REET ADDRESS, CITY, STATE, ZIP CODE 5 BRIDGE ROAD FFOLK, VA 23435	1 33	
(X4) ID PREFIX YAG	(EACH OEFICIENC	FATEMENT OF DEFICIENCIES Y MUIST BE PRECEDED BY FOLL LSC IDENTIFYING INFORMATION	IO PRCFI TAG		PROVIDER'S PLAN OF CURRECTION (EACH CORRECTIVE ACTION SHOULD I GROSS-REPERENCEO TO THE APPROPR OBJECTENCY)	\$E	(XS) CHMPLEHON DATE
F 583	Continued From pag the CNA who was tree to get it." During an interview of Resident #34 he stated about the roug When asked about the and whether ha gave this resident stated, "a camera to be in the Policy: This policy is for obtaining film and imagos or recordings patients created usin (defined collectively agency standards for retention of the imago Definition(S) Audio Recording - Franchick Technique Collective Individual's voice using video cameras, cellurecordors, wearable	e 27 eating him roughly) was going on 3/t6/18 at 9:30 A.M. with ed, he had spoken to his plutreatment of one CNA he camera being in the room e verbal or written consent 'No, I did not give consent for erroom." to define allowable purposes I digital photographs, video a and/or audio recordings of ag a camera or other device as Photography) within the rethe creation, use and es. or the purposes of this policy, ers to recording an ng video recording (e.g.,		583			
	agreement to the ph	cumentation of the patient's otography process (c.g., specialized consent, or rbal consent).					
	by law to act on beha parent of a minor, a	ative: The person authorized alf of the patient, such as the court appointed guardian or by the patient in a Power of					

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(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (XI) PROVIDEN/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		[X2] MULTIPI (A. BUILLINC _	CONSTRUCTION	(XX) DATE SURVEY COMPLETED	
		495206	B WING _		C 03/19/2018
	ROVINCE OF SULPLIER		l a	ITRFFT ADUKESS, CITY, STATE, ZIP CODE 1775 BRIDGE ROAD BUFFOLK, VA 23435	
(x4) ID PREHIX TAG	(CACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MITST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRCFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	G COMPLETION
F 583 F 609 SS≃D	"pholography" refors likeness (e.g., image (e.g., cameras, cellu wearable lechnology lhe future lhall may be images), video recording telephones), cameras, web cameras, web cameras, web cameras, web cameras, web cameras, of capturing does not include me not limited to MRIs, equipmont, etc. or im Reporting of Alleged CFR(s): 483.12(c)(1 §483.12(c)(1 Ensurinvolving abuse, nemistreatment, inclusionare and misappiare reported immed hours after the alleginate serious bodily injury the events that cause and do not reflicials (including the administrator of officials (including the adult protective serious including the adult protection in the adult pro	e purposes of this policy, lo recording an individual's e, picture) using pholography lar felephones, lablels, or and other devices now or in the capable of retaining such ding (e.g., video cameras, digital imaging (e.g., digital res), wearable technology , or other fechnologies an image (e.g., Skype). This dical imaging inchiding, but CTs, laparoscopy lages of specimons.	F 609	The sidents #34 is a discharged reside Administrator has spoken with resident ensure that resident is comfortable with actions and was reassured her well be a) The facility completed late federal/stroquired reporting on these FRI(facility incidents) per regulatory requirements. D) Facility completed internal investigatesident #75 and #34 with post incidents. C) Facility completed education with case in the facility staff members and contracted restaff on the facility policy and practice abuse. Education to facility staff on this policy included the following: a) Education related to the facility requand timelines for investigating and repallegations of abuse and state and fed requirements and timeframes. B) The abuse and Noglect process an reporting/investigation timelines were reviewed with Department managers,	#75 to if follow up ng/safety. ale reported ion on it follow regiver #1 ioriting regarding regarding retal d required also



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DEPARTMENT OF HEALTHAND HUMAN SERVICES	FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-0391
	Managers, Unit Managers and Leadership team. C) A process review meeting occurred with the Don/Abuse Coordinator/Administrator to review the practice and timelines of reporting to appropriate agencies and appropriate required forms and time frame requirements. 4) The DON/Abuse Coordinator will provide a report to Quality Assurance and Performance Improvement (QAPI) monthly on Abuse/Neglect allegations, findings and compliance with policy on reporting and investigating. 5) Date of Compliance 4/25/18
	D) Date of Compilation (1207)
	·
l I	i 1

STATEMENT OF QEFICIENCIES (X1) PROVIDERSHIPPLIET/CLIA AND PLAN OF CHRRECTION (IDENTIFICATION NUMBER:	A BIJII OII	NG	1 Griv	CUMPLETED		
						C
	495206	B WING_	-	SS, CITY, STATE, 7IP CODE		3/19/2010
NAME OF PROVINER OR SUPPLIER BON SECOURS-MARYVIEW NU	R\$ING C		4775 BRIOGE F SUFFOLK, VA	ROAD		
FREHIX (EACH DEFIGIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FIRE		v (E/	PROVIDER'S PLAN OF CORREC ACH CORPECTIVE ACTION SHO BS-REFERENCED TO THE APPI OFFICIENCY))ULD BE	(X5) COMPLETION LATE
designated represe accordance with St Survey Agency, wil incident, and if the appropriate correct This REQUIREMEI by: Based on staff intereview facility docut failed to notify the Stallegation of abuse residents (Resident sample. 1. The facility staff Survey Agency an Resident #75 within of the incident. 2. 1. The facility staff Survey Agency within 5 days an investigation Resident #34 was Agency within 5 days and the finding included 1. Resident #75 within 11/18. Diagnosts not limited to Type The current Minimassessment with a (ARD) of 2/9/18 coof a possible score Mental Status (Bit impairment, In additional incidents of a possible score Mental Status (Bit impairment, In additional incidents in additional incidents are seen according to the second mental Status (Bit impairment, In additional incidents according to the second mental Status (Bit impairment, In additional incidents according to the second mental Status (Bit impairment, In additional incidents according to the second mental Status (Bit impairment, In additional incidents according to the second mental Status (Bit impairment, In additional incidents according to the second mental Status (Bit impairment, In additional incidents according to the second mental Status (Bit impairment, In additional incidents according to the second mental Status (Bit impairment, In additional incidents according to the second mental status (Bit impairment, In additional incidents according to the second mental status (Bit impairments in additional incidents according to the second mental status (Bit impairments in additional incidents according to the second mental status (Bit impairments in additional incidents according to the second mental status (Bit impairments in additional incidents according to the second mental status (Bit impairments in additional incidents according to the second mental status (Bit impairments in additional incidents according to the second mental status (Bit impairments in additional incidents according to the second mental status (Bit im	ort the results of all and annihilative and to other officials in ale law, including to the State thin 5 working days of the alteged violation is verified ive action must be taken. The state action must be taken. The state and mentation, the facility staff state Survey Agency of an a timely manner for 2 of 41 it #75 and 34) in survey If failed to report to the State altegation of abuse involving in 24 hours of their knowledge that failed to ensure the results of alteged abuse involving reported to the State Survey ays.	F	609			

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STATEMENT OF DEFICIENCIFS (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495206	B, WING		<u> </u>		C 19/2018	
	ROVIDER OR SUPPLIER OURS-MARYVIEW NUR	SING C	STREET ADDRESS, CITY, STATE, ZIP CORE 4775 BRIDGIE ROAD SUFFOLK, VA 23435					
(X4) IO PREFIX LAG	(EVEH DELICIENE)	ALEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL (SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S INLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE ALPHOPR LIEFICIENCY)	30	(X5) COMPLETION DATE	
F 609	Continued From page	e 30	F	609	 -			
	bed mobility, dressing hygiene and bathing. have verbal behavior other behaviors direct of the 7-day assessm	g, loilet use, personal The resident was coded to s directed at others, and ted at others, 4 to 6 days out tent period. She was also 1.to.3 days out of the				••		
	Resident #75's comp	rehensivo care plan	·- ·					
	Activities of Daily Living oncralized weakness resident will attain main ADL care needs. Sintervention/approact but not limited to extert transfers, arcssing and During the initial tour 2:07 p.m., an intervier Resident #75 who stated the whole to don't trust her at night surveyor asked, "Who was mean and abusing replied, "The CNA to leg got caught under pushed the wheel cheausing a skin tear a stated, "That is nothing to the nurse." The	as/debility. The goal: the eximum level of functioning some of the nes to manage goal included nsive assistance of one with						
	right hand. An interview was cor Nursing (DON) on 3/ p.m., who stated, "I v	iducted with the Director of 12/18 at approximately 3:05 was informed this moming by ic was getting employee						

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

Even(ID: (YYX1)

Facility ID. VA0040

If continuation sheet Page 42 of 104



STATEMENT OF DEFICIENCIES (X1) I ROVIDERISDITILIERICI IA	(X1) I'ROVIDERISURILLIER/CHA	(×2) MULTIPI F CO	(X3) DATE SURVEY		
ANÚ (PLAN OF	CORRECTION	IOEN HEICATION NUMBER:	A BRIILDING		
		495206	n wing		C 1972018
		495206		FT ADDRESS, CITY, STATE, ZIP COOL	
NAME OF PI	ROVIDER OH SUFPLIFR		l l	BRIOGE ROAD	
BON SEC	OUR\$-MARYVIEW NUR	SING C	<u>,</u>	FOLK, VA 23435	
4/11/15	2 YSTAMMUS	YATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRE	[X2]
IX4) ID PREFIX TAG	(EACH DEFIGIENC	Y MUST NE PRECEDED BY FULL LUC IUENTITYING INFORMATION)	PRETIX TAG	JEACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	COMMITTEEN
F 609	Continued From pag	ge 31	F 609		
'	statements because	Resident #75 accused CNA			ł
	#1 of abusing her."]	The surveyor requested the			
	facility roported incid	Iont indicating the State			
	survey agency was	informed of the abuse			
	attegetion.				
	A facility canceled in	cident was faxed to the State			
		londay 3/12/18 at 5:40 p.m.,			
	and indicated it was	reported to the Director of			
	Nursing (DON) on 3	/12/18 an allegation of abuse.			
	The facility reported	incident reveated Resident			
		3/18 on the night shift a			}
	Certified Nursing As	ssistant (CNA) pushed her into			
		her wheelchair, her right hand	-		
	was bumped on the	doorjamb causing an open			
	area with bruising to	her right hand near base of the final report with the	- -		
	ner image inger.	stigation dated 3/16/18	- }		
	indicated CNA #1 w	as terminated from			
		following the care practices			
	that are the standar	d of (Healthcare System).			
į		onducted with License			1
	Practical Nurse (1 P	p.m., who stated, "CNA #1			
	approximately 2:50	ked if she could come into			
		n because she would not	<u> </u>		-
ļ	allow me to help he	r." The LPN went into	1		
1	Resident #75's root	m and asked, "What is wrong"			
	the Resident repties	d, "Last night on 3/7/18, CNA	1		
<u> </u>	#1 was taking me to	o the bathroom, hit my hand	1 1		
	against the walt; the	at's abuse isn't it, she abused			
	me." The LPN state	ed she reported the abuse			
	attegation to the RN	#1 but only after she /elumed			1
	to work on 3/9/18.	The surveyor asked the LPN,			
		ort an attegation of abuse" she			
1	replied, "Right awa	Ψ.			
	An interview was o	onducted with RN #1 on			<u> </u>
i .	1. 11. 11. 11. 11. 11. 11. 11. 11. 11.			······································	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIFR/CI IA IDENTIFICATIUN NUMBER:			CONSTRUCTION	(X3) DATE COMPI		
						C		
		495206	B. WING			03/-	19/2018	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	!	s	TREET ADDRESS, CITY, STATE, ZIP CODE			
			4775 BRIDGE ROAD					
BON SEC	OURS-MARYVIEW NUR	sing c		l s	UFFOLK, VA 23435			
2743.03	CHIMMADY ST	ATEMEN (OF DEFICIENCIES	10	<u>!</u>	FROVIDER'S (LAN OF CORRECTION	· 	(X.5)	
(X4) ID PRCFIX TAG	(EACH DEFICIENC)	Y MIRST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD INCRESS-REFERENCE OF TO THE APPROPRIES DEFICIENCY)	3E	TRIMFLETION DATE	
F 609	Continued From page	e 32	F	609				
	3/15/18 at approxima	itely 3:10 p.m. She said on						
Ì		ting Resident #75 to the					i	
		getting hor ready for bed				1		
		large foam dressing to the						
		The nurse asked the					1	
		ned to her hand, she replied,	'				1	
		e into the bathroom while in					1	
	my wheel chair and h	nit my hand on the bathroom						
	door," The nurse said	i she removed the dressing						
	रिकार the resident's गंद	ght harid and observed her	- -			 1		
	hand swollen with a g	gash (open area). The nurse						
	said she cloaned the	open area to residents hand	-					
	with Derinal Wound (Oleanser, applied Bacitracin	1		,			
	ointment and covered	d it with a dressing. The RN						
	stated, LPN #1 was v	working on another unit. She						
		w anything about the alleged	,				ĺ	
		tween Resident #75 and	İ				į	
		said, "Yes". The surveyor						
		is an allegation of abuse	1					
		eplied, "Within 2 hours but no				-		
		I should have reported the						
		out - I dropped the ball on						
Ì		yor asked when did yuu						
		ator or Director of Nursing				İ	ļ	
	, ,	gation of abuse? She					-	
		ON on the morning of			1			
		er that I was doing an						
ĺ	_	dent #75 because the	1					
	resigent tota me that 3/8/17."	CNA #1 abused her on						
	SIGI (I .	-						
	On 02/45/49 of energy	oximately 8:55 a.m., an				;		
		cted with the Administrator						
	*****	I, "We were told by our						
]		at we should not send the					,	
	- I	te office until they get the						
		It Protection Services," The						
-	surveyor requested t							
		"We still do not have the						
·	Authinatiator stated.	AAC ON OR HOLISTAC NIC						

PRINTED. 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF CORRECTION (X1) PROVIDER/SUPPLICE/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MUL A. BIJILDI		CONSTRUCTION	C 03/19/2D18		
			G VANDAG				
		495206	B, WING	•	TREET ADDRESS, CILY, STATE, ZIP CODE	03/1	3/AD 10
NAME OF PI	OVIDER OR SUPPLIER		,	l			
BON SEC	OURS-MARYVIEW NUR	RSING C	4775 BRIDGE ROAD				
DON BEG	75 115-1111-1111-11-11-11-11-11-11-11-11-11			3	UFFOLK, VA 23435		
(X4) IO PREFIX YAG	CEACH DEFIGIENCY MUST BE PRECIDED BY FOUN		IO PREC TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-RETERENCED TO THE APPROP) OFFICIENCY	BL	(X5) COMPLETION DATE
F 609	Continued From pag	go 33	F	609			
	slated, "They know completed investiga the final report for A	ministrator and DON both now they must send their tion even if they do not have PS." The DON stated, "I the been reported with 2 hours corred."					
	The above information was shared with Administration during a pre-exit meeting on 3/19/18 at 4:00 p.m. No additional information was provided.						
	12/19/17. This residing diagnoses which in tryperplasia with low Type 2 Diabetes Midialysis, chronic observer protein - callembolism and thror	s admitted to the facility on tent was admitted with cluded bettign prostatic wer urinary tract symptoms, ettilus, dependence on renal structive pulnionary disease, lone malnutrition, acute mbosis, chronic kidney live communication deficit.					
	assessed this residence of Cognitive Passessed as having Status (BIMS) as haroa of Cognitive Passessed as having noded as having noded, this residen	Data Set (MDS) dated 1/12/18 tent in the area of Hearing, as having no concerns. In the Patterns this resident was g a Brief Interview for Mental eaving a score of (13). In the Patterns this resident was concerns. In the area of I was coded as having no rea of Behaviors this resident ing no concerns.					
	Resident #34 mad concerning a staff assistant was trea	e an allegalion of abuse (CNA) certified nursing ling him roughly.					
	A review of the Fa	cility Reported (noident (FRI)					<u> </u>

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	OF DEFICIENCIES CORRECTION	(X1) PROVIUER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION		SURVEY PLITTED	
		495206	B. WING			1	С	
NOVAL OF U	KOVIUER OR SUITILIER	493206	B. WING			03	/19/2018	l
NAME OF 11	KONDER OR SULLLIER	•			RECT ADDRESS, CITY, STATE, ZIII CODE			l
BON SEC	OURS-MARYVIEW NUR	SING C			75 BRIDGE ROAD			l
				SL	UFFOLK, VA 23435			l
(X4) IO		ATEMENT OF DEFICIENCIES	in	\neg	PROVIDER'S PLAN OF CORRECTION		(52)	l
FREFIX TAG		Y MUS) BE PRECEDED BY FULL 1.8C IDENTIFYING INFORMATION)	PREFIX	۱ ۱	(EACH CORRECTIVE ACTION \$1101 II.D 6		COMPLETION	ĺ
17(6)	ALCON MICHAEL CHA	THE PERSON STREET, STR	1AG		CROSS-REFERENCED TO THE APPROPRI DEHICIENCY)	ATE.	5,112	
				-			<u> </u>	ĺ
F 609	0	- 24						ĺ
7 009	Continued From page		F 6	1603			[ĺ
	dated 2/14/18 indical	ed the following:		Ì			1	ĺ
			!				1	l
	Resident Involved: Re	esident #34.		-				l
	dat dan Mana annasa			ı				ĺ
	Injuries: None appare							i
	Incident Type:-Physic				· · ·			i
	Name of employee (s							i
	pending investigation	ated or taken: Sent home					1	-
_	Date notification prov			-4				L
	Responsible Party 2/			1	-			
1	Physician 2/14/18	1-7/10						
	APS 2/14/18						!	
	DHP 2/14/18							
	Ombudsman 2/14/18						i i	
	Facility Internal invest						!	
		forward to (State Agency)]	
	2/20/14 (sic).	. , ,					1	
	Namo and Title of rep	porting person: Director of					1 1	
	Nursing	- ·		,				
]	
		d gentleman admitted to		i				
	facility on 12/19/17. Is	s alert, pleasant and						
	cooperative, family is	•						
ŀ		ated intestine, DM, BPH,						
	ESKD, weakness, CK			İ				
	Cognitive communica							
1		0:30 A.M. resident stated to						
1		as very rough with him when					1	
		was not turning himself fast	1				 	
		s noted to have pushed	- {					
		Which caused resident						
	resident to complain o							
		ported to Nurse Manager the						
		ent home pending further						
	investigation.							
	Buring an iolaniass of	n 3/16/18 at 2:18 D M with						
	the Director of Nursing	n 3/16/18 at 2:15 P.M. with		-				
	THE CHECKY OF MILISH	a (non) and me						

-	DF DEFICIENÇIAS CORRECTION	(X1) PROMOEIVSUIP), IFRICLIA IDENTIFICATION NUMBER.	(XZ) MULT	IPLE CONSTRUCTION NO	(^-	COMPLETED	
			, , , , , , ,	···	•	c	
		495206	D WING			03/19/2018	
	ROVINER OR SUPPLIER OURS-MARYVIEW NUR	SING C	STREET ANDRESS, CITY, STATE, ZIP CODE 4775 BRIDGE ROAD SUFFOLK, VA 23435				
JX4) ID PRÉFIX TAG	EFIX (EACH DEFICIENCY MUSY BE PRECEDED BY FULL			√ I .√EACH CORR	RE INAN OF CORRECTION FOTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCYI	PUS) PHIMPLETION DATE	
F 609	Administrator, they were Reported Incident (F) and results reported Administrator stated been completed. Shinvestigative report f (APS). The facility's policy: 10/23/17). -Each resident has trabuse, neglect, expliphysical, mental, convoluntary seclusionsReport Time/Respondintstrator of the later than 2 hours at the events that cause or result in serious to 24 hours if the even not involve abuse at bodily injury. -All allegations of at unknown sources at resident property ar Administrator, the Sabuso agency and limits take law, by the designee. -If the resident sustance is no serious in the serious to matter than a serious that the resident sustance is no serious to the serious the resident sustance is no serious to the serious the resident sustance is no serious to the serious the resident sustance is no serious the serious the resident sustance is no serious the serious the resident sustance is no serious the serious the resident sustance is no serious the serious than	vere asked if the Facility (RI) had been investigated to the State Agency. The In investigation had not e was weiting on the final from Adult Protective Services Abuse Prohibition (Effective the right to be free from oitation; verbal, sexual, rpore) punishment and	F	609			

STATEMENT OF CORRECTION AND PLAN OF CORRECTION (X1) PROVIDER OF INTERPLIER OF INTERP	1 .	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO		
	:	495208	B WING_		C 03/19/2018
NAME OF PE	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COUE	00/15/2010
BON SEC	OURS-MARYVIEW NUR	SING C		4775 BRIDGE ROAD SUFFOLK, VA 23435	
IX4) ID I'REFIX IAG	JEACH DEFICIENCY	ATEMENT OF BEFICIENCIES Y MUST HE PRECEDED BY MILL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 609			F6	09	
	Act (the Elder Justice suspicion of a crime,	Section 1150B of the Social Act), if there is reasonable a report must be made to acy and to one or more local lies.			
	the Administrator or o	esligations will be report to lesignee and to the State of days of the incident.			
ั F 610 SS=D	Tinvestigate/Prevent/C	orrect Alleged Violation	+ F6	10 <u>F 610</u>	1/25/18
	- ,,	se to allegations of abuse, or mistreatment, the facility		1)Resident #34 is a discharged reside - The facility did complete a late federa required reporting on the FRI (facility r incidents) per regulatory requirements -Facility completed a late internal inve	al/state reported i.
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged phy invostigated.		on resident # 34 with post incident follo 2) Those residents who reside in the following potentially be at risk.	
	neglect, exploitation, investigation is in pro	-		 A) A process review meeting occurred Don/Abuse Doordinator/Administrator the practice and timelines of investigative reporting to appropriate agencies and 	to review ting and
	designated represent accordance with Stat Survey Agency, with incident, and if the all	the results of all administrator or his of her all all the and to other officials in a law, including to the State on 5 working days of the aged violation is verified a action must be taken.		appropriate required forms and require This also included the following: -The DON/Abuse Coordinator will report required all allegations of abuse to the Administrator and appropriate agencies the time frame requirement of immediations and appropriate agencies the time frame.	ort as es within aje/2
	This REQUIREMENT by: Based on record revi facility staff failed con	is not met as evidenced ews, and staff interviews the hiplete a thorough fility Reported Incident (FRI) ent #34) in the survoy		- The process of internal investigation, documentation and the follow up of findings/conclusion. 4) The DON/Abuse Goordinator will preport to Quality Assurance and Performprovement (QAPI) monthly on Abus allegations, investigation completions, conclusion findings in regards to comwith policy on reporting and investigation. 5) Date of Compliance 4/25/18	rovide a rmance sc/Neglect pliance

PRINTED: 03/30/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES	FORM APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICES		OMB NO	<u>), 0938-0391</u>	
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PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF CORRECTION STATEMENT OF CORRECTION IXAT PROVIDER STIPPLIER CLIA IDENTIFICATION NI IMBER:		A BUILUING					COMPLETED		
		495206	n WING		·-			03/19/2018	
	ROVIDER OR STIPPLIER OURS-MARYVIEW NUR	SING C	S INSET ANDRESS, CITY, STATE, ZIP CODE 4775 BRIDGE ROAD SUFFOLK, VA 23435			DE .			
(X4) ID PREFIX TAG	JEACH DEFICIENC	JATEMENT OF BEFICIENCIES BY MUST BE PRECEDED BY FULL I SC IDEN HEYING INFORMATION)	in PREFI IAG			'S PI, AN OF COI ECTIVE ACTION ENCED TO THE DEFICIENCYI	SHOULD BE	(XS) CRIMPLETION DATE	
F 610 	The findings include Resident #34 was an 12/19/17. This reside diagnoses which includes hyperplasia with low Type 2 Diabetes Medialysis, chronic obsistere protein - cale			610				-	
	An Initial Minimum E assessed this reside Speech and Vision a area of Cognitive Pa assessed as having Status (BIMS) as ha area of Cognitive Pa coded as having no Mood, this resident	ve communication deficit. Data Set (MDS) dated 1/12/18 ent in the area of Hearing, as having no concerns. In the atterns this resident was a Brief Interview for Mental aving a score of (13). In the atterns this resident was concerns. In the area of was coded as having no a of Behaviors this resident							
	concerning a staff (assistant was treating	lity Reported Incident (FRI)							
	Resident Involved: Injuries: Nono appa Incident Type: Phys Name of employee Employee action ini pending investigation Date notification pro	rent sical Abuse (s) involved: itiated or taken; Sont home on							

FORM CMS-2997(12/99) Previous Versions Obsolete

Evant ID: (YYX)1

Facility ID: VA0040

If continuation sheet Page 50 of 104



	OF DEFICIENCIES CORRECTION	(XI) PROVIDERVŠUPPLIFRICLIA IDENTIFICATION NUMBER	(X2) MULYIPI (A RUILDING		(x3) DATE SURVEY COMPLETED C	
		495206	n wing			3/19/2018
NAME OF 17	ROVIDER DR GUPPLIER		ľ	STREET ADDRESS, CITY, STATE, ZIP COL)G	
BON SEC	OURS-MARYVIEW NUR	SING C	l l	4775 BRIDGE ROAD		
			<u> </u>	SUFFOLK, VA 23435	551 (1101)	
()(4) ID PREFIX TAG	(FAGH OEFICIENC	TATEMENT OF NOTICIENCIES Y MUST BE PRECEDED BY FULL LSC INCINT, FYING INFORMATION)	ID PRCCIX TAG	PROVIDER'S PLAN OF CO JEACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I ȘI KOULD BE	(X5) CIMPLLITON CATE
F 610	Continued From pag	e 38	F 610			
	2/20/14 (sic). Name and Title of re Nursing Sommary: 87 year of acilily on 12/19/17, cooperativo, family in diagnoses are perfor ESKD, weakness, Cognitive communic Incident: At approximate family that CNA works family that CNA works family that CNA works family and CNA worksident over roughly resident to complain encounter. Family reconcern, CNA was sinvestigation. During an interview the Director of Nursiand Administrator, they worksident to complain the Director of Nursiand and results reported Administrator stated.	stigation 2/14/18 It forward to VDH/OLC Iporting person: Director of Ild gentleman admitted to Its alert, pleasant and Is attentive. Primary Instead intestine, DM, BPH, IKD, ARD, Dysphagia, Itstion deficit. IO:30 A.M. resident stated to Iwas very rough with him when Its was not turning himself fast Itstian to fright hip pain after Itsported to Nurso Manager tho Itstian in 13/16/18 at 2:15 P.M. with				
F 625 SS=D	investigative report (APS). Notice of Bed Hold	from Adult Protective Services Policy Before/Upon Trnsfr	 F62	25		
L			- ' -	<u> </u>		

	OF OEHICIENCIES CORRECTION	(X1) I'HOVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL'III A. BUII.DING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495206	B. WING		ķ.	40/2040
		453290		STREET ADDRESS, CITY, STATE, ZIP CODE	U3/	19/2018
NAME OF 1th	ROVIOER OR SUPPLIER			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
BON SECO	OURS-MARYVIEW NUR	SING C	l	4775 BRIOGE ROAD		ì
DOM DEQ.	SOUR MINISTER (401	9.14 <u>D</u> 0	ĺ	SUFFOLK, VA 23435		
(X4) IU	SUMMARY SI	ATEMENT OF DEPICIENCIES	10	I'ROVIOER'S PLAN OF CORRECTION	-	(CX)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(CACH CORRECTIVE ACTION SHOULD E CROSS REFERENCED TO THE APPROPRI OFFICIENCY)		DV.LE CONN ELLUN
F 625	Continued From page	e 39	F 62	25 <u>r 62</u> 5	, <u></u>	4/25/1X
	• ,	bed-hold policy and return-		1)Resident#109 is a discharged residen 2) Those residents admitted or transferr		
	§483.15(d)(1) Notice	before transfer. Before a		facility could potentially be at risk related	I to this	
		ers a resident to a hospita) or		practice.		
		therapeutic leave, the		3) The Policy and Practice of Bed Hold.	was	
	nursing facility must j	provide written information to	1	reviewed, and the practice was revised.		
	the resident or reside	ent representative that	.	a) An audit was conducted on current re		
	specifies-		1	to review if bod hold agreement is in pla	ce ironi	
• • • • • • • • • • • • • • • • • • • •	(i) The duration of the	state bed-hold policy, if		admission paperwork b) The Transfer packets for residents	_	
	any, during which the	rosident is permitted to		transferring outside the facility will include	le the	
	return and rosume re	sidence in the nursing		current bed hold policy/paperwork.	-0 0.2	
	facility;			c)An audit will be conducted monthly by	the	
	(ii) The reserve bed p	sayment policy in the state		admission Nurse to assure that each re-		
		of this chapter, if any;		has been provided the bed hold policy of	าก	
		ty's policies regarding		admission.	•	'
		ich must be consistent with		d)The Business office will review each r		!
		nis section, pennitting a		at am clinical meeting if a resident has r and if they have chosen to utilize a bod		
	resident to return; an			c) A report will be provided monthly from		
	(iv) The information s	pecifiod in paragraph (e)(1)	l	Admission nurse and the Business office	e to the]
	of Ihis section.			Administrator on the Bed holds status a compliance.		
	§483.15(d)(2) Ded-he	old notice upon transfer. At		4) The Administrator will report to Quali	ty	
	the time of transfer o			Assurance and Performance Improvem	ent	1
	hospitalization or the	rapeulic loave, a nursing		Committee (QAPI) monthly for 6 months		
		to the resident and the		findings on the bed hold audits and the	process	
		ve written notice which		to ensure ongoing follow up and compli	ance with	
		n of the bed-hold policy		the bed hold policy. 5) Date of Compliance 4/25/18		
		ph (d)(1) of this section.		b) Date of Compliance 4/20/10		·
	This REQUIREMEN	T is not met as evidenced				ļ
	by:					[
		views, clinical record review,				
		tation review, the facility staff				
		f the Bod-Hold Policy for 1 of				
		urvey sample (Resident				j
ļ	#109).					
]						
		d to provide Rosident #109 esentative, will: a written or a				

	DF DEHICIENCIES CORRECTION	(XI) PHOMDER/SUPPLIER/CLIA IDEN HEICATION MIMDER:	(X2) MUL A DIJILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(;
		495206	II WING			03/	19/2018
NAME OF P	ROVIDER (IR SUPPLIER)			នរ	REET ADDRESS, CITY, STATE, ZIP CODE		
				47	75 BRIDGE ROAD		ľ
BON SEC	OURS-MARYVIEW NUR	SING C		કા	JFFOLK, VA 23436		
(X1] 1D		ATFMENT OF DEFICIENCIES	10	'	PROVIDER'S PLAN OF CORRECTION	_	185)
PREFIX		Y MUST DE PRECEDEU BY FULL LSC IDENTIFYING INFORMATION	PREF		(FACH CURRECTIVE ACTION SHOULD IT CROSS REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	NEODITO ON L	EGO (GE)(10 (MIS) III GENERALIS III	7.5	·	DEHICIENCY		
	1		 				
F 625	Conlinued From pag	o 40	F	625		ļ	
	copy of the bod hold	policy after boing transferred					
	to the hospital on 1/2		ł				
	The finding include:		1				
	 Resident #109 was c	niginally admitted to the					
		Otagnosis for Resident #10		1			ļ
	included but not timit	ed lo Heart Faiture and				ļ	
	Seizuros.						'
,	The current Minimun	Data Set (MDS), a		ļ			,
		ssment with an Assessment		1			
		D) of 02/26/18 coded the	ļ	ĺ			
	resident with a 02 ou	it of a possible score of 15 on		j		I	
	!	r Mental Status (DtMS)					
		gnitive impairment. In					
		oded Resident #109 with totat eating and bathing, extensive					
		th bed mobility and toile(use,					
		of one with dressing and					
	personal hygiene.			1			
	, ,,						
ł		cated the following: on					:
		09 was observed breathing					
Į.	rapidly and using ac						
		were: (BP 131/78), (P-128), aturation at 85% on room air					
	and (T-97.5) The re	sident was started on	Ì				
		o physician was notified of					
1		with an order to send out to					
[the Emorgency Root	m (ER) for evaluation and					
		#109 was admitted to the		:			
		osis of hypoxia. The resident					
	was readmitted to th	e tacility on 1/29/16.					
1	On 03/15/18 at appr	oximately 2:55 p.m., a					
		the Administrator for					
ļ	evidence that the fac	citity provided written					
	information of the No	otice of Bed-Hold Policy to					<u> </u>

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN DE CORRECTION 10ENTRECATION NUMBER			(X2 MULTIPLE CONSTRUCTION A. BLILDING				(X3) DATE SURVEY COMPLETED		
		495206	O. WING			C 03/19/2018			
NAME OF P	AME OF PROVICER OR SUPPLIER				STREET ADORESS, CITY, STATE, ZIP CODE	<u></u> l	311312010		
BON SEC	DURS-MARYVIEW NUR	RING Ċ	,	ا ا	4775 BRIDGE ROAD				
				5	SUFFOLK, VA 23435				
(X411D		ATEMENT OF OFFICIENCIES	ID PREF		PROVIDER'S PLAN OF CORRECT		(KUI COMPLETION		
TAG TAG				;	FACH FIZIREC TIVE ACHION SHOUL CROSS-REFERENCED THE HE APPLY DEFICIENCY)		DATE		
F 625	Continued From page	g 41	 -	625	5				
	the resident or reside after being transferre	nl representative prior to or d to the hospital.							
	Ao interview was con Administrator on 3/15	ducted with the 5/18 at approximately at 1:35							
	p.ก., who slated, "Withat Rosident #109 o	e could not find evidence r his family member were							
•	ever informed of the :	lacility's bed hold policy."			m 1	,			
		imatel y at 1,5 0 p.m., an ⁻ ded with Admission who	 			- · .	-		
		act the family related to the			1				
		use the family came into the his personal belongings."							
		on was shared with the							
:		uring a pre-exit meeting on No additional Information							
	The facility's policy: \ (Effective 12/22/17).	⁄irginia Bed Hold Policy							
	(hereafter called "Fac	Systom) located in (State) cility") shall provide a written dident and his/her family							
	member or legal repr	esentative about the bed rission to the Fectility, and a							
		provided at the time a							
	resident is transforror therapeutic leave.	d to the hospital or goes on a							
	-In the care of an em	ergency transfer, the tive/family shall bo provided							
	-	thin 24 hours after the							
		ment is met if the resident's							
		notice is sent with the other g the resident to the hospital.							
	The written notice sh	all include the following							

	UF DEFICIENCIES GORRECTION	(XI) PROVIDER/SUPPLIEN/CUA IDENTIFICATION MUMBER:	(X2) MULTIPL A. BLIII DING	E CONSTRUCTION	(ХЗ) ПАТЕ СОМР	SURVEY LETED
		495206	B. WING	• • • • • • • • • • • • • • • • • • • •	ļ.	Antro46
		455246			03/	19/2018
NAME OF PI	RUNIULE OF PRIER		ŀ	STREET AOORESS, CITY, STATE, ZIP CORE		
BON SEC	OURS-MARYVIEW NURS	BING C		4775 BRIDGE ROAD		
				SUFFOLK, VA 23435		
(X4) ID	SUMMARYSI	A (EMENT OF DEFICIONGIES	10	PROVIDER'S PLAN OF CORRECTION		¢×5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	IFACH CORRECTIVE ACTION STITUTE OF CROSS-REFERENCED TO THE APPROPRIA		DOMPLETION DATE
			,,,,,	OFFICIENCY		
			_			
F 625	Continued From page	e 42	F 625	5		
	information:					
	-The duration of the s	state (Medicaid) bed Irold				
	policy					
	-The facility's policies	regarding bod hold periods				
	permitting a resident	to return.				
F 655			F 655	F 655		1/25/1 K
SS=E	CFR(s): 483.21(a)(1)	-(3)		1. Residents #25,64,213,96,103,51,57 wolfered the opportunity to review their cu		
				care plan and progress since admission.		
	7	sive Person-Centered Care		-Education and policy requirement provide		
	Planning	0 DI-		identified team members: #4,#5,#2, DOI	N, MDS	
	§483.21(a) Baseline			2. Those residents residing in the lacility	could	
		cility must develop and		potentially be at risk for this practice.		i i
		care plan for each resident ructions needed to provide]	3.		
ļ		centered care of the resident		A)The current practice was reviewed and modified to include:	J	
		standards of quality care.		-Baseline care plans will be offered to re	sident or	
	The baseline care pla			ropresentative during the interdisciplinar	у	
}		in 48 hours of a resident's	1	meeting and according the required time	line	
	admission.			roquirement.	_	
	(ii) Include the minima	ım healthcare information	ļ	The Signature page will be maintained a record of the baseline care plans being of		
	necessary to properly	/ care for a resident	1	and accepted or relused.	JIICICU	
	including, but not limi			B) The MDS Coordinator will audit newly	,	
Į	• • –	d on admission orders.		admitted residents and compile a log. If		
	(B) Physician orders.			Will indicate that a baseline care plan wa		
	(C) Dietary orders.			olfered and documented to new resident required timelino. This log will be provide		
!	(D) Therapy services		ļ	DON Monthly.	su ju tije	
	(E) Social services.	endation, if applicable.		4) The DON will report to Quality Assura	nce and	
	(F) PASARK TECORIE	endation, ii appik;able.		Performance Improvement Committee (QAPI) .	
	§483.21(a)(2) The fac	cilily may develop a		monthly for 3 months the linding of the b		
		plan in place of the baseline		care plan audit and any follow up actions		
	care plan if the comp	•		to maintain compliance with the baseline plan policy.	; care	İ
ļ		n 48 hours of the resident's		5) Date of Compliance 4/25/18		
	admission.			-, 0: - 0: 0:		
		ments set forth in paragraph	1			,
		cepting paragraph (b)(2)(i) of				
ļ	Unis section).					,

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

The state of the state of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDEŘÍSUPPI IFRICLIA IDENTIFICATION NUMBER-	(X2) MULTIPLE CO A. BUILDING	СОМ	SURVEY PLETED	
		495206	8. WING	·		/19/2018
	ROVIOLR OR SUPPLIER DURS-MARYVIEW NUR	SING C	4775	FET ADDRESS, CITY, STATE, 2IP COD 5 BRIDGE ROAD FFOLK, VA 23435	F	
[X4] ID PREFIX I AG	(EACH DEFICIENC	TATEMENT OF DEFICE NOTES Y MINST BE PRECEDED BY FILL LSC IDENTIFYING INFORMATION	IU PREFIX TAG	PROVIDERS PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE UEHICIENCY)	SHOULD DE	(7.5) CHIMPLETION DATE
	Continued From pag §483.21(a)(3) The faresident and their rejof the baseline care limited to: (i) The initial goals of (ii) Asummary of the dietary instructions. (iii)Any.services and administered by the fon behalf of the facility (Iv) Any updated information of the comprehensive This REQUIREMENT by: Based on clinical reinterview, and staff in provide baseline carresident or the resident failed to document in summaries were prothe survey sample (If #96, #103, #51, and The findings include 1. Resident #25 was 1/8/18. Diagnoses for were not limited to Commerce in the survey sample (If #96, #103, #51, and The findings include 1. Resident #25 was 1/8/18. Diagnoses for were not limited to Commerce in the survey sample (If #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #96, #103, #51, and #51, #51, #51, #51, #51, #51, #51, #51,	e 43 cility must provide the presentative with a summary plan that includes but is not of the resident. If the resident. It resident's medications and detections and detections and personnel acting by the care plan, as necessary. It is not met as evidenced cord review, resident merview, the facility failed to be plan summaries to the ent's respresentative; and in the medical record that vided for 7 of 41 residents in Residents #25, #64, #213, #57). In the medical record that vided for 7 of 41 residents in Residents #25, #64, #213, #57). In the medical record that vided for 7 of 41 residents in Residents #25, #64, #213, #57). In the medical record that vided for 7 of 41 residents in Residents #25, #64, #213, #57). In the medical record that vided for 7 of 41 residents in Residents #25, #64, #213, #57). In the medical record that vided for 7 of 41 residents in Residents #25 included but the cord of the facility on the resident #25 included but the cord of the facility of the fa	F 655			
	(MDS) with an Asse scored Resident #5 possible 15 BIMS (E Status) indicating no Resident required to with bed mobility an assistance with tran	erly Minimum Data Scl ssment Reference Date of with a score of 15 out of a brief Interview for Mental o cognitive impairment. The wo staff person assistance d required one staff person sfers, locomotion on unit, and personal hygiene.				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	(X3) LIATE SURVITY COMPLETEU	
		405000		· ————————————————————————————————————	С
		495206	P WING		03/19/2018
NAME OF P	ROVIDER OR SUPPLIFR			OTREET ADDRESS, CITY, STATE, ZIP COOK	
BON SEC	OURS-MARYVIEW NUR	sing C		4775 BRIDGE ROAO SUFFOLK, VA 23435	
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFIDIENCIES Y MUST OF PROCED ON FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S I'LAM OF CORRECTION (FACIL CORRECTIVE ACTION SHOULD I	SF. COMPLETION
TAC	NEGGENTON ON	ESC IDENTIFY INFORMATION)	IAG	CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	PATE TOTAL
F 655	Continued From page	- 44	f- 6s	55	
	The Comprehensive	Person Centered Care Plan	ĺ		
		dentified a focus area of			
		ed to COPD. The goal was			
	absorption through th	ptoms of poor oxygen e review date. Two			
		i oxygen via nasal canula 2			
		id oxygen supplies and			
	tubing changes/clean	ing per facility protocol.			
		nt's clinical record did nol			
	indicate that a baselir provided to the Resid	ie summary care plan was ent.			
;		/18 at approximately 2 PM recall receiving a summary			
	were not given baseli	tely 2:30 PM that Residents ne careplan summaries. ents were given a copy of			
	findings during a pre- approximately 3:55 P	ntion was informed of the exit briefing on 3/20/18 at M. The facility did not formation about the finding.			
	1/22/18. Diagnoses for	admilled to the facility on or Resident #64 included but pecified fracture of right			
:	with an Assessment F	y Miriimum Data Set (MDS) Reference Date of 2/5/18 with a 2 out of a possible 15 i impaired cognition,			

FORM CMS-2967(02-98)) Provincis Varsinns (theolete

Even| IO: TYYX11

Focility IIJ: VA0040

II continuation sheet Fage 57 of 104



	· ·	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D. 03/30/2018 MAPPROVED D. 0938-0391
STATEMENT (OF DEHICIENCIES CORRECTION	IXI) PROVIDER/SUPPLIER/CIJA IDENTIFICATION NUMBER:	JX2) MULT A. BUILDII		CONSTRUCTION	IXI) DATE	
		495206	B. WING				0 19/20 <u>18</u>
NAME OF PI	OVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				477	S BRIDGE ROAD		
BON SEC	OURS-MARYVIEW NUR	SING C	1	SU	FFOLK, VA 23436		
(X4) IU PREFIX TAG	(EACH DEFIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	io FREII YAG	1	PROVIDER'S PI AN OF CURRECTION IEAGI I COPRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE OFFICIENCY)	BE	IXS) COMPLESION DATE
F 655	indicate that a baseth provided to the Resident #64 on 3/14 PM was not able to received a summary. The Facility's Director 3/16/18 at approximated that reside their baseline careptor approximately 3:55 Foresent any further in 3. Resident #213 was the facility on 2/16/16 (1) Right Fibula Fractand (3) Hypertension The most recent corn Set (MDS) assessment 2/23/18. The Brief In (BIMS) was a 15 out Indicated Resident #210 and capable of daily. On 03/12/18 at 12:40 tour the resident inforwas a new admission a fractured ankle. The	ent's clinical record did not ne summary care plan was dent. 4/18 at approximately 1:45 espond when asked if she baseline careplan. For of Nursing stated on alely 2:30 PM that Residents line careplan summaries. The lents were given a copy of ans. ation was informed of the exit briefing on 3/20/18 at PM. The facility did not information about the finding is a 69 year old admitted to 8 with diagnoses to include ture, (2) Diabetes Mellitus. In prehensive Minimum Data ent was a 5 Day Admission Reference Date (ARD) of terview for Mental Status of a possible 15 which led 3 was cognitively intact decision making. D PM during the initial facility formed this surveyor that she in here for rehab because of the resident asked if she was	F- (855			
	was reviewed with h	ne care plan summary that or by the facility. Resident vasn't given anything like that newed with me."			•		

STATEMENT	OF REPROBLES CORRECTION	(XI) PROVIDER/SUPPLIERICLY, IDENTIFICATION NUMBER:	(X2) MOLTIPLE CO		(X3) FATE SURVEY COMPLETED	
			_		l.	c
		495206	B. WING			/19/2018
	ROVIDER OR SUPPLIER DURS-MARYVIEW NUR	şing C	4775	EET ADDRESS, CITY, STATE, 7IP COD BEHINGE ROAD FOLK, VA 23435	Ė	
(X4) IU PRFFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFT RENGED TO THE A DEFICIENCY)	SHOULO BE	IXS) EHMPLETION DAYE
F 655	Continued From page	e 46	F 655			
]	Resident #213's Bas	eline Care Plan was				
		ed that it had been initiated				
ļ	On 2/15/18 at 2:00 p.	.m. an intorview was MDS Coordinators Licensed				
	Nurse (LPN) #5, and	l) #4, Licensed Practical the Infection Control Norse				
:	who was responsible	N) #5. This group was asked for doing the 48 hour				
		nd summary with the control Nurso Registered o the 48 hour basoline care				
:	plan but we have not	t been doing the baseline ve no documentation in the				
	medical record to shi	ow what we were doing." we didn'I do the summaries				
	and a copy of the ph	copy of the initial care plan ysician orders. We should				
1		nt a 48 hour baseline care man's terms and have pedical record "				
	On 3/19/18 at 3:55 p	.m. a pre-exit conference				
	was held with the Dir were the above infor	rector of Nursing and RN #2 mation was shared. No				
	4. Resident #96 was	ras provide by the facility. admitted to the facility on netude but are not timited to				
	pneumonie, cognitiv	e communication deficit, anemia, gout, atrial flutter,				
	and primary hyperte	nsion.				
	for rosident #96 was assessed the reside	lata Set (MDS) assessment completed on 3/7/18 which nt in the area of Cognitive				
		Interview for Mental Status ndicating moderately				

PRINTED: 03/30/2016 FORM APPROVED OMB NO. 093<u>8-03</u>91

STATEMENT	OF REFICIENCIES CORRECTION	(X1] PROVIDER/SUPPLIER/CLIA IOEN HICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) OATE SURVEY COMPLETED	
		495206	D. WING	_				19/2018	
	ROVIDER OR SUPPLIFE DURS-MARYVIEW NUR	SING C	<u> </u>	4775	ET ADDRESS. CITY, STATE BRIDGE ROAO FOLK, VA 23435	ZIP CODE			
(X4) ID PREFIX FAG	(EACH DÉFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY HULL SECTION REYING INFORMATION)	ID PREF TAC		[EACH CORRECTIVE CROSS-REFFRENCH		2.8F	(XI) ISOMPLETION DATE	
F 655	impaired cognition. A section indicated resussistance with self-one staff member protransfers, tocomotion. Physician orders incognized and status, F/U with Carpacemaker check, Filicensed nurse round restorative nursing pron-pharmacological OT/PT/ST evaluate MNCC protocol, vital and weekly skin assistanties. An interview on 3/42.	Activities of Daily Living (ADL) sident #96 needed limited performance and support of covided for bed mobility, in on the unit, and toilet use. Itude: L.C.S., NAS diet, at times a day, Full Code. diovascular doctor for itoor mat white in bed, ding, may participate in program, al., pain management, and treat, skin care per all signs every shift for HTN, sessment on Monday7a - 7p.		655		CJENCY)			
	her care plan given with either the resid 5. Resident #103 wr 2/21/18, diagnoses acute on chronic rig diabetes type II, hypurnspecified, obstruct hypertension, and a An Admission Minimassessment was coresident. In the area Brief Interview for M12 indicating moder Activities of Daity Lingident #103 need self-performance in	num Data Set (MDS) impleted on 3/2/18 for the a of Cognitive patterns with a fental Status (BIMS) score of rately impaired cognition, ving (ADL) section indicated ed extensive assistance with bed mobility, transfers, and personal hygiene and							

	OF DEFICIENCIFS CORRECTION	(X11 PROVIDER/SULT-LIER/CLIA IOENTHICATION NUMBER:	(X2) Male		STRUCTION		ATF SHRVEY OMPLETED
		495286	B. WING				C 03/19/2018
	SOMETE OF STUDIES	433240	_	STREE	T AUDRESS, CITY, STATE, ZIP COL	<u></u>	03/10/2010
NAME OF IT	ROMPER OR SUPPLIER				RIDGE ROAD		
BON SEC	OURS-MARYVIEW NUI	rsing C			OLK, VA 23435		
(X4) ID PREHX TAG	(FACH OEFICIEN	TATEMENT OF DEFIGIENCIES CYMUST BE PRECEDED BY FILL R LSC INFNTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH FORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULO BE	COMPLETION DATE
F 655	Continued From pag	ge 48	F	655			
	NAS regular texture day, Full Code CPR from home at home apnea. Please applyinghl (3/9/18), PT & indicated, turn and ror chair documenter assessment Thursd An interview on 3/1: #103 determined the his care plan given with either the reside. Resident #51 was facility on 1/17/18 wascute kidney failure pressure and gastro (GERD. The most recent Mi assessment dated to nihe Brief Interview with a score of 15 coindicated the reside cognitive skills for data to the still that a score information of the still that a score infor	sician orders include: Diet f, fluid restriction 1800ml per g, May have C-Pap machine settings at bedtime for sleep y O2 to C-Pap machine at OT to evaluate and treat as reposition Q2hrs while in bed d q shift, weekly skin ay 7a - 7p. 3/18 at 3:13PM with resident ere had been no summary of within 48 hours to ur reviewed ent or his representative. Is admitted to the nursing with diagnoses that included on dialysis, high blood besophageal rethix disease minum Data Set (MDS) 2/7/18 assessed the resident and of a possible 15 which ent was fully intact with failly decision making. It care plan developed within that included the minimum tion necessary to properly on admission orders					
	During an interview	with the resident on 3/16/18					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

A95206 B. WING	STATEMENT (OF OEHICIENCIES	(X1) PROVIDER/SUPPLIFE/CLIA	(X2) MIJLTELE CO		(X3) OATE SURVEY COMPLETED		
INMEDITEDUCION OR SUPPLIER BON SECOURS-MARYVIEW NURSHING C OPIDID CANDID SECOURS-MARYVIEW NURSHING C STREET ADDRESS, CITY, STATE, JP CODE ATTS SHOOGE ROAD SUFFOLK, VA 23433 DEFOLK, VA 23433 SUFFOLK, VA 23433 PROVIDER'S PLAN OF CORRECTION REQUIATORY OR LOC IDENTIFYERS INFORMATION TAG F 655 Continued From page 49 a 9.30 a.m., ho stated he was not issued a copy of his care plan nor a summary of the basoline care plan that included the aforementioned requirements of the 48 hour care plan. An interview was conducted with the Administrator on 31/5/18 at approximately 6:15 p.m., who stated "Voc did not have a real. understanding that a baseline summary report nester to be those and reviewed the resittent." the surveyor asked, "Who are you referring to as we" sho replied, "Our MDS Coordinators, let me get litem so they can explain." On 3/15/18 at approximately 6:30 p.m., an interview was conducted with the infection Control Nurse, MDS Coordinator #1 and MDS Coordinator #2, the infection Control Nurse stated, "We didn't know anything about the baseline care plan as completed within 48 hours in Point Click Care and thon updated tater by MDS Coordinator #1 stated, "The process is to give he initial baseline care plan with the medication review to the resident of rex new yor asked for documentation that the baseline care plan was reviewed with the resident or RR, MDS Coordinator #1 stated, "Ne do not have any documentation showing to the care plan ever being reviewed with the resident or representative," the surveyor asked if a baseline	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			С	
INMEDIC PROVIDER OR SUPPLIER BON SECOURS-MARYVIEW NURSING C (MI) ID SUMMARY STALEMENT OF QUENCIFICIENCES SUPPLIE AND COMPRESS PLAN OF CORPRECTION SUPPLIE AND COMPRESS PLAN OF CORPRECTION PREPRY REQUILATORY OR LISO IDENTIFIEND IN PROCESS OF THE APPROPRIATE PRIPRY TASK PROVIDES PLAN OF CORPRECTION PRIPRY PRIPRY PROVIDES PLAN OF CORPRECTION PRIPRY PRIPRY PROVIDES PLAN OF CORPRECTION PRIPRY PRIPRY PRIPRY PROVIDES PLAN OF CORPRECTION PRIPRY PRIPR			495200	B. WING		e		
PREPRI TAG RESULTATION VINEST BE PERCELLED BY FILL RESULTANCE OF THE RESULTATION VINEST BE PERCELLED BY THE RESULTATION AND STORM IS COMENTATION OF USE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF HORSE OF THE AFROPRIATE OF THE AFROP				477 !	5 BHIOGE ROAD	OE		
at 9:30 a.m., ho stated he was not issued a copy of his care plan nor a summary of the basoline Care plan that included the aforementioned requirements of the 48 hour care plan. An interview was conducted with the Administrator on 3/15/18 at approximately 6:15 p.m., who stated "We did not have a real. understanding that a baseline summary report needed to be done and reviewed the resident." The surveyor asked, "Who are you referring to as we" sho replied, "Our MDS Coordinators, let me get them so they can explain." On 3/15/18 at approximately 6:30 p.m., an interview was conducted with the infection Control Nurse, MDS Coordinator #1 and MDS Coordinator #2, the Infection Control Nurse stated, "We didn't know anything about the baseline care plan was completed within 48 hours in Point Click Care and then updated later by MDS Coordinator with resident's goals. The MDS Coordinator with resident's goals. The MDS Coordinator with resident's goals. The MDS Coordinator with resident's goals. The MDS Coordinator with resident's provise of Resident Reprosentative (RR)." Tho surveyor asked for documentation that the baseline care plan was reviewed with the resident or RR, MDS Coordinator #1 stated, "We do not have any documentation showing to the care plan ever being reviewed with the resident or reprosentative," The surveyor asked for abseline to the reprosentative, we do not have any documentation showing to the care plan ever being reviewed with the resident or reprosentative," The surveyor asked for abseline	PREFIX	(EACTIDEHICIENG	CY MUST BE PRECEUEO BY FITLL	PHFFIX	(EACH CURRECTIVE ACTION CROSS-REFERENCED TO THE	N STIOULU BE : AFPROPRIATE	DATE DATE (XL)	
resident or RR, she replied, the MDS Coordinator replied, "Yes." The above information was shared with the Director of Nursing and the Unit Manager on the	F 655	at 9:30 a.m., ho state of his care plan that include requirements of the An interview was conditionally an interview was conditionally and a state of his care plan that includes the surveyor asked, we'' sho replied, "Or get It in so they can on a state of the surveyor asked, we'' sho replied, "Or get It in so they can on a state of the surveyor asked, we'' sho replied, "Or get It in so they can on a state of the surveyor asked on the surveyor asked conditional that it is a self in e care plan in the sale of the surveyor asked for document plan was reviewed. Resident Reprosentation sho being reviewed with reprosentative." The surveyor information in the sident or RR, sho replied, "Yes."	ed he was not issued a copy a summary of the baseline led the aforementioned 48 hour care plan. Inducted with the 15/18 at approximately 6:15 /c did not have a real. In baseline summary report and reviewed the resident." "Who are your referring to as ur MDS Coordinators, let me in explain." Eximately 6:30 p.m., an ucted with the Infection Scoordinator #1 and MDS Infection Control Nurse and anything about the summary." The resident's was completed within 48 is Care and then updated later or with resident's goals. The interest of the resident if appropriate or native (RR)." The surveyor lation that the baseline care with the resident or RR, MDS ted, "We do not have any wring to the care plan ever the the resident or ne surveyor asked if a baseline are been reviewed with the explied, the MDS Coordinator after was shared with the	F 665				

FORM CMS-Zi67(02 99) Previous Versions Chaptele

Eventio: TYYX11

Facility II): VA0040

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STATEMENT OF DEFICIT NOTES AND PLAN OF CONNECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. GUILDING			IX3I DATE SHRVEY COMPLETED	
		49 5 20G	a. wing			C 03/19/2018	
	ROVIDER OR SUPPLIER OURS-MARYVIEW NUR	SING C		STREET ADDRESS, CITY, STATE, ZIP CO 4775 BRIDGE ROAD SUFFOLK, VA 23435	υE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATFMENT OF OFFICIENCIES Y MUST BE PRECEDED BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG		N SHOULD DE		
F 655	Chesapeake Unit dur 3/19/18 at 4:00 p.m. was provided. 7. Resident #57 was 01/30/18. Diagnosis but not limited to Car and Muscle Weakner The current Minimum comprehensive asse Reference Date (ARI resident with a 15 ou the Brief Interview fo indicating no cognitiv the MDS coded Residependence of one wassistance of une with	admitted to the facility on for Resident #57 included diovascular Accident (CVA) as. Data Set (MDS), a assment with an Assessment D) of 2/9/18 coded the tof a possible score of 15 on a mental Status (BIMS) are impairment. In addition, dent #57 with total with bathing, extensive th bed mobility, transfer, and personal hygiene and	F	655			
	p.m., who stated "We understanding that a needed to be done a The surveyor asked, we" she replied, "Ou get them so they car On 3/15/18 at approxinterview was conductoriol Nurse, MDS Coordinator #2, the I stated, "We didn't know the setting care plan so hours in Point Click of the stated of the care plan whours in Point Click of the stated of the care plan whours in Point Click of the stated of the care plan whours in Point Click of the care plan whours in Point Click of the stated of the care plan who was a sta	5/18 at approximately 6:15 a did not have a real baseline summary report nd reviewed the resident." "Who are you referring to as r MDS Coordinators, let me					

AND BLANDE CORDITATION RELIEF A FON REMOTED		(X2) MDL A. QUIL DI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495206	B. WING	·		C 03/19/2018
	ROVIDER OR SUFFLIER DURS-MARYVIEW NUR	SING C		STREET ADDRESS, CITY, STATE, ZIP CODE 4776 BRIDGE ROAD SUFFOLK, VA 23436		
IX4) ID PREFIX TAG	[EACH DETICIENC	ATEMENT OF OUTFICIENCIES Y MUST BE PRECEDED DY FULL LOC IDENTIFYING INFORMATION)	ID PREIT TAG	(EACH CORI	R'S PLAN OF CORRECTION RECTIVE ACTION STIDITED E RENCEO 10 THE APPROPR DIFFICIENCY)	E COMPLETION
F 655	give the initial baseling medication review to Resident Representate asked for documentational plan was reviewed with a documentational plan was reviewed with a representative." The summery should have resident or RR, she replied, "Yes." The above information Director of Nursing a Chesapeake Unit due 3/19/18 at 4:00 p.m. was provided. The Facility Policy: P (Effective November Purpose: To provide that results in care a maintain the highost and psychosocial was resident comprehensional early and based on reach a comprehensive care and based on reach a comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and baseline within 48 hours of the provided to the resident comprehensive care and provided to the resident comprehensive care and provided to the resident comprehensive care and provided to the resident comprehensive care and provided to the resident comprehensive care and provided to the resident comprehensive care and provided to the resident comprehensive care and provided to the resident comprehensive care and provided to the resident comprehensive care and provided to the resident care and provided to the resident care and provided to the resident care and provided to the re	stated, "The process is to me care plan with the the resident if appropriate or alive (RR)." The surveyor alion that the baseline care ith resident or RR, MDS d, "We do not have any ing to the care plan ever the resident or surveyor asked if a baseline e been reviewed with the eplied, the MDS Coordinator on was shared with the eplied, the MDS Coordinator on was shared with the end the Unit Manager on the ring a pre-exit meeting on No additional information. Patient Centered Care Plant 2017). Independent of the established in the end of the unit be established in the ere plan will be established in a care plan if it is developed or resident's admission. aseline care plan will be ent and/or representative per ent and/or representative per	F	555		
	guidelines. The sum	mary will include, but is not	<u> </u>	<u> </u>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIFR/CLIA IDENTIFICATION NUMBER.	(X2) MIII A. BUILE		CONSTRUCTION	(X3) DATE SURVEY	
		495206	B. WING			03/1	19/2018
NAME OF P	ROVIOER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	· <u> </u>	-
				4	775 BRIDGE ROAD		
BON SEC	OUR\$-MARYVIEW NUR	SING C		s	UFFOLK, VA 23435	 (
(X4) ID PREFIX TAG	(ÉACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREJ- TAG	ιX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD IT CROSS REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 655	limited to the initial g medications, dietary and treatments to be summary will also in based on changes in care plan, as necess Care Plan Timing and CFR(s): 483,21(b)(2) §483,21(b) Comprel §483,21(b)(2) A combe- (i) Developed within the comprehensive a (ii) Prepared by an inincludes but is not lift (A) The attending phoroident. (C) A nurse aide with resident (D) A member of for (E) To the extent protection of the resident and their resident renot practicable for the resident's care plan (F) Other approprial disciplines as determor as requested by (iii) Reviewed and recomprehensive and assessments. This REQUIREMENT.	coals for the resident, instructions and any services administered. The clude any update information hade to the comprehensive sary. Id Revision (i)-(iii) thensive Care Plans aprehensivo care plan must 7 days after completion of assessment. Interdisciplinary team, that mited to— aysician. Is with responsibility for the in responsibility for the ad and nutrition services staff. It be included in a resident's is participation of the resident apresentative is determined the development of the the staff or professionals in mined by the resident's needs the resident. Existed by the interdisciplinary assessment, including both the		655	F 657 1) Resident # 34 is a discharged resider Resident #263's care plan has been revand revised as needed. 2) Those residents who reside in the facindividual needs that require their care pereiewed and revised could potential affected by this practice. 3) Process review and revisions include following: a) An Enhanced process has been initial the am clinical meeting that will include items that are reported and need care pupdates or revisions will be updated by unit managers at this meeting. b) The required need for update that is outside the am meeting will be directed mds/unit manager for ongoing update in between assessments. c) A monthly random audit will occur for plans and appropriate updates by the umanager and will be provided to the DC monthly. 4) The DON will report audit findings are plan compliance to Quality Assurance of Performance Improvement Committee monthly for 3 months to ensure compliance plan update process/policy. 5) Deto of Compliance 4/25/18	nt. iewed cility with blans to lly bo the ated at those blan mds or identified to the or care init DN and care and (QAPI)	
	and their resident re not practicable for the resident's care plant (F) Other approprial disciplines as detern or as requested by (iii)Reviewed and re- team after each ass comprehensive and assessments.	epresentative is determined the development of the testaff or professionals in mined by the resident's needs the resident. Evised by the interdisciplinary sessment, including both the liquarterly review			monthly. 4) The DON will report audit findings ar plan compliance to Quality Assurance of Performance Improvement Committee monthly for 3 months to ensure compliance plan update process/policy.	nd c and (QA	(PI)

AND BY AN OF CORDECTION		A. BUILD		(IV)	COMPLETED				
		496206	B. WING				C 93/19/2018		
	ROVIUER OR SUPPLIER DURS-MARYVIEW NUI	RSING C	1	STREET ADDRESS, CITY, STATE, ZIP CODF 4775 BRIDGE ROAD SUFFOLK, VA 23435					
(X4) ID PREFIX FAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR TSC IDENTIFYING INFORMATION)						PROVIDER'S PLAN OF C (FACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEHICHENCY)	N SHOULD BE C APPROPRIATE	(XS) COMPLETION DATE
F 657	interviews, facility diclinical record review review and revise the for 1 of 41 residents (Residents #263 and The facility failed to toenails on the care The findings include Resident #263 was 11/15/17. Diagnose but are not limited to Anxiety and Mycotic Resident #263's Signals Set (an assess Assessment Refere Resident #263 with Mental Status) scorindicating no cognitivas dependent on toilet use, and hygic The Comprehensive last revised 1/29/18 of thickened, long, Review of the Resident mented a Pod Podiatry note dated following: Reason for Consult Podiatry note documented documented documented and podiatry note documented docume	ion, resident interviews, staff occumentation review, and w, the facility staff failed to be comprehensive care plants in the survey sample d #34). The lude pathful thickened to plan for Resident # 263. ed: admitted to the facility on staff for Syndrome, comparished to Chronic Pain Syndrome, comparished to Chronic Pain Syndrome, comparished to Chronic Pain Syndrome, comparished to Chronic Pain Syndrome, comparished to Chronic Pain Syndrome, comparished to Chronic Pain Syndrome, comparished to Chronic Pain Syndrome, comparished to the protocol of 1/22/18 scored a BIMS (Brief Interview for comparished to the present for dressing the person Contered Care Plants did not include a focus area	F	657					
	10 nails."					457			

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 03/30/2018 M APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COM	F SURVEY PLETTO
		495206	B WING			C / 19/2018
MAME OF P	ROVIDER OR SUPPLIER			FT ADDRESS, CITY, STATE, ZIF CODE		
BON SEC	OURS/MARYVIEW NUI	RSING C		BRIDGË ROAD FOLK, VA 23435		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCICS CY MIST BE PRECEDED BY FIJI L R LSC IDENTIFYING INFORMATION	ID PREFUX IAG	PROVIDEN'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROUS-REFT RENCED TO THE AI OBFICIENCY)	HOULO BE	(XF) COMPLETION DATE
F 657	The websile (https://oig.hths.gov/df) documented the Nail debridement in toenail bed or viable performed manually an electric grinder. nail debridement to onychomycosis (i.e. loenails). The Director of Nur al approximately 3: currently without a facility. The facility date a Podiatrist metho OON was aske assist the Resident Gommunity Podiatrist per hand had been unsured and had been unsured and stated that the #263 stated that the #263 stated that the were curled under my skin. Resident up her hands and the fingerlips touch the following:	volves removal of a diseased e nail plate. This may be with an instrument, or with Podiatrists generally provide patients diagnosed with an invocation mycotic raing (DON) stated on 3/13/18 45 PM that the facility was Podiatrist to make visits in the was not able to state the last ade visits in the Facility. When d why the facility could not to make an outside rist, the DON stated, that they are reached out to the daughter accessful. Toximately 1:30 PM, Resident the had her toenails trimmed by felt so much botter. Resident and getting ready to grow into #263 demonstrated by holding curled her fingers under untit	F 867			

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		ND HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF OUTFICIENCIES CORRECTION	(X1) PROVIDER/SUPPI ICT/CCLIA IDENTIFICATION NUMBER	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495206	B. WING		C 03/19/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CORE	
BON SEC	OURS-MARYVIEW NUR	ISING C	-	4775 RRIDGE ROAD SUFFOLK, VA 23435	
			_ 		SECTION OF
JX4) ID J'REFIX FAG	JEACH DEHICIÉNO	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FIJL LSC IDENTIFYING INFORMATION)	PREFIX TAG	IROVIDER'S PLAN OF CORE EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD DE CHMFLETION
F 657	Continued From pag	gc 55	F 68	57	
	, -	keep nails trimmed, and to			
		. Refor diabetic residents or	; I		1
		atory impairment, cu/ved,			
		abnormalities to podiatrist			ł
		otify altending MD (Medical			Ì
		ler for podlatry consult."		·	
	•				
		ration was informed of the	"-		
	fınd <u>ings duri</u> ng a <u>pre</u>	exit briefing on 3/20/18 at	_	— i - ——	··
	approximately 3:55 F	PM. The facility did not	1		†
	present any further i	nformation about the finding.			
	The facility staff faile Resident #34	ed to revise a care plan for]
	2. Resident #34 was	s admitted to the facility on			
		ent was admitted with			 -
		duded benign prostatic	1	}	
		er unnary tract symptoms,			1
		ellitus, dependence on renal	İ		
	dialysis, chronic obs	structive pulmonary disease,			į
	severe protoin - calc	orie malnutrition, acute			-
	embolism and throm	nbosis, chronic kidney	}		
	disease, and cogniti	ve communication deficit.			
	The facility staff fails	ed to revise Resident #34's			
		interventions for the use of a			
	Video Monitor.				
	A told at Balantan and F	D-14 CAL (MIDC) d-144 1/1/2/19			
		Data Set (MDS) dated 1/12/18			
		ent in the area of Hearing, as having no concerns. In the			
	opeed) and vision a	as naving no concerns. In the atterns this resident was			
		a Brief Interview for Mental			
		aving a score of (13), in the			
		atterns this resident was			
		concerns. In the area of			
	widod, inis resident	was coded as having no ea of Bchaviors this resident	1		
	т сопсенья, пі іле ан	SO OF DOLLARIDIS HUS LESIONIH	i	I .	į.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILO	TIPLE CO		(XII) NATE SURVEY COMPLETED		
			ţ			1	C
		495206	B. WING			03/	19/2018
NAME OF PE	ROVIDER OR SUPPLIER			STRE	ET AUDRESS, CITY, STATE, ZIP CODE		
DOM SEC	OHNO BARDSHOEW **	IBeing c		4775	BRIOGEROAO		
MON SEC	OURS-MARYVIEW N	URQING C		ŞUF	FOLK, VA 23435		
(X4) IO PREFIX YAC	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDEN'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCELL TO THE APPROVIDENCY)	(INF	(XI) DATE
							
F 657	Continued From p	age 56	F	657			
	was coded as hav						
		_					
		the roominate to Resident					
		ay at the facility and during the					
		o Baby Monitor was placed in					
		staff had placed the Video					
	Monitor in the roor	m to a please Resident #163.					
	During the investig	ration of a CDI submitted by the					
		gation of a FRI submitted by the I34 complained to Nursing staff	l l				
		treated roughly by a CNA					
ļ		Assistant). During the facilities		Ì			
		iff member references a					
		the room in her written					1
		acility staff conducting the					
		ion. A written statement from					
		he FRI investigation indicated:					
	Resident #34 stat	od "You are on camera, [and					
		treating him roughly] was going		Ì			
	to get it."						
		= 0146149 at 0.00 A M with		1			
		w on 3/16/18 at 9:30 A.M. with		I			
		stated, he had spoken to his					
i	lamily about the n	ough treatment of one CNA. It the camera being in the room	l				
i		ave consent this resident stated,	[
	No I did not rive	consent for a camera to be in	Ì				
	the morn.	consont ior a connecta to be in					
		ew on 3/16/18 at 2:15 P.M, with					Ì
1	the Director of Nu	ursing (DON) and the		Ì			}
		DON stated, she had				•	-
	purchased a Digit	tal Video Baby Monitor and					1
	placed it in the ro	om to a please Resident #163					
	who was complai	ning of staff ignoring him and		Ì			
ł	not providing time	ely assistance."					
	The DON stated,	she purchased the Vidoo Baby					
1		Resident #163 was afraid. The					
	Video Monitor wa	s capable of having audio when	1	<u> </u>			

STATEMENT OF DEPICITNICIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLICATELIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUII DING	E CONSTRUCTION	(X3) DATE SURY COMPLETE	
		495206	B. WING		03/19/2	2018
	ROVIDER OR SUIPLIER DURS-MARYVIEW NUR	SING C		STREET ADURESS, CITY, STATE, ZIP CODE 4775 BRIDGE ROAD SUFFOLK, VA 23435		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATOMENT OF DEFICITINGIES Y MUST BE PRECEDED BY FULL LSC IDENTITYING INFORMATION	IO PREMX TAG	PROVIDER'S PLAN OF CORRECTICIN (CACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPE ORNICIENCY)	ואו פו	OCAL IMPLETION DATE
F 657	the screen is off so n resident. The camera	urses could monitor a or viewing devices were and placed on nursing cart. en bn able tu monitor	F 65	7		
	That a Care Plan for I During an interview of the DON and the Ad	al records did not indicate the use of the Video Monitor. on 3/16/18 a <u>t 2:15</u> P.M. <u>with</u> ministrator they stated, there rithe use of the Video	-			
F684 SS=D	The facility staff faile comprehensive care use of a Video Monit Quality of Care CFR(s): 483.25 § 483.25 Quality of a Quality of care is a fapplies to all treatme facility residents. Baassessment of a residents received accordance with propractice, the compredary plan, and the residents received the comprehensive of the c	was revised to include the or care undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure e treatment and care in fessional standards of themsive person-centered	F 68	1) Resident #267 is a discharged resident Education provided to staff member in #25 2) Those residents who receive insuling potentially be at risk 3) a) Education was provided to nurses of ellowing physicians order and stiding insuling coverage. b) The nurse managers will conduct we audits of the following and report finding DON wockly: medication pass/insuling coverage documentation related to insuling scale plorders of pharmacy will audit monthly those reconstiding scale coverage and provide to the DON monthly. 4) The DON will report to Quality Assu Performance Improvement Committee (QAPI)monthly for 3 months, the finding audits related to medication provided fecale and the follow up to sustain coin	dentified could n: scale for eekty gs to the rage, hysician esidents feedback rance and gs of the or stiding	5/18

PRINTED: 03/30/2018

FORM APPROVED

DEPARTMENT OF HEALTHAND HUMAN SERVICES	FORM	APPROVED				
CENTERS FOR MEDICARE & MEDICARD SERVICES	OMB NO	OMB NO. 0938-0391				
	with insulin coverage, glucometer checks and documentation. 5) Date of Compliance 4/25/18					
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FORM APPROVED
OMB NO. 0938-0391

PRINTED: 03/30/2016

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIFR/CLIA NO PLAN OF CORRECTION (OFNTIFICATION NUMBER:		(X2) MUI,T A. BUILDIN	PIF CONSTRUCTION _		(X3) DATE SURVEY COMPLETED		
		105700	B. WING			C	
		495206	IS. VVING			03/19/2018	
NAMEDEPI	RUVIUER OR SUPPLIER		l	STREET ADDRESS, CITY, STATE, ZIP COD	ŀ		
BON SEC	OURS-MARYVIEW NUR	SING C		4775 BRIDGE ROAD			
]	***************************************		ļ	SUFFOLK, VA 23435			
(X4] ID PREFIX I AG	(EACH DEHICIENC	TATOMENT OF DEFICIENCIES BY MUST BIT PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	IO I*REFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD RE	(X6) CI)MPF HIGN DATE	
F 684	Conlinued From pag	e 58	F 6	884			
	The findings included	d:					
	3/21/17. Diagnoses t but are not limited to #261's Admission Mi an ∿ssessment Refe	admilled to the facility on for Resident #267 included Diabotos Mellitus, Resident inimum Data Set (MDS) with Prenco Date of 3/28/17		·			
		ling no cognitive impairment.					
	documonted a 3/23/ The Goal documents from signs and symp throughout the review	ion! Centered Care Plan 17 Focus Area of Diabeles. ad the resident would be free bloms of hyperglycemia w date. One intervention ding Scale trisulin as					
	Resident #267's 3/2' documented the folk	1/17 Physician orders owing:					
	Inject as per sliding a If 151-200 inject 6 U 201-250 inject 8 Uni 251-300 inject 10 Un 301-350 inject 12 Un subculaneously before	nits Is nits rils ore meals and at bedlime for rall Medical Doctor less (ha)					
	Resident #267's Fac discharge date of 4/	e Sheet documented 1/17 at 11:42 AM.					
	Resident #267's 4/1 documented the follo	/17 11:42 AM, Progress note owing:					
	"Resident left AMA ('against medical advice) loday	-				

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A STATE OF THE STATE OF

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPLE CO		(X3) DATE SURVEY COMPLETED		
ND I'LAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _	· ·		C	
		495206	D WING		<u> </u>	3/19/2018	
	ROVIDER OR SLIPPLIER OURS-MARYVIEW N	JRSING C	4775	EY ANDRESS, CITY, STATE, ZII' CO BRIDGE ROAD FOLK, VA 23435	DE:		
5011 420				I'ROVIDER'S PLAN OF CO	DEBEC FION	(X5)	
(X4) ID PREHIX TAG	(CACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FUIL OR 1.5C IDENTIFYING INFORMATION	PREHX TAG	(FACH CORRECTIVE AC 110 CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 684	Continued From p	age 59	F 684				
	at 11;42 a.m. Resident times 3. Resident and had multiple 0	dent was alort and orienled and her daughter was upset complaints Before she left the as changed and dressed by live					
	CNA (certified Nur sugar was checke	rsing Assistant) and her blood ed and insulin given. Resident ymptoms of distress.					
	Review of Resident #267's Clinical Record March and April 2017 Medication Administration Records and Medication Audit reports documented the following:						
	documented and was documented April 1, 2017 6 Al	M and 11:30 AM Blood glucose nted and no sliding scale insulin					
·	on 3/19/18 at app conducted. The I March and April I Report. The DON Glucoses and In: 3/31/17 9:00 PM	the Facility Director of Nurses proximately 1:05 PM was DON and surveyor reviewed 2017 Medication Administration was asked if the Blood sulin were administered on and 4/1/17 6:00 AM and she documented it ain't done."					
	Phono calls to the and 3/15/18 were	e Resident on 3/13/18, 3/14/18 e placed without return calls,					
	The Facility doct Medication Adm documented the	ument titled, "Preparation for inistration" with no dale, following:					
	as prescribed in	r; Medications are administered accordance with good nursing ractices and only by persons			f continuation str		

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STATEMENT OF OFFICIENCIES (X1) I'NOVIDER/SUPPHIER/CLIA AND I'LAN OF CORRECTION IOENTIFICATION NUMBER:		(X2) MUL A, FIJII.O		(X3) OATE SURVEY COMPLETED			
			, , , , , , , , , , , , , , , , , , , ,		·	С	
		495206	B, WING			03/	19/2018
МАМГ ОГ РІ	ROVIDER OR SIJPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
	A. 155 1145 1145 115 115 115 115 115 115 1	au a c		47	775 ARIOGE ROAD		ì
BON SEC	OURS-MARYVIEW NUR	SING C		s	UFFOLK, VA 23435		
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF REFIGENCIES Y MUST BE PRECEDED BY FILL LSC IDENTIFYING INFORMATION)	IÜ PREH TAG		I 'ROYIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROLIF DEHICIENCY)	BL:	(X5) COMPLETION DATE
F 684	Continued From page	= 6 0	F	684			
,	legally authorized to	do so. Personnel authorized					
	- -	tions do so only after they	.				
ļ	have tamiliarized the						
]	medication."						
			i				
<u>'</u>		ions are administered at					
		pared. Modications are not			<u>-</u> -	-	
-	pre-poured."						
ļ —	Deer 44. "b Modinal	ions are administored					 -
		f scheduled time, except]		I		•
]	before or after meal						
		on mealtimes. Untess					
	=	y the prescriber, routine					
		inistered according to the					
		on administration schedute					
	for the facility."				·	-	
ŀ	Page 44: "Document	ation:					
1		administers the medication					
	dose records the adr	ministration on the resident's					
}	MAR directly after the	e medication is given. At the	1				
	end of each modicat		1				
		dications reviews the MAR	-				
	,	doses were administered	ĺ				
1	and documented. In						
1		istered the medications	1				
İ	report off-duty withou						
İ	administration of any						! :
		R is initialed by the person edication, in the space			1		
		ate, and on the line for that					
		lose administration. Initiats					
]		rified with a full signature in					
	the space provided,"						
	 On 3/12/18 during th	e Task of Medication					
		s observed that at 11:26 AM,					
		ere still being passed by					

FORM CMS-2:467(872-99) Previous Versions (Chsole):

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Cacilily IO. VAIII4()

Il continuation street Page 74 of 104



CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI. FIFLE	сонатпистюм	(X3) DATE SURVEY COMPLETED			
AND PI AN OH	CORRECTION	IDENTIFICATION NUMBER.	A BUILDING		С	
		495206	B. WING	<u> </u>	03/19/	2018
	ROYIDER DIK SUPPLIER OURS-MARYVIEW NU		47	TREET ADDRESS, CITY, STATE, ZIP GOUE 176 BRIDGE ROAD UFFOLK, VA 23435		
(X4) IO PREFIX	SUMMARY (FACH DELICIE)	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LIST, KIENTIFYING INFORMATION)	IU PREFIX TAG	PROVIDERS PLAN OF CORRECTION [EACH FORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES. DEFICIENCY)	DRF ((X5) COMPLETION DATE
F 684	Continued From particensed Practical The facility administindings during a papproximately 3:55 prosent any further COMPLAINT DEF Foot Care CFR(s): 483.25(b) \$483.25(b)(2) Foot Care that resume that resume that resume that resume the facility (i) Provide foot care to maintain the professional to prevent complimedical condition (ii) If necessary, a appointments will arranging for transpointments. This REQUIREM by: Based on observing the survey sample the survey sample findings inclinated in the survey sample findings inclinated in the survey sample resident #263 with 11/15/17. Diagnostical record in the survey sample findings inclinated in the survey sample resident #263 with 11/15/17. Diagnostical record in the survey sample findings inclinated in the survey sample resident #263 with 11/15/17. Diagnostical record in the survey sample findings inclinated in the survey sample resident #263 with 11/15/17. Diagnostical record in the survey sample resident #263 with 11/15/17. Diagnostical record in the survey sample resident #263 with 11/15/17. Diagnostical record in the survey sample resident #263 with 11/15/17. Diagnostical record in the survey sample record in th	age 61 Nurse #25. Istration was informed of the pre-exit briefing on 3/20/18 at 5 PM. The facility did not a information about the finding. Inciency Inci	F 684		ds could ds could sidents who order for the qualified that could thist could thist could those and follow up fill be kept by provided to vided on a of foot/nail	25/18

PRINTED: 03/30/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIFR/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF GORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 495206 B. WING 03/19/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4775 BRIDGE ROAD BON SECOURS-MARYVIEW NURSING C SUFFOLK, VA 23435 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIONCIES (X4) IO IĐ. (X5) COMFLETION IEACH CORRECTIVE ACTION SHOULD BE LEACH DEFICIENCY MUST BE I'RECEDEO BY FUI I PREFIX PREFIX CROSS-REPERENCED TO THE APPROPRIATE DATE REGULATORY OR USC IDENTIFYING INFORMATION! IAG TAG DEBICIENCY Conlinued From page 62 F 687 Resident #263's Significant Change Minimum Data Sot (MDS) with an Assessment Reference Date of 1/22/18 scored Resident #263 with a BIMS (Brief Interview for Montal Status) score of 15 of a possible 15 indicating no cognitive impairment. The Resident was dependent on one staff person for dressing, toilet use; and hygiene neods. The Comprehensive Person Centered Care Plan last revised 1/29/18 did not include a focus area of thickened, long, painful Loenails. Resident #263's last documented Podiatrist visit was on 5/10/17. A Podiatry note dated 3/19/18 documented the following: Reason for Consultation: Mycolic Toenails." The Podiatry note documented under Plan: "Debridod 10 nails." The website (https://oig.hhs.gov/oei/reports/oei-04-99-00460.p df) documented the following: Nail debridement involves removal of a diseased toenail bed or viable ваіl plate. This may be performed manually with an instrument, or with an electric grinder. Podiatrists generally provide nail debridement to patients diagnosed with

toenails).

onychomycosis (i.e., mycosis or mycolic

On 3/12/18 at approximately 1:45 PM, during the initial tour, the resident complained of painful toenails. The Resident removed her shoes and her toenails were observed hickened and long. She stated the great toe nails were painful. Resident #263 stated that she had informed the

	UF LIEFICIENCITS CLIBRECHON	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	IX2) MUII A. BUILD		ONSTRUCTION		(X5) DATE SURVILY COMPLETED	
		495206	B. WING		 .	İ	03/1	; 19/2018
	ROVIOER ON SUPPLIER	sing C		477	FET ADUKESS, CITY, STATE, ZIP CODE 6 BRIDGE ROAD FFOLK, VA 23435			
(X4) ID PREFIX LAG	(EACH DÉFICIENC	ATEMEN): OF DEFICITNCIES Y MIST BE PRECEDED BY FILL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IÓ) IFO BI		IAU) COMPLETION CALE
F 687	staff several limes. On 3/14/18 at approx#263 was observed a she stated that her to that she had no Podition 2015/18 at approx Resident reported the with a Podiatrist on Managhter was concergetting her in and outon 3/13/18 at approx of Nursing (DON) state a Podiatrist management of Nursing (DON) state a Podiatrist management of Nursing (DON) state a Podiatrist management of Nursing (DON) state a Podiatrist management of Nursing (DON) state a Podiatrist management of Nursing (DON) state a Podiatrist management of Nursing (DON) state a Podiatrist management of Nursing (DON) state and state and assist the Resident to community Podiatrist facility could assist the Appointment and had and had been unsued that the Nursing Podiatrist where she and stated that the were curled under a my skin. Resident #3 up her hands and cuthe fingertips touched.	dimately 1 PM, Resident sitting in her wheelchair and benalls continued to hurt and alry appointment. dimately 4:45 PM, the at she had an appointment flonday and reported that her med about having difficulty. I of the car. dimately 3:45 PM the Director ated that the facility was odiatrist to make visits in the as not able to state the last de visits in the facility. When why the facility could not o make an outside to make an outside to the DON stated, that the ne Resident with making an I reached out to the daughter cessful. Extimately 1:30 PM, Resident thad her toenails trimmed felt so much better. Resident Doctor told me my Ioenails and getting ready to grow into 263 demonstrated by holding inted her fingers under until	F	687				

•	OF DEFICIENCIES CORRECTION	(X1) PROVIDERISTIPPLIET/CLIA IDENT#:ICATION NUMBER:	(X2) MUI. A BUILD		© CONSTRUCTION		E GURVEY PLETED	
		495206	R WING			(, 19/2018	
NAME OF P	ROVIOEK OK SUPPI IFR			,	STREET ADDRESS, CITY, STATE, ZIP CODE			
BON SEC	OURS-MARYVIEW NUR:	SING C		1	4775 BRIDGE ROAO			
DDN OLO				<u> </u>	SUFFOLK, VA 23435			
(X4) ID PREFIX TAG	(CACH DEFICIENC)	ATEMENT OF DEPENDIES Y MUST BE PRECEDED BY FULL LSC IDENTE YINC INFORMATION)	ID I'REF TAC	ìΧ	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD E CHOSS-REFERENCED TO THE APPROPE DECICIENCY)	F.	OXSI COMPLE PON DATE	
F 689 SS-J	clean the nail bed, to prevent infections residents with circular mycolic or other nail PRN (as needed). No Doctor) to obtain ord— The facility administre findings during a preapproximately 3:55 F present any further in Free of Accident Haz CFR(s): 483.25(d)(1) The facility must ensight \$483.25(d)(1) The reas free of accident has free of accident has signed as free of accident has signed as free of accidents. This REOUIREMEN by. Based on observation interview, facility docular record review.	ses of this procedure are to keep nails trimmed, and to Refer diabetic residents or tory impairment, curved, abnormalities to podiatrist otify attending MD (Medical er for podiatry consult." attorn was informed of the exit briefing on 3/20/18 at PM. The facility did not information about the finding, cards/Supervision/Devices (2) s. the that - exident environment remains azards as is possible; and esident receives adequate islance devices to prevent. This not met as evidenced on, resident interview, staff eximentation review, and with facility staff failed to comment for 2 of 41 residents.		687	F689 1. Plan of Correction/Abalcment provide immediale follow up for oxygen use and for residents #25 and #4. A) Residents #25 and #4's care needs incoxygen use were reviewed and their calcupdated as needed. 2. Those residents who receive oxygen utilize tanks could potentially be affecte practice. 3. A) Education was provided to nursing con: The oxygen administration, slorage, sidocumentation practice per the oxygen documentation practice per the oxygen B) Audits/rounds will be conducted daily Nurse Managers and Environmental seteam related to oxygen storage and sail	ed with I safety cluding re plans and d by this are staff afety and policy, y by lhe rvices fety.	4/2.5/LK	
	a level four isolaled	tation was originally fourid at and upon acceptance of the was lowered to a lovel Iwo			C) The results and any necessary action the safety audits will be provided to the Administrator daily as needed and weel report. 4. The Administrator will report to Quality and Committee (CARI) monthly.	kly by ty		
	observed in Resider	n oxygen E tank was nl #40's room. The lank was as approximately 2000 PSI			Assurance Committee (QAPI) monthly trionths the findings of the safety/oxyge rounding and audits and any action iter assure compliance with the oxygen pol 5.Date of Compliance 4/25/18	n ns to		

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DEPARTMENT OF HEALTHAND HUMAN SERVICES FORM APPROVIDENCE & MEDICARD SERVICES OMBINO. 0938-0			M APPROVED
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	DE OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUC A. BUII D		ASTRUCTION		ATE SHRVEY DMPLETED
		495206	H. WING				C 03/19/2018
		433204		etoss	EL AUDRESS, CHY, STATE ZIP COO		00/10/2010
•	ROVIDER OR SUPPLIER OURS-MARYVIEW NUI	RSING C		4775	3RIDGE ROAD FOLK, VA 23435	, <u> </u>	
X4] ID PREFIX I'AG	(EACH DEFICIEN	RTATEMENT OF DEFICIENCIES CY MILIST BE LINECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IU PREF TAG		PRINVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEUTO THE DEFICIENCY)	N SHOOLD BE	[35] SOMPLETION BATE
	gauge of the tank. I or holder, left of the the observation co immediate jeopardy. An additional unser observed sitting in troom. There was agon the gauge of the in a black sleeve but of the observation. The findings include 1. Resident #25 was 1/8/18. Diagnoses were not limited to Pulmonary Disease Minimum Data Set Reference Date of out of a possible 18 Mental Status), ind impairment. The Rindings include 1.	quare inch) reading on the I was sitting, without a stand door geing out to the half, nstituted the notification of the corner of Resident #4's approximately 2000 PSI reading tank. The oxygen tank was at was not secured at the time	F	689	DEFECIENCY		
	locomotion on unit, personal hygione. The Comprehensive revised on 10/27/1 oxygen therapy reli	esistance with transfers, dressing, toitet use and dressing. Toitet use and dressing toitet use and dressing to contered Care Plan 7 identified a focus area of ated to COPD. The goal was to ptoms of poor oxygen					
	absorption through interventions included Liters continuously tubing changes/de	the review date. Two led oxygen via nasal canula 2 and oxygen supplies and aning per facility protocot.					
	Physician Orders	of 1/8/18 documented the					cot Prov 86 ol 104

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SUKVEY

A STATE OF S

STALEMENT	OF DEFICIT NOISES	(XI) PROVIDER/GUPPLIER/GUA IDENTIFICATION NUMBER	[X2] MULTIPLE CO A. BUILDING	INSTRUCTION		F SUK VE Y M/LTEU
		40000	B. WING		a	C 3/19/2018
NAME OF IN	ROVIDER OR SUPPLIER	496206		ET ADDRESS, CITY, STATE, ZIP C		
•			4775	BRIDGE ROAD		
BON SEC	OURS-MARYVIEW NU	IRSING C	SUF	FOLK, VA 23435		
(X4) IU PREHX TAG	IFACH DEFICIES	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEUED BY FULL DR LSC IDEN BEYING INFORMATION)	PREFIX TAG	PROVIUER'S PLAN OF JEACH CORRECTIVE ACTI CROSS-REFF.RENCED TO I DEFICIENC	ION SHÓULD DE HE APFRÓPRIATE	O(S) COMPLETION DATE
F 689	following: Oxygen canula continuousle Contin	at 2 L/hr (liters/hour) by nasal by every shift for COPD. proximately 11:40 AM, during sident #25 stated he gets shorting to the bathroom because in tank for his wheel chair is not exygen concentrator was esident's room. asked where his portable tank didn't know, that it was "over" A free standing oxygen typo E the left of the door going out to was not secured in a holder to	F 689			
	survey learn met State Agency. Aft Agericy Supervisical Immediate Jo On 03/12/18 at at Survey Team met Director of Nursir Immediate Jeopat On 03/12/18 at at surveyor walked showed the freest Administrator and	pproximately 12:10 PM the If with the Administrator and the ng (DON) to discuss concern of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MILLTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY .COMPLICTED	
			A. BUILLI	NO			c l
		495206	B. WINC			03/	119/2018
NAME OF P	ROVIDER OR SUPPLIER				THEE I AUDRESS, CITY, STATE, ZIP CORF		
BON SEC	OURS-MARYVIEW NURS	BING C	1		1775 BRIDGE ROAD BUFFOLK. VA 23435		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENY OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDCNTIFYING INFORMATION)	ID PRFFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECT TIVE ACTION SHOULD) CROSS REFERENCED TO THE APPRUI'S DEFICIENCY)	3E	(XE) COMPLETION JIATE
f 689	Continued From page	e 67	F	689			
	E tank was lifted by the nurses station where tank and held it while	nd to secure it, The oxygen ne DON and taken to the LPN#31 took the oxygen E the DON was directing her place in in the Resident's addy.	:		·		
		ximately 4:35 PM, the Correction (POC) was					
	received from Admini reviewed by the Surve	strator and DON was			,		
	and Administrator we required prior to the a	ximately 4:37 PM the DON re informed of changes acceptance of POC and at as denied due to being	-				
		imately 11:05 AM, the POC e Administrator and DON.					
	accepted after interviewstated they were nove	ed by survey learn but not ewing 7 staff members who or in-serviced on the proper anks as part of the POC.					
	State Agency was info	AM, the supervisor at the ormed that the POC was strator but not accepted by					
	interviowod about bei	AM, two staff membors were ng in-serviced on proper anks. Staff statert they were					
	On 3/13/18 at approxi was again denied.	imately 12:04 PM, the POC					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROMITT/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			re survey aptereo			
	٠	495206	B. WING		0	3/19/2018
NAME OF 11	OVIOER OR SUPPLIER		ì	EL ADDRESS, CHY, STATE, ZIP COO	DE	
BON SEC	DURS-MARYVIŒW NU	RSING C		BRIDGE ROAD FOLK, VA 23435		<u> </u>
(X4) ID PREFIX TAG	(SACH REFICIEN	STATIONENT OF DEFICIENCIER ICY MUST DE PRECEDED BY FILL IR LSC IDENTIFYING INFORMATION)	ID I'REFIX TAG	PROVIDER'S PLAN OF CO (EACH CONRECTIVE ACTION CROSS-REFERENCEO.TO THE DEFICIENCY)	ISHOULD BE	COMPLETION COMPLETION
F 689	00,1,	=	F 689			
	Survey Team receit Administrator and for by survey team and	oximately 12:46 PM, the ved the POC from the DON. The POC was reviewed denied and returned to the dditional information.				
	On 3/13/18 at approvas accepted and abated. The POC of 1, 3/12/18 surveyor cylinder was teft in removed from resident's oxyoxygen tank holder for carrying and stocanisters. Surveyor was found to be situated to back of 2. All residents with reviewed to determ on a continuous becompleted 3/12/18 physical inspection remove unsecured completed 3/12/18 3. Nursing, houself theraples will be in portable "F" oxyge securing of tank in per policy, 3/12/18 through agency will proper use and sto	eximately 1:00 PM, the POC the immediate Jeopardy was locumented the following: I noted that unsecured exygen resident room, said lank was tent room by DON at 1220 agen tank will be secured in an error exygen tank eart, designed orage of exygen "E" cylinder in identified that exygen tank atting in corner of room black sleeve to secure to and not to be at this time, was see of room by DON and wheelchair at 1226 PM. In orders for exygen will be asis or as needed basis. If at 1400 (2:00 PM); 100% in of facility to Identify and exygen canisters in alt areas, at 1300 (1:00 PM). Reeping, facilities, activities, reserviced in the safe use of an cylinders including the device designed for that use it; staff coming into facility the area of exygen prior to start of ag 3/12/18; new employee				
	orientation will include storage procedure	lude review of safe oxygen s and securement in alignment ds of signatures to be kept by				

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	OF DEFIGIENCIES CORRECTION	IDENTIFICATION NUMBER	A. BUIL DI		ONSTRUCTION		E SURVEY
		495206	n.wing			03	C 8/19/2018
	ROVIDER OR SUPPLIER OURS-MARYVIEW NUR	RSING C	•	477	EET ADDRESS, CITY, STATE, ZIP DODE 5 DRIDGE ROAD FFOLK, VA 23436		
(X4) ID PREFIX TAG	(FAÇI I DEFICIENC	TATEMENT OF DITTOUTNIES 23 MUST BE PRECEDED BY FULL 4 LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF COR (EACH CORREC (IVEACTION S CROSS REPERENCED TO THE A NEFFICIENCY)	SI IQUILD BE	(X5) COMPLETION DATE
F 689	education department. 4. Nursing Supervise make rounds on resistanks and will observed variar corrected and noted audit sheet will be given presponsible for onsure completed and will a and further actions of the first 7 day audit analyzod and audits per week for 7 days, audits will be reported Assurance and Perficommittee for additing recommendation for audits. 5. Responsible - DO Administrator 6. Implementation 3/2 On 03/15/18 at approvious approximate was a control of the wheelchair oxion the wheelchair	or and/or Charge Nurse will idents with portable exygen we each designated exygen runit every shift for 7 days. Inces will be immediately as such on audit sheet; daily even to DON who is uring that audits are unalyze for trends, patterns necessary; upon completion lits, the trends will be may be reduced to 3 times. The results of the 2 week ed to QAPI (Quality permance Improvement) ional oversight-and-the frequency of continued wh/Night Supervisor/Nurse	F-	689			
		sitting in the corner of	<u> </u>		hato staggati (f	configuration chost	

FORM CMS-2567 (02-09) (Fravious Versions Obsolete



PRINTED: 03/30/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY IXII PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING _ 03/19/2018 B WING 495206 STREET ALLURESS, CITY, STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 4775 BRIDGE ROAD BON SECOURS-MARYVIEW NURSING C SUFFOLK, VA 23435 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLCTION CATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRITIX (EAC) I DEHICIENCY MUST BE PRECEDED BY FILL PRETIX CRUSS-REFERENCEO TO THE APPROPRIALE TΛG REGULATORY OR LSC IDENTIFYING INFORMATION! TAG DEFICIENCY F 689 F 689 Continued From page 70 Resident #4's room. The oxygen tank was in a black siceve which to be secured to a wheelchair. The oxygen tank was found not to be secured at the lime. Residont #4 was admitted to the facility on 9/26/17 with diagnoses which included major laceration of spiecn, Hypo-osmolality and hyponalremia, history of falling, elevated white blood cell count, reflux, anxiety, depression. Chronic Obstructive Pulmonary Disease, hypertension, hypothyroidism, arteriosclerolic heart disease of native coronary artery without angina pectoris, vitamin B 12 deficiency, anemia, and chronic atrial fibrillation. Resident #4's unscoured oxygen tank was noted to have 2000 PSI remaining in the lank. A Quarlerly Minimum Data Sel (MDS) dated 3/12/18 assessed this resident in the areas of Hearing, and Speech as having no concerns. This resident was assessed in the area of Vision as requiring glasses. In the area of Cognilive Patterns this resident was coded in the area of Brief Interview for Montal Status (BIMS) as a 15. This resident had no concerns in the area of Mood, or Behaviors. In the area of Activities of Daily Living (ADL) this resident was assessed as requiring supervision or limited assistance in the areas of transfer, dressing, eating, toilet use and personal hygiene. This resident was assessed as using a walker and wheelchair as mobility

assessed.

devices. In the area of Special Treatments, Procedures and Programs no concerns were

A Revised Care Plan dated 10/16/17 indicated: *Focus- History of Congestive Heart Failure

	OF DEFICITIONS CORRECTION	(X1) PROVIDENSUPPI (FRICLIA IDENTIFICATION NUMBER	A. BUII II		CONSTRUCTION		DMI'LE I ED	
							С	
*	·	495206	B. WING				03/19/2018	_
_	ROVINER OR SUPPLIER OURS-MARYVIEW NU	RSING ¢		477	REET ADDRESS, GRY STATE, ZIP CODE 'S BRIOGE ROAD FFOLK, VA 23435			
IXALID PREMX TAG	SUMMARY STATEMENT OF DEFICIENCIES III FACH DEFICIENCY MUST BE PRECEDED BY FULL. PRE REGULATORY OR LSC IDENTIFYING INFORMATION) TA				I'HOWDER'S PI AN DE CORRE (CACHCOHRECTIVE ACTION SH CROSS REFERENCED TO THE APP DEHICIENCY)	ՕՄԻՄ ԱԼ	(25X) KONTELIPANCO BTAG	И
F 689	Intervention- Oxygo PRN (as needed) a saturation) to be of Focus- History of faresident needs a siloors free from spirit focus- Luse Oxygo of Employsema and have shortness of s/sx (signs/sympto Intervention- Chan troors to facilitate to drainage. Give me physician. Monitory offectiveness. If the oxygen still must be different manner (anast canula). Relicativery method af -Oxygen 2 L via na 93% as needed as tubing changes /climate Chieck O 2 sats Onesal canula (Dyspeeded." The Administrator were called to Res	on 2 t. (liters) via nasal canula as ordered. O/2 sals (oxygen obtained every shift as ordered. alls Interventions. The safe environment with even lis and or clutter. Therapy at times because d. History of CHF. Sometimes I breath. Goal- I will have no ms) of poor oxygen absorption. Ge residents position every 2 ung secretion movement and dications as ordered by document side effects and coresident is allowed to eat, e-given to the resident but in a e-g. changing from mask to a time resident to usual oxygen ter the meat. Oxygen Seltings asal canula to keep SpO2 > 1 ordered. Oxygen sopplies and eaning per facility protocol." In dated 10/2/17 indicated: (every) shift, oxygen 2/L via onea) to keep SpO2>93% as and the Director of Nursing sident #4's room on 3/12/18 all the time the oxygen lank was	F	689	-			
	the Administrator of they were asked if as first observed.	w on 3/12/18 at 12:30 P.M. with and the Director of Nursing, the oxygen lank was secured They both stated, "No." The xygen tank should have been						

	DE OEFICIENCICS CORRECTION	(X1) PROVIDEN/SUPFLIER/CLIA INFNTIFICATION NUMBER.	ī	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
		495206	B. WING		1 0	3/19/2018	
	ROVIDER OR SUPPLIFR	SING C		STREET ADDRESS, CITY, STATE, ZIP COD 4775 BRIDGE ROAD SUFFOLK, VA 23435			
(X4) ID PREFIX TAG	(CACH DEFICIONE	IATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY HULL LSG IDENTIFY ING INFORMATION)	IU PREFIX TAG	PROVIDEN'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OPTIGIENCY)	N SHOULD BE F APPITOLIRIATE	(X4) COMPLETION LIATE	
F 689	Continued From page secured in the black Resident #4's wheeler of 1/2's wh	sloeve and allached to chair. Itre facility Policy and cygen Tank Storage" with an 218 ws reviewed and awing: c stored in compliance with rus keeping residents and fily. These and maintains a safe, eart: interior spaces mech the population and are safe and treatmont and services ry source of oxygen for	F 6	OFFIGIENCY			
	consistent mannor. 1. All O2 tanks must Ox tank storage rad. 2. All O2 tank storation by Facility Services. 3. Empty O2 tanks from Full or Mid-Ra. B. Other O2 tanks. 1. All O2 tanks are approved O2 tank.	at be stored in an approved k. ge racks must be approved					

	OF OLI-ICIENCIES	(X1) PROVIDER/SHPPLIER/CLIA	(X2) MULTIPI.	F CONSTRUCTION	(X3) OATE SUF COMPLET	
ANU I'LAN OF	CORRECTION	IOENTIFICATION NUMBER:	A DIJILDING		COMPLET	1-11
		·			С	
		495206	R, WNG		03/19/	/2018
NAME OF IT	ROVIDER OR STJPPLIER			STREET AODRESS, CITY, STATE, ZIP CODE		Ì
50N 620	NUDE MADVICIS NUES	enic c		4775 BRIDGE ROAO		
BON 25C	OURS-MARYVIEW NUR	SING C		SUFFOLK, VA 23435		ļ
(X4)10	SUMMARY ST	ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION		(XIM
PRITIX TAG		Y MUST BE PRECEDED BY FULL LSO IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCE OT THE ALPROPRI OEFICIENCY)	-	DAYE
F 689	Continued From page		F 689	9		}
	O2 tanks will not b position.	e left in free-standing				
F 697	Pain Management		F 697	7		
SS-D	CFR(s): 483.25(k)			F 697	4/2:	25/18
				Resident #263 received her ordered a prescribed pain medication. Resident #263.	and 253's	1
ł l	§483.25(k) Pain Mau	agement.		pain medication regime/orders have been		
]		ure that pain management is	1 .	reviewed_and residents_care plan has.b	een	
•		Who require such services,		updated and revised as needed.		
<u> </u>		ssional standards of practice,	- -	2. Those residents that receive pain me	di cation	_ —
·		person-centered care plan,		could potentially be affected by this prac-	mce. [
		als and preferences.		Education has been provided to nurs	ing staff	
		T is not met as evidenced		related to pain medication policy and pr	ocess.	
	by:	on, resident interviews, staff		this includes:		
		cumentation review, and		- Stat medication process		
		, the facility staff failed to		Problem solving, documentation and re	porting	`
. !		ment with prescribed	Į.	process if the pain medication is not ave B) Clinical Managers will review and ac	dit the	-
Ī		Hospice services were	ľ	following areas daily and provide a ropo	ort to the	
	discoutinued for 1 Re	esident of 4 t residents in the	ļ	DON weekly:		
	Survey Sample (Res	sident # 263).		-Audit for those medications that are or	dered	
]		•		and reordered for pain control for availar -Audit of the documentation of medication	Dility	
	The findings included	d:	-	administration for those medications or	dered for	
				pain control		
		admitted to the facility on	1	4) The Don will report monthly for 3 monthly	nths to	
)		s for Resident #263 included Chronic Pain Syndrome,	1	the Quality Assurance and Performance	э .	
	But are not limited to Anxiety and Mycotic			Improvement Committee(QAPI) the line	lings and	
	Allkicty and Mycodo	TOURIS.	Ì	results of the audits for pain control meavailability and documentation.	aication	
1	 Resident #263's Sig	nificant Change Minimum		5) Date of Compliance 4-25-18	1	Ì
1		ment protocol) with an				
	Assessment Referer	nce Date of 1/22/18 scored				
	Resident #263 with	a BIMS (Briet Interview for				
1	Mental Status) score	e of 15 of a possible 15				
		ve impairment, The Resident		,		
		ne staff person for dressing,				
	toilot use, and hygic	ne needs.				
į	The Comprehensive	Person Centered Carc Plan				

STAYEMENT OF DOTIGIENCIES IXI AND PLAN OF CORRECTION		(X)) PROVIDER/SUPPLIEN/CLIA (LISNTIFICATION NUMBER:	(X2) MULT A. BUILDS		STRUCTION		TE SURVEY MPLETED
		495206	D. WING			n	C 3/19/2018
NAME OF P	OVIDER OR SUPPLIER		1	STREE	T ADDRESS, CITY, STATE, ZIP CONC		di i Villa i C
7000000011	CANDELL OIL OIL OIL		1		RIDGE ROAD		
BON SEC	DURS-MARYVIEW NUR	SING C			OLK, VA 23435		ļ
				0011			
(X4) IEI PREFIX TAG	(EACH DERICIENC	A LEMENT OF DEFICIONCIES Y MUST BE 1'RECEDED BY FUIL I SC INENTIFYING INFORMATION	IO PRITI TAG	- 1	PROVIDER'S PLAH OF CORI (EACH CORRECTIVE ACTION S CROSS-REFFRENCEO TO THE A DOTIGIOUSY)	בות מ. וו למו #B	(X5) COMPLETION DATE
F 697	for pain related to the Syndrome, Anxiety, (Pancroas, Lupus, Os acute upper gastro-ir (gastro-esophageal r with current dentition level of comfor through the comfort through the comfort of the comfort of the comfort of the comfort of the comfort of the comfort of the comfort of the comfort of the comfort of the comfort of the comfort of the compliant of the com	dentified the Resident at risk diagnosis of Chronic Pain Chronic Inflammation of the setoarthritis, status post nestinal bleed, GERD sefulx disease), discomfort. The goal was "I will voice a light the review date." d but are not limited to the uragesic* (1) patch as	F	697	DCFIGIENEY)		
	possible. Staff to Assess pain management and do	ve/limit causes where every 4 hours for pain cument in Nursing Progress ention and Responses as			•		
	following Physician (1/16/18 Physician or Hour 75 MCG/HR Ap one time a day every	ical Record documented the Order: dered Pentanyl Patch 72 oply 1 patch transdermally y 3 days related to Chronic remove per schedule.					

PRINTED, 03/30/2018 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE STIRVEY (X2) MULTIPI E CUNSTRUCTION (X1) I'ROVIDER/SUPPLIER/CLIA STATEMEN) OF DEFICIENCIES COMPLETED IUENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING .__ C 03/19/2018 B. WING 495206 STREET ADDRESS, CITY, STAYE, ZIP CODE NAME OF PROVIDER UK SUPPLIER 4775 BRIDGE ROAD BON SECOURS-MARYVIEW NURSING C SUFFOLK, VA 23435 PROVIDERS PLAN OF CORRECTION (X5) CHMPLETION DATE SUMMARY STATEMENT OF DEHICIENCIES 1D (X4) IU (FACH CORRECTIVE ACTION SHOULD BE PREFIX (FACH DEFICIENCY MUST BE PRICEDED BY FULL PREFIX CROSS REFERENCED TO THE APPROPRIATE REGIJI.ATURY OR LSC IDENTIFYING INFORMATION] TAG TAG DEFICIENCY) F 697 Continued From page 75 1/16/18 Physician ordered Oxycodone HCl Tablel 5 MG Give 1 tablet by mouth every 6 hours as needed for pain Review of Resident #263 January 2018 Medication Administration Record documented the last applied Duragesic 100 Patch 72 hour 100 MCG/HR was applied on 1/9/18/21:00 (9 PM) and removed 1/12/18 20:59 (8:59 PM), The Duragesic 75 MCG/HR patch was applied on 1/20/18 at 21:00 (9 PM) Resident #263's Clinical Record progress notes documented the following: 1/15/18 15:00 (3 PM) Received call from ... hospice stating that patient was discharged from hospice services as of 1/14/17 (sic - 2017 was date documented) 1/15/18 18:28 (6:28 PM) This writer called Dr. (Physician Name) office requesting scripts for Duragesic palch and Oxycodone 1/15/18 20:17 (8:17 PM) Duragesic 100 Patch 72 Hour 100 MCG/HR (micrograms per hour) Apply 1 patch trandermally every 72 hours for pain and remove per schedule. No patch available in E stat (emergency stat) Call placed to MD (Medical Doctor) per off going nurse. 1/15/18 20:19 (8:19 PM) No patch on resident. 1/16/18 19:01 On cal MD notified that fentanyl patches are not un site and is not available from

FORM CMS-2507(02-99) Freeings Versions Unsoleic

back-up pharmacy. Order received to hold Fentanyl patches until arrive on 1/17/18.

1/17/18 00:10 (12:10 AM) Oxycodone HCl Tablet

Evoni ID TYYX11

Facility ID: VA0010

If continuation sheet Page 90 of 104



STATEMENT OF CEPTCIENCIES AND PLAN OF CORRECTION	(X1) THO VIDER/SUPPLIFTICALA IDENTIFICATION NUMBER	1 ' '	(X2) MITCTIPUS CONSTRUCTION A. BUILDING		(X3) DATE SI/RVCY COMITCETED	
	495206	H- WING			C 03/19/2018	
NAME OF PROVIDER OR SUPPLIER BON SECOURS-MARYVIEW NU	RSING C		STREET ADDRESS, CITY, STATE, ZIP C 4775 BRIDGE HOAD SUFFOLK, VA 23435	OUE		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST OF PRECEDEU BY FULL OR USC IDENTIFYING INFORMATION!	IO I'REFI TAG		ON SKOULD BE UE APPROPRIA		
hours as needed for 1/17/18 08:21 (8:21 75 MCG/I IR Apply time a day every 3 Syndrome and rem remove d/I (tlue to) resident's body price 1/17/18 08:25 (8:20 mcg/time patch was parea. Resident that the patch. Review of Resident that the patch. Review of Resident documented the for 1/12/18 20:00 8 PN being worst pain ex 1/13/18 08:00 4 PI 1/13/18 12:00 12 PI 1/13/18 16:00 4 PI 1/14/18 20:00 8 PN 1/15/18 00:00 12 AI 1/15/18 00:00 12 AI 1/15/18 00:00 12 AI 1/15/18 00:00 12 AI 1/16/18 00:00 12 AI 1/16/18 00:00 12 AI 1/16/18 00:00 12 AI 1/16/18 00:00 12 AI 1/16/18 12:00 12 FI 1/16/18 12:00 12 FI 1/16/18 12:00 12 FI 1/16/18 12:00 12 FI 1/16/18 12:00 12 FI 1/16/18 16:00 4 PN 1/16/18 16:00 4 PN 1/17/18 00:00 12 AI 1/17/18 0	Give 1 lablet by mouth every 6 or pain 1 AM) Fentanyl Patch 72 hour 1 patch transdermally one day(s) related to Chronic Pain love per schedule, nothing to a no old patch noted on or to placing a new fentanyl. 5 AM) A new fentanyl 75 placed to right upper arm near niked this writer for applying at #263 January 2018 MAR flowing pain assessments 1 - 5 of 10 pain scale with 10 pain scale of 10 pain scale of 10 pain scale of 10 pain scale of 10 pain scale of 10 pain scale of 10 pain scale 2 of 10 pain scale 2 of 10 pain scale 5 of 10 pain scale 8 of 10 pain scale 8 of 10 pain scale 8 of 10 pain scale 8 of 10 pain scale 8 of 10 pain scale 8 of 10 pain scale 4 of 10 pain scale 4 of 10 pain scale 4 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10 pain scale 6 of 10	F	697			

STATEMENT OF DEFICIENCES (XI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SHRVEY COMPLETED C	
		495206	B. WING _		0	3/19/2018
İ	ROVIDER OR SUPPLIER OURS-MARYVIEW NUR	SING C		STREET ADDRESS, CITY, STATE, ZIP COU 4775 BRIDGE ROAD SUFFOLK, VA 23435	E	
(X4) IU PREEIX TAG	(EACHOEHICIENO	TATEMENT OF FICTICIENCIES BY MIJET BE PRECIDED BY FULL LISC IDENTIFYING INFORMATION)	IU PREHIX TAG	PRINDER'S PLAN OF CO. (EACH CORRECTIVE ACTION GROSS-REFERENCED TO THE DEFICIENCY)	SHOULO BE	(XS) DOMPLETION DA (E
F 697		e 77 eport showing times of	F6	97		
		patch applied documented				
	1/12/18 20:59 (8:59	/HR Patch last applied PM) R Patch began 1/20/18 21:00				
	group meeting, Resi patch was stopped f	oximately 1:30 PM, during dent #263 stated her "nerve" for days. The Resident pain during this time.				·
-	confirmed that Residual without her Fentany resident was on Hosand Hospice had dis	ector of Nursing (DON) dent #263 did go several days I Patch. She stated that the spice Services at one point scontinued caro and the re until the Fentanyl Patches rided.			·	
	Assessment, Reass	and Procedure titled, "Pain essment and Management" to of 2/2018 documented the				
	resident's right to opmanagernent. Pain residents in the organishall also address the effectiveness of pain Rationald: Effective managernent can repsychological and puncelieved pain. Opmestdent experiencial	pain assessment and				

	A LEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLIES OF PLAN OF CORRECTION TO DENTIFICATION NUMBER		A. GUILDI	TPLE CO NG	COWL	COMPLETER COMPLETER		
		495206	a. WING			·	19/2018	
	ROVIDER DIE SUPPLIER OURS-MARYVIEW NU	JRSING C		4775	ET ADORTISS, CITY, STATE, ZIP CODE BRIDGE ROAD FOLK, VA 23435			
(X4) ID PREFIX TAG	(EACH DEFICIT	STATEMENT OF OFFICIENCIES NCY MUST TIE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCE DITO THE APPROVIDENCY)	D UE	(X5) COMPLETION DATE	
F 697	wellness, it is bend or her family and/o appropriate, to be her care, including During the assess be gathered on the effect on many as pain is rarely a state process shall be devent. The informassessment shall plan of care with gamanagement. The facility adminifiedings during a papproximately 3:5 present any furthed Definitions: 1. Fentanyl/Duragedocumented the formation around who cannot be tree fentanyl is in a classification around who cannot be tree fentanyl is in a classified and pain. Transdermal fent to the skin once every about the same to change it. Follow prescription labely appropriate the same to change it. Follow prescription labely appropriate to the same to change it. Follow prescription labely appropriate to the same to change it. Follow prescription labely appropriate to the same to change it. Follow prescription labely appropriate to the same to change it. Follow prescription labely appropriate to the same to change it. Follow prescription labely appropriate to the same to change it. Follow prescription labely appropriate to the same to change it.	eficial for the resident and his or support structure, as involved in all aspects of his or pain management, ment process, information shall be existence of pain and its pects of the resident. Since tic process, the assessment agoing, not simply a one-line allow for the formulation of a goals related to pain istration was informed of the pro-exit briefing on 3/20/18 at 5 PM. The facility did not a posic Patch: Medline plus	F	697				

	IX1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/		CONSTRUCTION	(X3) DATE COMP	SURVEY LETER	
				, , , , , , , , , , , , , , , , , , ,		c
		495206	B. WING		03/	19/2018
	ROVIDER OR SUFFILIER OURS-MARYVIEW NURS	SING C	4	TREET AUDRESS, CITY, STATE, ZIP CODE 775 BRIOGE ROAD SUFFOLK, VA 23435	-	
(X4) IO PRFFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FIJI.I. LSC IOENTIFYING INFORMATION)	IN PREFIX 1AG	I 'ROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION COATE
F 698 SS=D	directed. Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure inequire dialysis received with professional star comprehensive personal star comprehensive personal star comprehensive personal star comprehensive personal star comprehensive personal star residents' goals at This REQUIREMENT by: Based on observation record review, the fact communicate ongoing and monitoring for conditional dialysis treatments for survey sample (Resident Facility staff failed assessments for Resoulpatient dialysis that Tuesday, Thursday, at The findings include: Resident #51 was add on 1/17/18 with diagristage renal disease (and gastroesophages)	are that residents who we such services, consistent adards of practice, the concentered care plan, and and preferences. Its not met as evidenced assessments of condition assessments of condition assessments of condition assessments of condition assessments in the dent #51).	F 698		vices on tool cation ng staff d the ialysis Il audit indings to the nce and nonthly e and	4/25/18
	on the Brief Interview with a score of 15 our indicated the residen	7/18 assessed the rosident for Mental Status (BIMS) t of a possible 15, which t was fully intact with lly decision making. The		5)Date of Compliance is 4/25/18		

		(X1) PROVIDENSUPPLICACLIA IDENTIFICATION NOMBER.	A. BUILDI		NSTRUCTION		DATE SHRVEY COMPLETED
		495206	B. WING				03/19/2018
	ROVIDER UIL SUPPLIFR	₹3ING C		4775	ET ADDRESS, CITY, STATE, ZIP COD BRIDGE ROAD FOLK, VA 23435		
(X4) ID PREFIX IAG				x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	BHOULD BE	DATE DATE
F 698	Continued From pay	ge 80 to receive outpatient dialysis	F	69 8	-		
'	freatments.	то предлеги шазуыз					
	order, signed and d	sician orders contained an aled on 1/17/18, for outpatient ee days a week on Tuesday , rday.					
	3/17/18 indicated the vital signs and weig Communication She	eel" when the resident left out re was no return information					
	rebord, the electron	observed in the clinical ic chart, or in the binder, that of a resident assessment from					
	interviewed about the dialysis. The residence documentation (such him from the facility clinic or if the dialys back to the tagility seemed.	a.m., Resident #51 was the facility and his Inps to ent was asked if he took any ich as a notebook) over with y to share with the dialysis sis clinic ever sent anything staff with him. Resident #51 with him on dialysis days and in the same binder.					
	Practical Nurse (LF dialysis communical a traveling nurse, a information from the weight, vital signs, regarding the tolerals well as any other	0 a.m., the assigned Licensed PN) #6 was asked about alion sheets. She said she was and always saw return e dialysis center regarding dressings and a note ation of the dialysis treatment, er pertinent information. She e examination of Resident					

		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/30/2016 ORM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER		(X2) MUL A DHILO		NSTRUCTION		DATE SURVEY OMPLETED	
		495206	8. WING			[3	C 03/19/2018
NAME OF PE	ROVIUER OR SUPPLIER			SHE	ET ADDRESS, CITY, STATE, ZII' (COOE	
BON SEC	OURS-MARYVIEW NU	RSING C		1	BRIOGE ROAO FOLK, VA 23435		
(X4)10 PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY F(III.) R I SC JUENTIFYING INFORMATION)	IO PI(EF T/A(·iX	PROVIDER'S PLAN OF JEACH CORRECTIVE ACT CROSS-REFFRENCED TO T DRFICIENC	ION SHOULD DE HE APPROPRIATE	(X5) COMPLETION DATE
F 698	Continued From pa	ge 81	F	698			:
	#51's Dialysis Communication was	munication Sheet, the s only one way.					
	and Unit Manager to they expected dialy communication pro assessment dotails	cess to document resident to include vital signs,		-]			
-	and thrill and ospec	condition of the access, bruit is ally the post dialysis weight completion of dialysis					
	the pre-exit debrief hold with the DON, project Administrat	p.m., the facility's not present in the facility for ing, thus the debricfing was Director of Long-Term Care or and Clinical Analyst, No was provided prior to exil.			. -		
	and Diatysis dated communication she current and post ca intent of this policy that each resident the provision of he	and procedure tilled ESRD 2/2018 indicated a dialysis eet will be utilized for pre, are of the dialysis resident. The was that the facility assures receives care and services for modialysis consistent with					
	professional standard ongoing assessments and monitoring for dialysis treatments facility; ongoing as resident before an ongoing communic	aids of practice including the ent of the resident's condition complications before and after received at a certified dialysis assument and oversight of the differ dialysis treatments; and cettion and collaboration with regarding dialysis care and					
F 73 0 SS≕E		n Review-12 hi/yr In-Scrvice (7)		F 730			

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETEO	
		405000	B. WING		[19/2018	
		495206	D. WING			19/2016	
	ROVIOER OR SUPPLIER OURS-MARYVIEW NUI	RSING C		STREET AUDRESS, CHY, STATE, ZIP CODE 4775 DRIDGE ROAD SUFFOLK, VA 23435			
(X4) ITI I'REFIX I AG	(EACH DEFIGIEN	STATEMENT OF DEHICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IOENTIFYING INFORMATION)	IO PREF TAG		OULD DE	(XS) CONFLETION DATE	
F 730	The facility must co of every nurse aide months, and must peducation based or reviews. In-service requirements of §44 This REQUIREMENT by: Based on an extend the facility's compended the facility's compended to the facility staff failed to hours continual cores of CNAs. The findings included During an interview Coordinator (SDC) stated she and the discovered problem transference of an required education electronic portal synot recognized the compotencies were They further said, a referencing and an requirements, as widentified 5 CNA's their mandatory and hours. All 6 had "O" The SDC presented training that include annual competence.	plar in-service education. Implete a performance review at least once every 12 provide regular in-service in the outcome of these training must comply with the 83,95(g). It is not met as evidenced Ided survey task, a review of tencios for the Certified (CNA) was completed. The codemonstrate the required 12 Impetencies were completed for ed: If with the Staff Development In 3/19/18 at 10:45 a.m., she Director of Nursing (DON) Ins existed with the old paper system of recording al competencies to the new stem. They stated they had problem existed until the CNA or requested by this surveyor. Interested by this surveyor. Interested any of cruss allysis of educational Itell as interviews, they that had not completed any of inual competencies to equal 12 Indicate the following mandatory	· ·	1. No resident was identified in this 2. The residents who reside at the potentially be effected by this prace. Those slaff members who were ided not neet the educational 12-h requirement were removed from the state of the educational 12-h requirement. We also the monitor state compliance monthly with the requirement. B) A process was developed for the Educator /DON to take necessary ongoing and monthly, regarding a who do not meet the 12-hour requirement who is a monthly regarding a section of the Cinical Educator will monistall members compliance of educator requirements and provide a report 4) The DON will report to the Qualand Performance Improvement Companity for 6 months, the findings Education requirements audits and following action items to onsure compliance of Compliance 4/25/18	s citation. facility could tice. lentified and our reschedule. sist the Clinical ff members for ired education. laff members irement and to tor monthly calional to the DON. lity Assurance ommittee of the dany needed		

FORM CMS-265/µ17-99) Previous Versions Obsulete

EvenUD: TYYX11

Facility ID, VA004II

If confimulation shock Page 97 of 104



STATEMENT OF DEFICIENCIES (XI)		(X1) PROVIDER/SUPPLIER/CUA (XX		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIH	G	COMPLE	- '	
					C		
		495206	n. WING		03/19	9/2018	
NAME OF PR	OVIUER OR SUPPLIER			STREET ADURESS, CITY, STATE, ZIP CODE			
		nino o		4775 BRIDGE ROAD		Ì	
BON SECO	DURS-MARYVIEW NUR	SINGC	4	SUFFOLK, VA 23435			
JXA) ID PREHX TAG	(EACH DEFIGIENC)	ATEMENT OF DEFICIENCIES Y MUST NE PRECEDED BY FUCC LSC IDENTIFYING INFORMATION)	ID PREFIX IAG	I'ROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SI IDLI CROSS REFERENCED TO THE APPRO UEFICIENCY)	T) AE	(X5) COMPLETION DATE	
	-Mandatory reporting abuse, 'neglect, abar-Basic technical skills-Personal care skills -Mental health and s-Care of cognitively infection control During the pre-exit d 3/19/18 at 4:00 p.m. Long-Term Care prostated she removed until they comploted because they were refailed to attempt any She stated there was CNA training and on Pharmacy Stres/ProcER(s): 483.45(a)(b \$483.45 I harmacy STR (s): 483.45(a)(b \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrug the strength of th	interpersonal skills interpers	F	F. 755 1. Resident #5's medications and cathave been re-evaluated and care plans needed. -The medication is now being delive and monitored via the facilities extern pharmacy vendor. 2. Those residents who have medicate brought in from an outside source or reconcited could potentially be affect practice. 3. A) A review of the policy related to reprovided by family or an outside source.	re needs ons updated rcd, labeled hat lions r need led by this medications arce was	1/25/1X	
	that assure the accudispensing, and add	rices (including procedures urale acquiring, receiving, ninislering of all drugs and the needs of each resident.		completed by the Don/Administrator B) Education was provided to the number of medical and practice of medical may be brought in from an outside seducation also included the following	rrsing staff itions that source. The		

PRINTED: 03/30/2018

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES	FORM APPROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-039
C.I. N. J. LING TO C. MAR. DIGGING CO. M	If medication is requested to be brought in from an outside source it will be communicated to the DON for review and consideration and practice adherence of the current policy. C) A review and audit will be completed weekly of those residents who may have medications requested or received by an outside source. This audit and action items will be provided to the Don weekly. 4) The Don will report to the Quality Assurance and Performance Improvement Committee.
	(QAPI) monthly for 3 months the findings and needed action items regarding medications from any outside source and actions items for policy compliance. 5) Date of Compliance 4/25/18

Event (D: TYYX 1

DEPARTMENT OF HEALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF CORRECTION (X1) PROVIDERSUPPLIERIGHA IDENTIFICATION NUMBER:			A. BUILDING				C C		
		495206	a. WING	-		•	0	3/19/2018	
	ROVIDER OR SUPPLIFR	SING C		4775	ET ADORESS, CITY, STA BRIOGE ROAD FOLK, VA 23435	NE, ZIP COOF			
(X4) ID FREFIX IAC	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST DE PRECEDEO BY FULL LSC IOENTIFYING INFORMATION:	i) PRERI LAG		(EACH CORREC CROSS-LIEFERENC	PLAN OF CORRECT FIVE ACTION SHOU CED TO THE APPINC SFICIENCY)	בוף חב	IXAI IIOMPLLTION OATE	
F 756	Continued From pag	o 84 Consultation. The facility	 F	755					
	must employ or obtain pharmacist who-	in the services of a licensed			·				
		es consultation on all ion of pharmacy services in							
		ishes a system of records of on of all controlled drugs in able an accurate							
	order and that an action is maintained and pe	nines that drug records are in count of all controlled drugs riodically recensiled. I is not met as evidenced							
	Based on observation documentation reviee the facility staff failed accepted from family	on, staff interview, facility w, and clinical record review, to ensure medications or outside sources woro ility for 1 of 41 residents in Resident #5).							
	The findings included	d:							
		mitted to the facility on 5/1/17. ent #5 included but are not s disease.							
	(MDS) with an Asser 2/19/18 scored Resi 15 out of a possible impairment, The Res	erly Minimum Data Set serment Reference Date of dent #5 with a BIMS score of 15, indicating no cognitive sident was dependent on let use, personal hygienc, asters.							

DEPARTMENT OF HITALTH AND HUMAN STRVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN)	OF TITTICIENCIES	(XI) PROVIDER/SUPPI ITRICIA	(X2) MITILTIPLE C	ONSTRUCTION		TT. SUKVEY NPLITTED
ANTI PLAN OF	CURRECTION	IÚENTIFICATION NUMBER:	A BUILTING	·		C
		495206	B. WING		a	3/19/2018
	ROVIDER OR STIPPLIER OURS-MARYVIEW NUR		477	REET ADDRESS, CITY, STATE, ZIP C 6 BRIDGE ROAO FFOLK, VA 23435	enr	
(X4) ID PREFIX "FAG	(EACH DEFICIENC	TATEMENT OF TITERNENCIES Y MRIGTBE PRECITIED BY FULL LSC ITENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACH) CROSS-REFERENCETI TO 11 OEFICIENCS	ON SHOULD BE HE APPROPRIATE	(XIMPLE IJON DATE
F 755	Continued From pag	e 85	F 755			
	last revised 10/23/1/2 a Duopa Pomp via F disease. The goal will complications related through review date. Administer Duopa S Suspension is to be pump per orders. I'a minutes before infus 5/11/17 Physician of following: Duopa Suspension (milligrams/milliliter) morning for Parkins hours equals 13 ml infusion pump, one The Facility Pharma approximately 2 PM the Duopa Suspensine Unit Nurses. The that the Resident's medication. The Phoanghter brought in cost medication. The Phoanghter brought in cost medication. The refrigerated appropriately appropriately. A page 26 docume documented the following page 26 documented the following review of the following page 26 documented the following residented the following review of the following page 26 documented the following review of the follow	ders documented the 4.63-20 MC/ML Give 12 ml via J-Tube in the on's disease. 3 ml/hr for 4.3 to be infused with extomal cassette daily. Acist stated on 3/10/18 all that she had once looked all sion as requested to do so by a Facility Pharmacist stated daughter brings in the armacist stated that the nather medication as it is a high the Pharmacist was asked how do that the medication was kept riately. The Pharmacist stated dent's daughter, so she would are the medication				

DEPARTMENT OF HEALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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MANE OF PROVIDER OR BUPPLER BON SECCURS-MARYVIEW NURSING C CHOID SUMMARY STATINEN IS CORPORATED BY THE CONTROL OF STATE OF STAT		CORRECTION DF OEFICIFICIES	(X I) PROVIDER/SUPPHIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A FILII.OI			COMP	LEIED
MANE OF PROVIDITE OR SUPPLIER BON SECOURS-MARYVIEW NURSING C SUPPLIA CALLIDATE STATTMENT OF OFFICE PLIES FOR SUPPLIES STATMENT OF PRECEDED IN THE PRESENCE OF THE PRESENCE				(1.147115	L AGRAIG.			·
BON SECOURS-MARY/IEW NURSING C CO- 10 SUMMARY STATMEN IS OFFICENCES PROVIDERS PRO			495206	B. WINIS.			03/	19/2018
ICANIO CONTROL SCUMBARY STATUSEN OF OFFICE TIES SUMBARY STATUSEN OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFICE SCUMBARY STATUS OF OFFI OFFI OFFI OFFI OFFI OFFI OFFI	NAME OF P	ROVIDER OR SUITPLIER						
F 755 Continued From page 85 DY RESIDENT OR FAMILY MEMBER?" Policy: Medications brought not the facility by a resident or family member are used only upon written order by the resident's sulcived only when the facility of uncertainty in the packaging meets the facility's guidelines. Other unsulthorized medications brought to the facility by ne resident or family member are used only upon written order by the resident's attending physician, after the contents are vortified, and if the packaging meets the facility's guidelines. Other unsulthorized medications are not accepted by the facility of the facility by ne resident or family member is allowed only when the following conditions are met. 1. The medication name, dosege form, and strength have been verified by: a. consulting a table t dendification reference, e.g.—Physicians's Deak Reference, or b. calting the dispensing pharmacy for a physical description of the medication. 2. The medication was ordered by the resident's physician and entered in the resident's physician and entered in the resident's modical record for bedside storage and sent-administration by the resident. 3. The inedication container is clearly labeled in accordance with facility procedures for medication accordance with facility procedures for medication are received directly from another health care facility, e.g., discharge medications arriving with the resident's physician, or unacceptable for other reasons, are returned to the family or designated agent. If unclaimed within thirty days, the medications are disposed of in accordance with facility procedures for disposed of in accordance with facility procedures.	BON SEC	DURS-MARYVIEW NUR	SING C	,	•			
BY RESIDENT OR FAMILY MEMBER?" "Policy; Modications brought into the facility by a resident of family member are used only upon written order by the resident's attending physician, after the contents are vorified, and if the packaging meets the facility's guiderines. Other unauthorized medications are not accepted by the facility." "Procedures" "a. Use of medications brought to the facility by a resident or family member is allowed only when the following conditions are met. 1. The medication hame, dosage form, and strength have been verified by: a. consulting a tablet identification reference, e.g., Physicians's Desk Reference, or b. calling the dispensing pharmacy for a physical description of the medication. 2. The medication was ordered by the resident's physician and entered in the resident's supplication and entered in the resident's necifical record for bedside storage andseft-administration by the resident container is closely labeled in accordance with facility procedures for medication labeling and packaged in a manner consistent with facility guidelines formedications. 4. The medications are received directly from another health care facility, e.g. discharge medications arriving with the resident from an acute hospital in the interim until medications for the resident are received from the provides pharmacy. b. Medications not ordered by the resident's physician, or unacceptable for other reasons, are returned to the family or designated agent. If unclaimed within thirty days, the medications and disposed of in accordance with facility medications and disposed of in accordance with facility medications and disposed of in accordance with facility medications and disposed of in accordance with facility medications and disposed of in accordance with facility medications and disposed of in accordance with facility medications and disposed of in accordance with facility medications and disposed of in accordance with facility medications and	PREFIX	(EACH OEFICIENC)	Y MUST DE PRECEUEO RY FILL	PREH		(EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROPE	⊎E Ì	COMPLETION .
	F 755	BY RESIDENT OR F "Policy: Medications resident or family me written order by the r physician, after the country the packaging meets Other unaulhorized r by the facility." "Procedures" "a. Use of medication resident or family me the following condition to the following condition to the following at able e.g., Physicians's Debugger of the medication of the medication of the medication of the medication of the medication and enterer record for bedside stoy in a resident. 3. The medication consistent with facility. The medication abotting accordance with facility. The medications arriving acute hospital in the tho resident are recepharmacy, b. Medications not ophysician, or unaccereturned to the family unclaimed within this disposed of in accordance or the samily unclaimed within this disposed of in accordance or the samily unclaimed within this disposed of in accordance or the samily unclaimed within this disposed of in accordance.	brought into the facility by a smber are used only upon esidont's attending ontents are vorified, and if the facility's guidelines, medications are not accepted as brought to the facility by a ember is allowed only when one are met. ame, dosage form, and verified by: t identification retorence, esk Reference, or sing pharmacy for a physical edication. vas ordered by the resident's medical forage and self-administration container is clearly labeled in facility, e.g., discharge with the resident from an interim until medications for elived from the provider or designated agent. If the days, the medications are dance with facility medication are dance with facility medications are dance with facility medications are dance with facility medications.	F	755			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 03/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND I LAN OF CORRECTION		(X1) PROVIDER/SUPPLIFICLIA IDENTIFICATION NUMBER.		(X2) MULTIPLE CUPIST RUCTION (X3) DA CO			
		495206	B. WING			03/1	19/2018
	ROVIDER OR SUIPLIER DURS-MARYVIEW N	JRSING C		477	RFIT ADUKESS, CITY, STATE, ZIP CODE 5 BRIOGE ROAD FFOLK, VA 23435		·
(X4) ID PREHX TAG	(CACH UEFICIE	STATEMENT OF DEFICIENCIES NOV MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PRCF TAG		PROVIDER'S PLAN OF CORDECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROIDERICIENCY)	υ 8 E	(X5) COMPLETION DATE
F 755	Continued From p	age 87	F	755			
	documented with "Medication Mana to facility by Resid following: "Policy: It is the pormedications brough Resident or respoil permitted by the are verified before Procedure: 1. Medication brough administered until been met: a. State regulations management of the contents of labeled in according pharmacy policies of the contents of	and Procedure Manual a revision date of 5/25/16 tillett, gement - Medications Brought lent/Family" documented the olicy of this facility that all ght into the facility by the insible party/family only be used State regulations and that they is use in the facility. ught into the facility may not be the following conditions have insiallow such use in the facility just be ordered by the tian on the orderform of each container must be since with State regulations and of each container must have entified by a licensed at identified by the pharmacist or systician must be returned to the					
F 842 SS≃D	findings during a approximatoly 3:5 present any furth Resident Record CFR(s): 483.20(f) §483.20(f)(5) Res	istration was informed of the pre-exit briofing on 3/20/18 at 55 PM. The facility did not er information about the finding is - Identifiable Information (5), 483.70(i)(1)-(5) sident-identifiable information not release information that is	 	= 842	F842 1) Resident #413 Ted Hose is in plac ordered . Residents care needs wer and care plans were updated as nec -Staff member #2 was educated reta	e reviewed, :ded.	4/25118

FURMICMS 2567(02-00) Provious Versions Oncolete

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Facility III 1 VA0010

If continuation sheet Page 103 of 104



DEPARTMENT OF HEALTHAND HUMAN SERVICES	PRINTED. 03/30/2018 FORM APPROVED OMB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES	policy and documentation requirements. 2) Those residents who have care needs or Ted hose ordered and require documentation of this device/product could potentially be at risk for this practice. 3) A) Education has been provided to nursing staff related to the application and required documentation of this product on the PAR(Treatment Administration Record). This education also included: -Education was also provided related to documentation of care that is completed vs. documentation if care is not completed. B) Audits will be completed weekly by the Clinical Nurse managers for application and documentation on the TAR for the use of TED hose products. C) The Nurse managers will provide the feedback and follow up actions of the TED hose/documentation audit to the DON weekly. 4) The DON will report to Quality Assurance and Performance Improvement Committee (OAPI) monthly for-3 months the findings and action items for the TED/Hose documentation audit and compliance with this practice/policy. 5) Date of Compliance 4/25/18
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DEPARTMENT OF HEALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATTMENT OF FIFTICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (UENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA LUENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	C C		
		495206	B. WING			03/	19/2018	
	COVIDER OR SUPPLIER DURS-MARYVIEW NUR	SING C	-L-	4	TREET ADDRESS, CITY, STATE, ZIP CUOE 775 BRIDGE ROAD JUFFOLK, VA 23435			
(X4) ITI PREFIX TAC	(EACH DEFICIENC	ATEMENT OF INTICIENCIES Y MUST BE PRECEDED BY FULL LSC IDANTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLANDE CORRECTION TEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPHOR DEFICIENCY)	1 BC	IX5 COMPLETION DATE	
F 842	resident-identifiable (ii) The facility may resident-identifiable accordance with a cragrees not to use or except to the extent to do so. §483.70(i) Medical residential facility of the extent to do so. §483.70(i) Medical residential facility of the interest material medical that are- (i) Complete; (ii) Accurately documential regardless of the for records, except when (i) To the individual, ropresentative where (ii) Required by Law (iii) For treatment, properations, as permitted that the formation of the interest of the formations, as permitted that the formation of the interest of the formations, as permitted that the formations of the formations, as permitted that the formations of the formations, as permitted that the formation of the interest of the formation of the interest of the formation of the interest of the	to the public. elease information that is to an agent only in portract under which the agent disclose the information the facility itself is permitted ecords. ordance with accepted rds and practices, the lacility cal records on each resident mented; ble; and organized cility must keep confidential sined in the resident's records, orn or storage method of the en release is- or their resident e permitted by applicable law; it; eayment, or health care eitted by and in compliance	ŗ	842				
	§483.70(i)(3) The ii	асицу приздавления песиса	<u> </u>					

PRINTED: 03/30/2018 DEPARTMENT OF HEALTHAND HUMAN SERVICES FORM APPROVED OMB NO. 0938 0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XI) PROVIOER/SUPPLIER/CLIA (X3) DATE SURVITY (X2) MILITIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES. COMPLETED IDENTIFICATION NUMBER. AND PLAN OF CORRECTION A. BUILDING _ Ċ 495206 03/19/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4775 BRIDGE ROAD BON SECOURS-MARYVIEW NURSING C SUFFOLK, VA 23435 SHAMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1X4) IO COMPLETION JEACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD FIC PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE RECULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 842 Continued From page 89 F 842 record information against loss, destruction, or unauthorized usc. §483.70(i)(4) Medical records must be retained (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 Stale 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 otherlicensed 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 observations, record review, and staff interview, the facility staff failed to ensure medical records were accurately documented for 1 of 41 residents in the survey sample (Resident #413).

Facility staff failed to maintain accurate Treatment

Resident #413 was admitted to the facility on 3/7/18, diagnoses included but not limited to GI

hemochromatosis, essential hypertension,

Administration Record (TAR).

bleed, hyperlipidomia, hereditary

The findings included:

DEPARTMENT OF HEALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	DEPICIENCIES CORRECTION	(XI) PROVIDENSLIPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI C.CO	NISTRUCTION		(X3) DATE SURVEY COMPLETED C		
		495206	B. WING		0	3/19/2018		
	ROVIDER OR SUPPLIER OURS-MARYVIEW NUR	SING C	4775	ET ADORESS, CITY, STATE, ZIP CODE BRIDGE ROAD FOLK, VA 23435	E			
(X4) IO PREFIX YAG	(EACH DEFIGIEND	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRFFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS REFERENCED TO THE A OBFICIENCY)	SHOULD BE	IXSI COMFLCTION DATE		
F 842	Continued From page 90 atherosclerotic heart disease, acute embolism		F 842					
	and thrombosis of le	disease, acute embolish Il lower extremity, metabolic I chronic liver disease.						
	This rosident was ad discharged on 3/16/1 completed.	mitted on 3/7/18 and 18 and did not have an MDS						
	Diuretic therapy rela Resident will be tree side effects of diuret review date, Interver	of discomfort or adverse to therapy through the next tions - Administer Lasix as						
	Monitor dose, Repor (Especially HCT, Na Daily Living needs re Goal - Will atlain ma ADL care needs, Inti	medications as ordered, I pertinent lab results to MD +, K r). Focus - Activities of elated to impaired mobility, ximum level of functioning in ervention - Occupational and evaluate and treat as						
ļ.	diel regular consiste checks 2x a day, da increased fluid load, OT/PT/ST to evalua (Thrombo-Embolic C	ew included: Diet LCS, NAS ncy, Full Code CPR, Accu ily weights x 14 days due to licensed nurse rounding, le and treat, apply TED Deterrent) hose in the and remove per schedule						
	observed resting in side. The resident w edema in bitateral fo	PM resident #413 was bed with his daughter at his as noted to have pilling over extremities. The resident at LED hose in place.						
		0 AM Resident #143 was apy gynn working with the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				<u>OMB NO</u>	0.0938-0391
	OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIFR/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. ELIILO		E CONSTRUCTION .	(X3) DATE COMP	SURVEY LETED
		4952 0 6	n. WING			C 03/19/2018	
NAME OF P	ROVIOER OR SUITPLIER			<u> </u>	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
				ı	1775 BRINGE ROAΩ		
BON SEC	OURS-MARYVIEW NUR	5ing C		1	BUFFOLK, VA 23436		
(X4) IO PREFIX TAG	LEACH DEFICIENC	ATEMENT OF DEFICIENCIES: Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF FAC		PROVIÚER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRA DEFICIENCY)		DATE CONFLETION (X5)
F 842	Physical Thrapy. Res TED hose. The TAR was review. TED hose was signed	e 91 dident #143 was not wearing ed on 3/13/18 at 11:40 AM, d off at 0600 (6:00 AM) as	F	842			
	having been applied.						
		ed on 03/13/18 at 11:35 AM eck to see if the resident had	<u> </u>				
, , _	On 3/13/18 at 11:40 A reviewing the TAR who 0600 on 3/13/18. Who for documenting Resident TED hose is to work have signed-the TED	AM, RN#2 was observed nich has been signed off at en asked how the process ident #413 application of RN#2 said "she should not tose off if she did not apply - th another nurse to find a					
	observed in his room TED hose as ordered the TED stockings we	AM Resident #413 was and was not weating his I. A review of the TAR noted are signed off at 03/14/18 at /2 was made aware by the					
F880 SS≃E	and Recording notes: Procedure # 6 Treath recording treatment c a.) The specific treath location/site, and duri Intection Prevention 8	nent Ordors - When orders, specify: nent, frequency, specific ation of the treatment. & Control	F	880	F <u>880</u> 1. Resident # 103 and #96 have had no i		4/25/18
	§483.80 Infection Co The facility must esta	ntrol blish and maintain an			effects from this practice. Residents #103 and #96's respiratory do will be stored according to policy and app infection control practice.		

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OMB NO. 0938 0391 CENTERS FOR MEDICARE & MEDICAID SERVICES Education was completed for staff members #5#2#26 regarding Infection Control Practices. 2 Those residents who have respiratory devices or that reside within the facility could potentially be affected by these practices. A) The Infection Control Coordinator will complete monthly tracking /trending and reporting on infections and infection prevention within the facility. This report will be provided to the DON/Administrator monthly for lifeir review. B) Education was provided to nursing care slaff on infection control policy and practices. This education included the following: Hand washing policy including practices followed during the dining and meal times. -Practice of glucometer checks and protection barriers during this practice. Nebulizer/respiratory device storage C) The Infection Control Coordinator will conduct monthly review/audits of the Infection control tracking numbers, handwashing, glucometer infection control practices and respiralory device storage. The findings of these audits and action items will be provided to the Don monthly for review. 4) The DON will report to the Quality Assurance and Performance Improvement Committee monthly for 6 months the findings and action items of those audits to assure practice/policy compliance with infection control practice and policy. 5) Date of Compliance of 4/25/18

Facility ID: VAUI40

DEPARTMENT OF FEALTH AND FIUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	DE DEFICIENCIES CORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDEN HEICATION NUMBER:	(X2) MULTI A. BUILDIN	II'LE CONSTRICTION NG		(X3) DATE SURVEY COMPLETED C		
		495206 B. WING			0	03/19/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BON SEC	OURS-MARYVIEW NUR	SING C		4775 BR/DGE ROAD SUFFOLK, VA 23435	·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PHOVIDER'S PLAN OF COR ((FACH CORRECTIVE ACTION: CROSS REFERENCED TO THE A DEHICIENCY)	SHOULDBE	COMPLETION DATE		
F 880	infection prevention of designed to provide a comfortable environment and tradiseases and infection program. The facility must estand control program a minimum, the following formunicable of staff, volunteers, visity providing services un arrangement based conducted according accepted national staff and communicable of the procedures for the pout are not limited to (i) A system of surver possible communicable communications before the persons in the facility (ii) When and to wind communicable disease reported;	and control program a safe, sanilary and ment and to help prevent the insmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at wing otements: em for preventing, identifying, ng, and controlling infections diseases for all residents, tors, and other individuals inder-a contractual - upon the facility assessment in to \$483.70(a) and following andards; on standards, policies, and regrain, which must include, introduced designed to identify able diseases or interced to other y; om possible incidents of use or infections should be	FE	380				
	to be followed to pre (iv)When and how is resident; including b (A) The type and du	ansmission-based precautions event spiead of infections; solation should be used for a out not limited to: ration of the isolation, infectious agent or organism						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIFR/CLIA IDENTIFICATION NUMBER	(X2) MIJLTI A. BUILDIN	IPLE CONSTRUCTION		E SURVEY I'LE (ED
		Intraca				C
		495206	B. WING_		103	3/19/2018
NAME OF PE	KÖVIÐER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		Ì
BON SEC	OURS-MARYVIEW NUI	RSING C		4775 BRIDGE ROAO		
2411 041-			_	SUFFOLK, VA 23435		
(X4) IU PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDIED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)		ID PRESIX TAG	PROVIDER'S I'LAN OF CIRR ([EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF OEFICIENCY)	IDI ILO BE	(X9) COMPLETION DATE
F 880	least restrictive post circumstances. (v) The circumstance must prohibit emploid disease or infected contact with resider contact will transmit (vi) The hand hygien by staff involved in (si) S483.80(a) (4) A systematic time actions to safe transport linens so infection. S483.80(f) Annual ransport linens so infection. S483.80(f) Annual ransport linens so infection. S483.80(f) Annual ransport linens so infection. S483.80(f) Annual ransport linens so infection. S483.80(f) Annual ransport linens so infection.	nat the isolation should be the sible for the rosident under the resulter of the rosident under the result of the facility yoes with a communicable skin lesions from direct at or their food, if direct at eprocedures to be followed direct resident contact. It he disease; and resident contact. It he disease; and recording incidents facility's IPCP and the aken by the facility. Indie, store, process, and resident of the spread of review. It is not met as evidenced being record review, and staff interviews, the results and staff interviews, the results and staff interviews, the results and staff interviews and their prevent the development of communicable diseases and	F8			
	control measures w	failed to ensure infection vere implemented during a o prevent the polential of n.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER(STIPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BIJILD	ING	LE CONSTRUCTION	(X3) OATE SURVEY COMPLETED			
		495206	D. WING			03	/19/2018	_
	ROVIDER OR SUPPLIFER OURS-MARYVIEW NUR	SING C			STRITT ADDRESS, CHY, STATE, ZIP CODE 4775 BRIDGE ROAD SUFFOLK, VA 23435			
(X4) IO PREHX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEHICIENCY MUST BE PRECEDED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION)			IX 3	PROVIDER'S PLAN OF CORRECT K (EACH CORRECTIVE ACTION SHOULD CRUSS-REFERENCED TO THE APPROP DEFICIENCY)	9E	(X5) CUMPLEUCN DATE	
F 880	Continued From page	e 94	 F	880	o d			
	between feeding of n	ailed to ensure handwashing psidents in the dining room prevent the potontial of cross						;
	4. Facility failed to or was stored in a sanita	nsure resident # 96 nebulizer ary manner.						
-	5. Facility failed to st a sanitary mannor for	ore respiratory equipment in resident #103.						Ī
}	The findings included	f:						
	facility Infection Cont with the Infection Gor Nurse) #5. The review							
	Infection Control Nur- The surveyor asked infection control prog "No, not the entire ye data. I now have the a PIP (Performance I compliance, I have a	M an interview with the se, RN #5 was conducted. If there was an effective ram in place. RN #5 stated, ar. I did find months with no pathway and we have done improvement Plan) for much better understanding row to do the tracking from						
	January 2017 through	surveyor with a timeline from h February 2018 of the of program months that had ata reported or tracked hin part, as follows:						

DEPARTMENT OF HEALTHAND TUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2018 FORM APPROVED OMB NO. 0938-0391

MAIN OF PROPULER OR SUPPLER BON SECOURS-MARYVIEW NURSING C CYNTD PRITTIX TAB F 880 Continued From page 95 April 2017: Chesapeake Unit: No Data Nansemond Unit: Listing Report Only Nansemond Unit: Listing Report Only Nansemond Unit: Listing Report Only Nansemond Unit: Listing Report Only The facility policy litled, "Infection Control Plan 2017-2018" is documented in part, as follows: Plan Document: 'The Infection Prevention and Control Plan and only organization wide programs for incorrectional of the prevention, control and only of the programs and maintains an active, organization wide programs for incorrection and control Plan and maintains an active, organization wide programs for incorrection and control plan and programs and maintains an active, organization wide programs for incorrection and control plan and maintains an active, organization wide programs for incorrection and control plan and maintains an active, organization wide programs for incorrection and control plan and maintains and active, organization and control plan and maintains and active, organization and control plan and control propagation for incorrections and control plan and maintains and active, organization and control plan and control propagation and control propagation and control plan and control plan and control plan and control plan and control plan and control plan and control plan and control plan and control plan and control plan and control plan and contr	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIS	PLE CONSTRUCTION	(X3) DATE SURVEY		
MANY OF PROMISE OF SUPPLER BON SECOURS-MARRYVEW NURSING C (49) ID PRITTY PROMISE CONTINUES OF PROMISES OF PROMISE CONTINUES OF PROMIS			495208	B. WING				
Copin Provided Notes Provided Note	NAME OF PE	ROVIDER OR SUPPLIER			STREET AUDRESS, CITY, STATE, ZII' COL			
F 880 Continued From page 95 April 2017: Chosapeake Unit: No Data November 2017: Chosapeake Unit: No Data November 2017: Chosapeake Unit: No Data Nansemond Unit: No Data Nansemond Unit: No Data Nansemond Unit: Listing Report Only Nansemond Unit: Listing Report Only Nansemond Unit: Listing Report Only Tebruary 2018: Chesapeake Unit: Listing Report Only Nansemond Unit: Listing Report Only The facility policy Billed, "Infection Control Plan 2017-2018" is documented in part, as follows: Plan Document: "The Infection Prevention and Control Plan shall ensure that Plan properties of the prevention and dovelops, implements and maintains an active, organization wide programs for the prevention, control and	BON SEC	OURS-MARYVIEW NUF	RSING C					
April 2017: Chosapeake Unit: No Data Nansemond Unit: No Data September 2017: Chesapeake Unit: No Data October 2017: Chosapeake Unit: No Data Nansemond Unit: No Data Nansemond Unit: No Data November 2017: Chosapeake Unit: No Data November 2017: Chesapeake Unit: No Data Nansemond Unit: No Data Nansemond Unit: No Data Nansemond Unit: Listing Report Only Nansemond Unit: Listing Report Only Nansemond Unit: Listing Report Only January 2018: Chesapeake Unit: Listing Report Only Nansemond Unit: Listing Report Only Nansemond Unit: Listing Report Only The facility policy tilled, "Infection Control Plan 2017-2018" is documented in part, as follows: Plan Document: "The Infection Prevention and Control Plan shall ensure that this organization develops, implements and maintains an active, organization wide program for the prevention, control and	PREFIX	(EACH DEFICIENT	CY MINST BE PRECEDED BY FOLL	PREI-IX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	1SHOUTE COMPLETION		
investigation of infections and communicable diseases in order to reduce the risks of endemic	F BBO	April 2017: Chesapeake Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Nansemond Unit: Lanuary 2018: Chesapeake Unit: Nansemond Unit: Lanuary 2018: Chesapeake Unit: Lanuary 201	No Data lo Data lo Data lo Data lo Data lo Data lo Data lo Data lo Data lo Data lo Data listing Report Only isting Report Only isting Report Only isting Report Only listing Report Onl	F8	80			

FORM EM5-2567(02-99) Previous Versions Obsolate

Event ID TYYX11

Facility ID: VA0040

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDEN HEICATION NUMBER:	A. BUILDI		INSTRUCTION		COWL	LETED
								ا . ا
		495206	D. WING				03/	19/2018
NAME OF P	ROVIDER OR SUPPLIER				EFT ADDRESS, CITY, STA	TE, ZIP CODF		
BON SEC	DURS-MARYVIEW NU	RSING C	1		BRIDGE ROAD			
				SUF	FOLK, VA 23436			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	In In	.		PLAN OF CORRECTION TIVE ACTION SHOULD I		OFF EXAMPLETION
PREFIX TAG		ICY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION]	PREFI			CEO TO THE APPROVE		DATE
					DE	EFICIENCY)		
F 880	Continued From pa	ige 96	F.	880				
	and epidemic infect	tions in residents, visitors and						
	healthcare workers	and to optimize use of						
	resources.							'
	*O the status as	Manager and Minush and	Ì					:
		identified, priorilized and afection Prevention and Control						
		ection Preventionist(s) shall		1				
		I measurable objectives based	.			•	•	
		ks which will be used to	_ _					
<u> </u>		n Prevention and Control Plan.						
1								
		p.m. a pre-exit conference						
Ì		Director of Nursing and RN #2		İ				
ļ		dormation was shared. The		1				
		was asked if the facility had on Control Program in place.						
		rsing stated, "No, we did not,		.		'		
]		ul Nurse RN #5 just look over						
ļ		surveyor asked, "Why should		}				
1		effective infection control		ļ				i
		The Director of Nursing		Ì				
		track infections to see if they						
		ilies and provide education and						Į
j	prevent the spread	of infections."		1				
	Dring to evit no furt	her information was shared.						
	THE TO CARTIO INT.				•			
		oproximately 4:04 PM, LPN						
		lo gather supplies to perform a						
		The LPN gathered the]					1
	glucometer and glu	ucometer box and entered the					•	
		he I.PN placed a barrier on the placed the glucometer on top	1					
		r. The I PN placed a plastic box	İ					
}	containing ducom	cler supplies, lancels, alcohol						
		Resident's bed. The LPN						
1		meler and proceated with						
l		ose check after the glucometer						
	<u> </u>	· · · · · · · · · · · · · · · · · · ·						

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	J. 03/30/2018 APPROVED . 0936-0391
		(X1) PROVIDER/SUPPLIET/CLIA INFNTIFICATION NUMBER:	(X2) MUL A. BUJI DI		CONSTRUCTION	(X2) OATE SURVEY COMPLETED	
		495206	B. WING				19/2018
ΝΑΜΕ ΩΕ ΡΙ	RUVIDER OR SUMMELIER		•	3	THEET ADDRESS, CITY, STATE, ZIP CODE		
BON SEC	OURS-MARYVIEW NUR	SING C		1	1775 BRIDGE RDAD SUFFOLK, VA 23435		
(X4) IO PREFIX (AG	(FACH OFFICIENC	TATEMENT OF OUTIGIENCIES LY MUST BE PRECTOED BY FULL R LSC INENTHYING INFORMATION)	ID I HEF TAC	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPHOPE DEFICIENCY)	30	(XX) COMPLETING DATE
г вво	Conlinued From pag	ge 97	F	880			
	The LPN proceeded and then gathered he medication cart. The glucometer.	to obtain the glucose check, er supplies to return to the LPN sanitized the					
	about placing the gli resident's bed, LPN control issure." Whet for it being an infect	what her thoughts were accommented box on top of a #26 stated, "It's an infection asked the specific reason ion control issue, LPN #26 bity spread infection from one					
	effective date of 3/2	and Procedure with an 8/17 titled, "Equipment and Storage and Cleaning Of" lowing:					
	stored, handled and	nent and supplies will be deleaned according to Joint fection Control Standards."					
!	oxpectation of the goon a resident bed a medication cart on 10:46 AM. The DOI should be cleaned	ses (DON) was asked her plucometer box being placed nd then returned to the 3/16/18 at approximately N stated that equipment and placed on barrier when in d after use to prevent the infection.					
	Findings during a pr	tration was informed of the re-exit briefing on 3/20/18 at PM, The facility did not					

present any further information about the finding.

3. An observation was made on 3/13/18 at

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X) I PROVIDENSUPPI IEROLIA ILJENTIFICA I KON NUMBER	(X21 MUI 7. BUILU		E CONSTRUCTION	COMPLETED		
		495206	n WING	-	<u></u>	03	/19/2018	
NAME OF PROVIDER OR SUPPLIER BON SECOURS-MARYVIEW NURSING C			_	4	STREET ADDRESS, CITY, STATE, ZIP CIDE 4775 BRIDGE ROAD SUFFOLK, VA 23435			
(X4) ID PREHX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION)	ID I'REF T'AG	ХF	PROMOFR'S PLAN OF CORRECTIVE ACTION SUMULI CROSS-REFERENCEN TO THE AFPROF DEFICIENCY)	18E	(X5) COMPLETION DATE	
F 880	approximately 12 nor of CNA #5 silling beth female resident and feeding the second in handwashing. CNA #1 table of 4 residents. assisting two resident was observed on occasions while silting male resident to assaround and assist the observed to perform occasion the CNA as blow his mose, then putable and turn aroun the female resident as utensil and feed the hygiene between the Cn 03/13/18 at approvas asked if she alwher two residents she she did sanitize dun sanitized after feeding the next resident and feed the sanitized after feeding the next resident with an eff 1/2012, documented "Indications for Han "CDC Recommendat. Before and after patient. 8. After contact with	on, in the main dining room ween two residents feeding a then turning around and esident without #5 was observed sitting at a The CNA was observed its during lunch. The CNA casion get up from the table fitize hands prior to returning. A was observed on multipleing between a ferriale and ist the fernale and then turn around pick up hand hygiene. On one esisted the male patient to blace the soiled napkin on the diand take a utensil and feed and then turn around pick up he male resident without hand a care of the two resirlonts. In oximately 12:23 PM, the CNA ways sanitized hands between he stated, "No." She stated hig their meal. Asked if she ing one every time prior to ident, the CNA stated, "No." Ind Procedure titled, "Hand fective date of the following:						
l								

DEPARTMENT OF DEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2		TIPI E CONST		JX3) DA JE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	Ex-Military Ole Familiani.	A ULIPO	JAKG			С	
		495206	R WING			1 0	3/19/2018	
		485206	1	eracar	ADORESS, CHY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				NOGE ROAD			
BON SEC	OURS-MARYV(EW NU	rsing c			LK, VA 23435			
				SUFFO				
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEPICIENCIES CY MUST, BE PRECEDED BY FILL R LSC IDENTIFYING INFORMATION)	OJ PRET DAT		PROVIDER'S PLAN OF COI JEACH CONRECTIVE ACTION GROSS-REFERENCED TO THE DEFICIENCY)	SKOULD DE	(X5) COMPIEIRÚN DATE	
F 880	Continued From page	ge 99	F	880				
	"Proper hand hygie job performance in	ne is a basic expectation of the health care environment."						
	expectations of har during feeding two that her expectation	PM, was asked the dwashing between residents residents. 'the DON stated n was to either wash hands or						
	The facility administing a proproximately 3:55	reen resident care." Iration was informed of the re-exit briefing on 3/20/18 at PM. The facility did nol information about the finding.						
	2/10/18, diagnoses proumonia, cogniti	is admitted to the facility on include but are not limited to we communication deficit, by anemia, gout, atrial flutter, ension.						
	for resident #96 wa assessed the residence patterns with a Brid (BIMS) score of 11 impaired cognition section indicated reassistance with section staff member	Dala Set (MDS) assessment as completed on 3/7/18 which lent in the area of Cognilive of Interview for Mental Status i, indicating moderately. Activities of Daily Living (ADL) esident #96 needed limited If-porformance and support of provided for bed mobility, ion on the unit, and toilet use.						
	-Diagnosed with N (MAC), Goal - nor administer Rifamo	ed 2/11/18 indicated: Focus lycobacterium Avium Complex le listed. Intorvention - lin and Zithromax daily on day, and Friday as ordered.				<u></u>	-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DETICIENCES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETEO	
							С	
	· · · · · · · · · · · · · · · · · · ·	495206	II, WING			03/	19/2018	
NAME OF PE	ROVIDER OR SUITILIER				STREET ADORESS, CITY, STATE, ZIP COOF	-	.]	
DOM COO	TIDE MADIANCIAN DISC.	RIMÓ C			4775 BRIOGE ROAD			
BON SECI	DURS-MARYVIEW NUR	SING	,		SUFFOLK, VA 23435			
[X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREHX	[FACH OFFICIENC	Y MUST RE PRECEDED BY FULL	PREF		[EACH CORRECTIVE ACTION SHOULD!		COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	ì	CROSS-REFERENCES TO THE APPROPR OBJECTIONS OBJECT O	A1F	29111,	
E					Ì			
F 880	Continued From page		F	880	0			
	_	is. Listen for crackles and						
		unds due to atelectasis (In						
,		a rhonchi and wheezing are				į		
	also present), Monito		1			ŀ		
		ental changes, stupor, and						
		art failure. Also Caré						
		Recent episode of wheezing						
		e no complications related to						
		<u>reath) th</u> ough the <u>roview</u>			 	 -		
'		Obtain chest x-ray as			-			
		DuoNeb via inhalation every	!					
		nonitor and document						
		n, increasod restlessness,						
		er. Monitor breathing						
	•	alities, report to MD. Obtain						
		xygen) sats every shift x 5						
,	days as ordered. "	·		•	1	••••		
		served on 03/12/18 at 12:15			1			
		hine at the bedside. The	ļ				Ì	
		ched and placed on top of						
	,	bag). The mouthpiece was						
	dated 3/12/18.						ţ	
		TARA HAR AND AND AND AND AND AND AND AND AND AND						
		PM, the Nobulizer was	ļ					
		an resting on lop of tha					ļ	
	machine.							
1	A A0M0/40 15 02	DRS Also Make Name	1					
	On 03/13/18 at 2:35		1				1	
		erved resting on top of the]	
	machine, not in a ba	9-						
Į	O_ 00/44/40 =4 40-04	E DM Decident #825					ļ	
	On 03/14/18 at 12:35						· i	
		e, and tubing were observed						
	piaced on the begsio	le table, not in a bag.						
	0 = 0140 MO =4 0 40 P	M with Dogistare & Nurse	- {					
	t =	M with Registered Nurse						
1		to observe resident #96's			·		1	
J	nepulizer equipment	, RN#2 was observed to walk					<u> </u>	

DEPARTMENT OF HEALTHAND HUMAN SERVICES CONTERS FOR MEDICARE & MEDICAID SERVICES

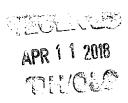
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AND LEAVE,	WINKE HOT		A. BUILDING	, , ,		С	
		495206	B. WING		03	/19/2018	
-	ROVIDER ON SUPPLIFR OURS-MARYVIEW NUR	sing c	47	RRET ADDRESS, CITY, STATE, ZIP RO 75 BRIOGE ROAD JFFOLK, VA 23435	OE		
(X4) ID FREHX TAG	JEACH DEFICIENC	YATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LOC IDENTIFYING INFTRMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OFFICIENCY)	N (3) KOULÚ BE E APPROPRÍATE	CEMPIL HON CEMPIL HON	
F 880	to the nebulizer mac was located on the bille resident's bed. Requipment and state will lake care of this, #2 at 3/14/18 at 2:44 asked why it should prevent the spread of the subtitle Medication Aerosol: Procedure # 7. Stormarked with the date between uses. 5. Resident #103 was 2/21/18, diagnoses acute on chronic rigidiabetes type II, hypurispection, obstruct hypertension, and a An Admission Minimassessment was coresident. In the area Brief Interview for M12 indicating moder Activities of Daily Linesident #103 needself-porformance in dressing, toilet use, support of two staff A Care Plan initiate Use of oxygen abs	Inine and mouthpiece which hedside lable, to the right of the withs should be in a bag, I have picked up the diffusion and interview with RN in PM when the surveyor be in a bag, RN#2 stated to of infection. SNF-030) for Respiratory diffusion and maintenance noted under on Nebulizer/Continuous and resident's name, as admitted to the facility on include but are not limited to but the artifusion and resident's name, with the primary that fibrillation. Suppose a primary that for the primary that fibrillation. Suppose a primary that for the primary that status (BIMS) score of ately impaired cognition. Ving (ADL) section indicated and extensive assistance with bed mobility, transfers, and personal hygiene and	F 880				

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Event ID: TYYXI1 ' Facility ID: VA0040

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION SUPPLIER/CLIA STATEMENT OF DEFICIENCIES LIVENTY FICATION NUMBER:		A. BUILD		COMI	COMPLETED		
		495206	B. WING				/19/2818
	OURS-MARYVIEW NUM	RSING C	<u>.l.</u> ,	477	FFT ADURESS, CITY. STATE, ZIP CODF 5 BRINGE KOAD -FOLK, VA 23435		
(X4) ID PREFIX I AG	JEACH DEFICIENT	RATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PRII TAC	xr x	PHOVIDER'S PLAN OF CORRECTIVE (FACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROP DEFICIENCY)	ם מ כ	(XM) COMPLETION DAILE
F 880	ambulatory, provided oxygen apparatus. It by physician, monitor effectiveness. Monitor of the physician, monitor effectiveness. Monitor of the physician of the physician oxygen via nasal companies. It is a provided at the physician oxygen via nasal companies. Interventions of the physician oxygen via nasal companies. Intervention oxygen via nasal companies. Intervention oxygen via nasal companies. Intervention oxygen via nasal companies. Intervention oxygen via nasal companies. In the physician oxygen via nasal	ated. Resident who should be extension tubing or portable Give medications as ordered or/document side effects and tor for s/sx of respiratory to MD PRN: Respirations, eased heart rate (tachycardia) horesis, Headaches, Actelectasis, Hemoptysis, An Accessory muscle usage, e Planned for-Focus Apnea. Goal- be free of any ed to OSA through the review May have C-PAP to Airway Pressure) machine e settings. Apply at HS ed:- sician orders included: May ne from home @ home for sleep apnea. Please apply the at as indicated, turn and hille in bed or chair , weekly skin assessment 30 PM, Resident #103 was 12 concentrator administering annula at 2 liters. The CPAP ere onbserved on top of the	F	880		· · ·	
					M	Programme 1	Page 120 of 184

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		[X1) PROVIDER/SUPPLIER/ELIA IDENTIFICATION NUMBER	[X2] MOLTIPLE A BUILDING		(XII) DATE SURVEY COMPLETED	
	•		X IIIILOING			c {
		495206	B WING	·	03	/19/2018
	RUVIDER OR SUPPLIER DURS-MARYVIEW NUR	sing c	47	IREET ADDRESS, CITY, STATE, 7IP COUL 775 BRIDGE ROAD UFFOLK, VA 23435	-	
[X4) ID PREFIX TAG	JEACH DEFICIENT	IALEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 1 SE, IDEN LIFYING INFORMATION)	ID PREFIX I'AG	PROVIDER'S PLAN OF CURREC (EACH FOURLECTIVE ACTION SHO CROSS-REFERENCEU TO THE APPL DEFILIENCY)	OLD RF	(XS) COMPLETION DATE
f 880	sleep apnea." The mobserved placed directed for that not been placed. On 03/14/18 at 12:36 observed on the bed bag. On 3/14/18 at 12:35 #2 was asked to conto observe his CPAF walk to the machine, located in the guest resident's bed. RN#2 apparatus and place. On 3/14/18 at 12:40 the CPAP should be should be in a bag. If then asked why it should be in a bag, if the certain the stated to prevent the A review of the facility resident when not in use.	ars a CPAP mask at night for lask and tubing were extly on the bedside table and in a plastic bag. PM the CPAP mask was side visitor chair, not in a PM, Registered Nurse (RN) no to Resident #103's room PRN #2 was observed to mask and tubing which were chair, to the right of the PM, RN#2 was asked how as observed to pick up the eit on the bedside lable. PM, RN#2 was asked how astored. RN#2 stated "this will fix this." The surveyor would be in a bag and RN#2 aspread of infection. Ity policy #SNF-030 for ent - Use and Maintenance title CPAP: itore mask in a plastic bag	F 880			

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