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

PRINTED: 08/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495346	A. BUILDING _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS DEPAUL,TCC	150 KINGSLEY LANE NORFOLK, VA 23505

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/7/18 through 8/9/18 Corrections are required for compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegations of compliance. All alleged deficiencies have been or will be corrected by the date indicated	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.	E 015	1. No residents were affected by this practice. 2. Residents residing in the facility could potentially be affected by this practice. 3. The emergency preparedness plan was reviewed and updated by the Administrator to ensure: a) A system was in place for communicating provision of subsistence needs for staff and individuals. b) A process was determined, documented and implemented to determine supply needs and alternate energy sources as outlined in this regulation. c) The Emergency Preparedness Safety team reviewed and approved these updates as required in this regulation. d) The Emergency Preparedness plan was submitted and approved with these additional updates by the QAPi committee. 4. The Administrator will be responsible to report and update monthly at the QAPI committee any ongoing changes or needs related to subsistence needs for staff and patients as changes or updates occur with the Emergency Preparedness Plan. 5. Date of Compliance Sept 14th 2018 RSV	

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AUG 24 2018
VDH/OLC

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

Administrator 8-23-18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 015	Continued From page 1 (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to ensure policies were in place for the provision of subsistence needs for staff and individuals. The facility staff failed to document their supply needs and alternate energy sources necessary to maintain temperatures to protect patient health and safety, lighting, fire detection, the alarm system, sewage and waste disposal during an emergency. The findings included: An interview was conducted on 8/8/18 at 10:15 a.m., with the Administrator and Emergency Preparedness (EP) Director. There was no	E 015		

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E 015	Continued From page 2 documentation to demonstrate their supply needs; food, pharmaceuticals, medical supplies, fire detection including extinguishing and alarm systems as well as sewage and waste disposal. The Administrator stated (name of fuel supplier) would deliver more fuel prior to exhausting the 2.5 days' worth of fuel the generator currently has, however there was no documentation to support what was stated.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE]	E 018	E 018 1) No residents were affected by this practice. 2) Residents residing in the facility could potentially be affected by this practice. 3) A policy was developed to include the following requirements as outlined and specified in this regulation to include the following: a) A Process to track individuals and on-duty staff in the facility's care during an emergency event. b) A Process to track the location of on-duty staff and sheltered individuals who are relocated during the emergency c) The Emergency Preparedness and Safety team reviewed the Emergency Preparedness plan and these policies and approved these updates as required in this regulation. d) The Emergency Preparedness plan and policies were submitted and approved with these additional updates by the QAPi committee. 4). The Administrator will be responsible to report and update	

monthly at the QAPi committee any ongoing changes or policy needs related to the process of tracking of staff and patients as outlines in this regulation

5).Date of Compliance Sept 14th, 2018

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E 018	Continued From page 3 must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis	E 018		

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E 018	Continued From page 4 facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to develop a policy to track individuals and on-duty staff in the facility's care during an emergency event. The facility staff failed to ensure a policy was in place to track the location of on-duty staff and sheltered individuals who are relocated during the emergency. The findings included; An interview was conducted on 8/8/18 at 10:15 a.m., with the Administrator and Emergency Preparedness Director. The Administrator stated, their system was through The Virginia Healthcare Alerting & Status System (VHASS)*. The Administrator stated he would enter the information in the VHASS tracking system at the time the event occurs or print a face sheet, however, there was no policy that included the tracking system. *VHASS OVERVIEW: This site (info.vhha-mci.org) was created to document the VHASS application functionality, permissions, and system information, it is not the VHASS application. To access the VHASS application go to VHHA-MCI.org Download VHASS Application Overview Overview VHASS is a secure, web-based emergency	E 018		

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E 018	Continued From page 5	E 018		

management system to coordinate and streamline individual and regional health care response to all hazards. Fully interoperable, built -in modules "handshake" with one another to save time, reduce confusion and provide intelligent real-time responses.

System development began early in 2002 with funding from the federal government to enhance the distribution of critical emergency management information needed by Virginia hospitals and health care providers and to help these entities better prepare for and manage mass casualty incidents.

The project has been funded by HHS/AHRQ (HRSA/ASPR programs) and managed by a coordination/collaboration between the Virginia Department of Health and the Virginia Hospital and Healthcare Association.

Early development focused on the need for a communication and collaboration tool for hospital and healthcare workers involved or potentially involved in hospital emergency preparedness activities. The system has grown since that time due to various HRSA, and now ASPR, requirements and ongoing user/organization needs, requirements, and suggestions.

The system was completely re-written and re-deployed in 2017. The new system includes an Events and Situation Reporting module to allow VA Dept. of Public Health and VHHA members to collaborate and share information with Virginia Dept. of Management. The system also includes updates to existing modules with the use of dashboard widgets and responsive design for tablet and mobile applications.

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E 018	Continued From page 6 The system is a robust multifaceted system that helps the Virginia hospital and healthcare infrastructure better prepare, communicate, collaborate, and report conditions and statuses during incidents.	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.	E 020	1. No residents were affected by this practice. 2. Residents residing in the facility could potentially be affected by this practice. 3. The Administrator updated the Emergency Preparedness plan and policies as outlined in this regulation to include: a) Documentation that the emergency preparedness plan includes a policy and procedures for the safe evacuation from the facility as required in this regulation. b) The Emergency Preparedness Safety team reviewed and approved these updates as required in this regulation. c) The Emergency Preparedness plan was submitted and approved with these additional updates by the QAPi committee. 4. The Administrator will be responsible to provide a report and update monthly at the QAPI committee on any ongoing changes or needs related to the process or policies surrounding safe evacuation from the facility as required in this regulation. 5. Date of Compliance Sept 14th, 2018	

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E 020	Continued From page 7 * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the emergency preparedness plan included policy and procedures for the safe evacuation from the facility. The findings included: An interview was conducted on 8/8/18 at 10:15 a.m., with the Administrator and Emergency Preparedness Director. The Administrator was asked for documentation of how the facility would safely evacuate the patients from the facility and how transportation, identification of evacuation locations, care for the residents, and alternate means of communication with external resources and staff responsibilities would be managed. The Emergency Preparedness Director stated if the elevators are down they would sled the patient's down the stairway and (name of the company) would transport the patients to sister facilities or	E 020		

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E 020	Continued From page 8 others who can accept them. The Emergency Preparedness Director escorted the surveyor to the command center where one sled is located. The Emergency Preparedness Director stated the (name of the company) is expected to transport their patients but a contract has not been made for services during an emergency. The facility staff failed to have documentation that the emergency preparedness plan included policy and procedures for the safe evacuation from the facility.	E 020		
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:	E 031	1. No residents were affected by this practice. 2. Residents residing in the facility could potentially be affected by this practice. 3. The Administrator updated the Emergency Preparedness plan to include the requirements as outlined in this regulation as well to include the following: a) Documentation that required emergency official's contacts information included in the communication plan and necessary information was readily assessable to staff in the event of an emergency. b) The Emergency Preparedness and Safety team reviewed the Emergency Preparedness plan and these policies and approved these updates as required in this regulation. c) The Emergency Preparedness plan and policies were submitted and approved with these additional updates by the QAPi committee. 4. The Administrator will be responsible to provide an update monthly at the QAPI committee	

			on any ongoing changes or policy needs related to contacting emergency officials and staff during an emergency. 5. Date of Compliance Sept 14th, 2018	

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E 031	Continued From page 9 (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on review of the facility's emergency preparedness plan and staff interview, the facility failed to ensure documentation that all required emergency official's contacts information included in the communication plan and was readily assessable to staff in the event of an emergency . The findings include: An interview was conducted on 8/8/18 at 10:15 a.m., with the Administrator and Emergency Preparedness Director. The Administrator present a card with emergency official numbers provided by VHASS and stated the VHASS representative stated to keep the information beside his telephone in his office and it would be accepted by the surveyor. At 4:20 P.M., the Administrator stated the nursing supervisor would have access to all Emergency Preparedness information when he wasn't present. An interview was requested with the nurse supervisor and she was contacted by the Administrator. The Administrator spoke to the nurse supervisor by phone and stated she told him she didn't desire to get involved or talk to a surveyor. The emergency official's contact information was not included in the communication plan.	E 031		
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 10 An unannounced Medicare/Medicaid standard survey was conducted 8/7/18 through 8/9/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 24 certified bed facility was 16 at the time of survey. The survey sample consisted of 9 Current Resident reviews (Residents #2, #5, #7, #8, #11, #12, #15, #67, and #69) and 3 closed record reviews (Residents #17 through 19).	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	1) Resident ,#7, Resident #8, Resident #11, Resident #12, and Resident #2's care plans were reviewed and revised to include Person-Centered Comprehensive Care Plans in activities. 2) Residents residing in the facility could potentially be affected by this practice. a) Care plans were reviewed and updated as needed for those residents currently residing in the facility to include person centered-comprehensive care plans in activities. 3) A monthly review/audit of Care plans to include person centered comprehensive care plans in activities will be conducted by the Director of Nursing or designee. 4) The results of the monthly review of care plans will be reviewed by	

			the Director of Nursing /Designee. The DON/Designee will be responsible to report these findings to QAPI monthly for 3 months to assure and maintain compliance. 5) The Date of Compliance is Sept, 7th, 2018	

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F 656	Continued From page 11 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and facility document review the facility staff failed to ensure the Person-Centered Comprehensive Care Plan was complete to include Activities for 5 of 12 Residents in the survey sample, Resident #7, Resident #8, Resident #11, Resident #12, and Resident #2. 1. The facility staff failed to ensure that Resident #7's Person-Centered Comprehensive Care Plan dated 7/25/18 was complete to include Activities. 2. The facility staff failed to ensure that Resident #8's Person-Centered Comprehensive Care Plan dated 7/25/18 was complete to include Activities. 3. The facility staff failed to ensure that Resident #11's Person-Centered Comprehensive Care	F 656		

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Plan dated 7/31/18 was complete to include Activities.

4. The facility staff failed to ensure that Resident #12's Person-Centered Comprehensive Care Plan dated 7/24/18 was complete to include Activities.

5. The facility staff failed to ensure that Resident #2's Person-Centered Comprehensive Care Plan dated 6/26/18 was complete to include Activities.

The findings included:

1. Resident #7 was a 67 year admitted to facility on 7/13/18 with diagnoses to include (1.) Diabetes Mellitus and (2.) Fractured Tibia.

The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission 5-Day with an Assessment Reference Date (ARD) of 7/20/18. The Brief Interview for Mental Status (BIMS) was a 14 out of a possible 15 which indicated that Resident #7 was cognitively intact and capable of daily decision making. Under Section F Preferences for Customary Routine and Activities Resident #7 was coded as being "Very Important" to her for the following activities: listening to music she liked, being around pets, keeping up with the news, doing things with groups pf people, doing favorite activities, and going outside for fresh air. Under Section F Preferences for Customary Routine and Activities Resident #7 was coded as being "Somewhat Important" to her for the following activities: having books, newspapers, and magazines to read, and to participate in religious services.

Resident #7's Person-Centered Comprehensive

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Care Plan dated 7/25/18 was reviewed. There was no Activity focus, goal, or planned interventions initiated on Resident #7's Person-Centered Comprehensive Care Plan.

On 08/08/18 5:15 PM An interview was conducted with the MDS Coordinator regarding Resident #7's Person-Centered Comprehensive Care Plan dated 7/25/18. The MDS Coordinator was asked if a activities care plan had been initiated for the resident. The MDS Coordinator stated, "I do not see a activity care plan in their comprehensive care plan." Surveyor then asked who was responsible for initiating the activities care plan for the residents. The MDS Coordinator stated, "The Activities Director did it before she left and I was supposed to be responsible for doing the Activities care plan after she left. Activities should be included in the Comprehensive care plan."

On 08/08/18 at 5:35 P.M. and interview was conducted with the Director of Nursing. The Director of Nursing was asked if Resident #7's Person-Centered Comprehensive Care Plan should have included activities. The Director of Nursing stated, "Yes, activities should be included on the care plan."

The facility policy titled, "Care Plans-Resident Centered" effective date May 2018 was reviewed and is documented in part, as follows:

Purpose: To provide necessary care planning that results in care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being consistent with the resident comprehensive assessment and plan of care and based on regulations as outlined in the

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F 656	Continued From page 14 2016 Final Rule. Procedure: 1. The care plan will be driven by identified resident issues and conditions and by resident's unique characteristics, strengths and needs. 4. The care plan will include the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 8. A comprehensive person-centered care plan will be developed within 7 days after completion of the comprehensive assessment and will include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 9. The care plan will be prepared with the input of the interdisciplinary team which includes but is not limited to: a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a case manager or social worker, the attending physician, a member of food and nutrition services staff and a member of the activities staff. A pre-exit debriefing was conducted on 8/9/18 at 4:50 P.M. with the Administrator and the Director of Nursing where the above information was shared. No further information was provided by the facility. 2. Resident #8 was a 69 year admitted to facility on 7/17/18 with diagnoses to include (1.) Congestive Heart Failure and (2.) Hypertension.	F 656		

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F 656	Continued From page 15 The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with a Assessment Reference Date (ARD) of 7/24/18. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #8 was cognitively intact and capable of daily decision making. Under Section F Preferences for Customary Routine and Activities Resident #8 was coded as being "Very Important" to her for the following activities: listening to music she liked, being around pets, keeping up with the news, doing things with groups pf people, doing favorite activities, to participate in religious services and going outside for fresh air. Under Section F Preferences for Customary Routine and Activities Resident #8 was coded as being "Somewhat Important" to her for the following activities: having books, newspapers, and magazines to read. Resident #8's Person-Centered Comprehensive Care Plan dated 7/25/18 was reviewed. There was no Activity focus, goal, or planned interventions initiated on Resident #8's Person-Centered Comprehensive Care Plan. On 08/08/18 5:15 PM An interview was conducted with the MDS Coordinator regarding Resident #8's Person-Centered Comprehensive Care Plan dated 7/25/18. The MDS Coordinator was asked if a activities care plan had been initiated for the resident. The MDS Coordinator stated, "I do not see a activity care plan in their comprehensive care plan." Surveyor then asked who was responsible for initiating the activities care plan for the residents. The MDS Coordinator stated, "The Activities Director did it before she left and I was supposed to be responsible for doing the Activities care plan after	F 656		

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she left. Activities should be included in the Comprehensive care plan."

On 08/08/18 at 5:35 P.M. and interview was conducted with the Director of Nursing. The Director of Nursing was asked if Resident #8's Person-Centered Comprehensive Care Plan should have included activities. The Director of Nursing stated, "Yes, activities should be included on the care plan."

A pre-exit debriefing was conducted on 8/9/18 at 4:50 P.M. with the Administrator and the Director of Nursing where the above information was shared. No further information was provided by the facility.

3. Resident #11 was a 54 year admitted to facility on 7/11/18 with diagnoses to include (1.) Right Wrist Fracture and (2.) Hypertension.

The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with a Assessment Reference Date (ARD) of 7/12/18. The Brief Interview for Mental Status (BIMS) was a 14 out of a possible 15 which indicated that Resident #11 was cognitively intact and capable of daily decision making. Under Section F Preferences for Customary Routine and Activities Resident #11 was coded as being "Very Important" to her for the following activities: being around pets, keeping up with the news, doing things with groups pf people, doing favorite activities, and going outside for fresh air. Under Section F Preferences for Customary Routine and Activities Resident #11 was coded as being "Somewhat Important" to her for the following activities: having books, newspapers, and magazines to read, listening to music, and to

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F 656	Continued From page 17 participate in religious services. Resident #11's Person-Centered Comprehensive Care Plan dated 7/31/18 was reviewed. There was no Activity focus, goal, or planned interventions initiated on Resident #11's Person-Centered Comprehensive Care Plan. On 08/08/18 5:15 PM An interview was conducted with the MDS Coordinator regarding Resident #11's Person-Centered Comprehensive Care Plan dated 7/31/18. The MDS Coordinator was asked if a activities care plan had been initiated for the resident. The MDS Coordinator stated, "I do not see a activity care plan in their comprehensive care plan." Surveyor then asked who was responsible for initiating the activities care plan for the residents. The MDS Coordinator stated, "The Activities Director did it before she left and I was supposed to be responsible for doing the Activities care plan after she left. Activities should be included in the Comprehensive care plan." On 08/08/18 at 5:35 P.M. and interview was conducted with the Director of Nursing. The Director of Nursing was asked if Resident # 11's Person-Centered Comprehensive Care Plan should have included activities. The Director of Nursing stated, "Yes, activities should be included on the care plan." A pre-exit debriefing was conducted on 8/9/18 at 4:50 P.M. with the Administrator and the Director of Nursing where the above information was shared. No further information was provided by the facility. 4. Resident #12 was a 70 year admitted to facility	F 656		

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F 656	Continued From page 18 on 7/5/18 with diagnoses to include (1.) Diabetes Mellitus and (2.) Hypertension. The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with a 5-Day with an Assessment Reference Date (ARD) of 7/24/18. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #12 was cognitively intact and capable of daily decision making. Under Section F Preferences for Customary Routine and Activities Resident #12 was coded as being "Very Important" to her for the following activities: having books, newspapers, and magazines to read, listening to music she liked, doing things with groups pf people, doing favorite activities, to participate in religious services and going outside for fresh air. Under Section F Preferences for Customary Routine and Activities Resident #8 was coded as being "Somewhat Important" to her for the following activities: being around pets and keeping up with the news Resident #12's Person-Centered Comprehensive Care Plan dated 7/24/18 was reviewed. There was no Activity focus, goal, or planned interventions initiated on Resident #12's Person-Centered Comprehensive Care Plan. On 08/08/18 5:15 PM An interview was conducted with the MDS Coordinator regarding Resident #12's Person-Centered Comprehensive Care Plan dated 7/24/18. The MDS Coordinator was asked if a activities care plan had been initiated for the resident. The MDS Coordinator stated, "I do not see a activity care plan in their comprehensive care plan." Surveyor then asked who was responsible for initiating the activities care plan for the residents. The MDS	F 656		

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Coordinator stated, "The Activities Director did it before she left and I was supposed to be responsible for doing the Activities care plan after she left. Activities should be included in the Comprehensive care plan."

On 08/08/18 at 5:35 P.M. and interview was conducted with the Director of Nursing. The Director of Nursing was asked if Resident #12's Person-Centered Comprehensive Care Plan should have included activities. The Director of Nursing stated, "Yes, activities should be included on the care plan."

A pre-exit debriefing was conducted on 8/9/18 at 4:50 P.M. with the Administrator and the Director of Nursing where the above information was shared. No further information was provided by the facility.

5. Resident #2 was admitted to the facility on 6/26/18 with diagnoses that include but are not limited to laminectomy with spinal fusion (surgical procedure to fuse the some of the bones of the spine), Multiple sclerosis, low back pain, diabetes Type 2, and hypertension (high blood pressure).

A comprehensive MDS 3.0 (Minimum Data Set) was completed with an ARD (Assessment Reference Date) of 7/3/18 for Resident #2. A BIMS (Brief Interview for Mental Status) coded Resident #2 with no cognitive impairment. Under the section titled Preferences and Customary Routines was a list of activity preferences: Resident #2's responses were coded as "very important" to have books, newspapers, and magazines to read, listen to music you like, be around animals such as pets, do things with groups of people, do your favorite activities, go outside to get fresh air when the weather is good,

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and participate in religious services or practices.

A review of Resident #2's care plan which was prepared on 6/26/18 noted no problems, goals, or implementation strategies, to address needs for activities to enhance his psychosocial well-being.

On 8/8/18 at 5:09 PM MDS RN# 1 was interviewed. MDS coordinator RN# 1 reviewed the comprehensive care plan for Resident #2. She stated "there is no activities care plan for [Resident #2]". When asked what the process includes for preparing the person centered care plan she stated "the previous activities director did the activities care plan," and when she left "I was supposed to write the activities care plan now. I failed to put an activities care plan in place." When asked how she identifies the person centered needs she stated it is on the MDS, and "if it didn't trigger in the CAA's [Care Area Assessment- indicated the need for additional assessment based on problems identified during the assessment, known as trigger care areas] I didn't trigger for activities."

On 8/8/18 at 5:20 PM an interview with the DON (director of Nursing) was conducted. When asked to review Resident #2's care plan, she commented that "he doesn't have a care plan for activities and he should have one."

A review of the facility policy titled Care Plans - Resident Centered, effective date May 2018 included:

Purpose: To provide necessary care planning that results in care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being consistent with the

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F 656	Continued From page 21 resident comprehensive assessment and plan of care and based on regulations as outlined in the 2016 Final Rule. Procedure: 1. The care plan will be driven by identified resident issues and conditions and by resident's unique characteristics, strengths and needs. 4. The care plan will include the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 8. A comprehensive person-centered care plan will be developed within 7 days after completion of the comprehensive assessment and will include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 9. The care plan will be prepared with the input of the interdisciplinary team which includes but is not limited to: a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a case manager or social worker, the attending physician, a member of food and nutrition services staff and a member of the activities staff. An exit conference with the administrator and DON was conducted on 8/9/18 at 4:50 PM and no further information was provided.	F 656		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be	F 680	1. There were no residents specifically cited in this regulation. a) A Qualified Activity Professional has since been hired and is on staff at the facility. The Qualified Activity Professional/Director	

meets the qualifications as outlined in this regulation.

2. Residents residing in the facility could potentially be affected by this practice.
   a) The Activity Professional/Director will be introduced to current residents residing in the facility.
3. The Activity Professional will coordinate and oversee the activity department and the identified needs of the residents.
   a) The activity calendar and notes/ logs will be directed daily by the Activity Professional.
   b) The Activity professional will complete a monthly report of the activities and feedback from the residents. This report will be provided to the Administrator.
4. The Activity Professional will report findings of the monthly report of Activities to the Administrator. The Administrator will be responsible to report to QAPI monthly for three months to assure and maintain compliance.
5. Date of Compliance Sept 7th, 2018.

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F 680	Continued From page 22 directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and facility document review the facility staff failed to ensure that their activities program was being directed by a qualified professional. The facility staff failed to ensure that the activities program was directed by a qualified therapeutic recreation specialist or an activities professional who-Is licensed or registered, if applicable, by the State in which practicing; and Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D)	F 680		

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F 680	Continued From page 23 Has completed a training course approved by the State. The findings included: During the initial tour the facility Activity Calendar was observed in some resident rooms and a large bulletin board Activities Calendar was noted in the hallway past the nurse's station. The August calendar showed a daily activity on Mondays at 11 AM which was "Music with David (Guitar), Tuesdays, from 10 AM to 12 PM was "Leisure Activity", Wednesdays from 10 AM to 12 PM alternated every other week between "Coffee & News" to "Sittercise", Thursdays from 10 AMto 12 PM was "Movie Day!" and Fridays from 10 AM to 12 PM alternated every other week between "Free Friday" to "Bingo" with no other planned activity times noted. On Saturday and Sundays the activity was "Leisure a la mode" with no time identified. On 8/7/18 at 3:10 PM the Administrator was asked who the Activities Director was. The Administrator stated, "We just hired a new Activities Director and she was in orientation yesterday and would be back Friday of this week." The Administrator was then asked how long he had been without an Activities Director and who had been doing activities with the residents in the meantime. The Administrator stated, "The last Activities Director left the end of June and we have had a hard time finding a replacement. Since she has been gone the Rehab. (Rehabilitation) Tech has been covering activities." The Activity Participation Logs for the end of June, July, and August were reviewed. There	F 680		

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F 680	Continued From page 24 were on Activity Participation Logs for Mondays, Wednesdays, and Fridays. On 8/8/18 at 2:45 P.M. and Interview was conducted with the Rehab. Tech with the Administrator present. The Rehab. Tech was asked verbatim from the State Operations Manual is she was a qualified therapeutic recreation specialist or an activities professional who-Is licensed or registered, if applicable, by the State in which practicing; and Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. The Rehab. Tech stated, "No, I ' m none of those." Facility documentation provided from the Administrator indicated the last Activities Director ended employment with the facility on 6/25/18 and the new facility Activities Director will be testing for certification on 9/17/18. The facility "Job Description for Activities Manager" was reviewed and is documented in part, as follows: II. Employment Qualifications: Graduated from a college or university with major studies in therapeutic recreation or related field, or an equivalent combination of training and experience is preferred. Completion of the 40 hours training to meet the requirements of the	F 680		

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	495346	A. BUILDING _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 680	Continued From page 25 National Certification Council for Activity Professionals will be necessary. A pre-exit debriefing was conducted on 8/9/18 at 4:50 P.M. with the Administrator and the Director of Nursing where the above information was shared. No further information was provided by the facility.	F 680		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761	1) There were no specific residents cited in this citation. a) All identified medications were immediately removed and disposed of according to regulation to assure appropriate labeling and storage as identified in this regulation. 2) Residents residing in the facility could potentially be affected by this practice. 3) The policy and practice of labeling/storage of medications were reviewed with the pharmacist and revised as needed. a) The practice of labeling has been revised to include dating when opening. b) An audit will be conducted weekly by the DON or designee to validate labeling of open medication and most specifically vials. 4) The DON or designee will provide the weekly medication audit findings to the Administrator. The Administrator will be responsible to report these findings to QAPI monthly	

for three months to assure and maintain compliance.

5) Date of Compliance Sept 7th, 2018

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F 761	Continued From page 26 Based on observations, staff interviews, manufacture guidelines and facility documentation the facility staff failed to ensure that 3 medications were stored according to manufacture recommendations . The facility staff failed to date 3 bottles of Xalatan 0.005% ophthalmic solution when opened to ensure they would be discarded within 6 weeks based on manufacturer recommendations . The findings included: On 08/08/18 at 9:46 AM the the facility's only medication room was inspected. In the locked refrigerator 3 open bottles of Xalatan 0.005% ophthalmic solution Lot# 292601F were observed not dated. The Pharmacist was in the medication room and was asked who was responsible for dating the bottles when opened. The Pharmacist stated, "The nurse that opens the bottle is responsible for dating it." The Director of Nursing was asked when and who should have dated the Xalatan 0.005% ophthalmic solution bottles. The Director of Nursing stated, "The nurse that opens the bottle should date it when she opens it." The manufacture recommendations for Xalatan 0.005% ophthalmic solution were reviewed and are documented in part, as follows: Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees Celsius for 6 weeks. The facility policy titled "Proper Storage and Security of Medications" last revised on 1/2016 was reviewed and is documented in part, as follows:	F 761		

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F 761	Continued From page 27 Purpose: To ensure proper security and storage of medications under proper manufacturer recommended conditions to ensure stability. Policy: All medications throughout "Facility Name" must be procured, stored, administered, monitored and disposed of according to Federal, State, Local guidelines and laws as well as standards of accrediting institutions. This is to be carried out by all faculty and staff who order , dispense, and administer medications to patients. Procedure: 6. Medications are stored underconditions suitable for product stability. 7. No medications are expired. A pre-exit debriefing was conducted on 8/9/18 at 4:50 P.M. with the Administrator and the Director of Nursing where the above information was shared. No further information was provided by the facility staff.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812	1) There were no residents identified in this citation. a) The food that was identified in this citation was immediately removed and disposed of. b) The areas identified for additional cleaning were scheduled for immediate cleaning. 2) Residents residing in the facility could potentially be affected by this practice. 3) An audit was developed and will be conducted by Dietary manager or designee to include : a) Walk through validation of food storage/disposal according to dates weekly for 3 months and then randomly	

thereafter
b) Walk through validation of cleanliness and cleaning schedules weekly for 3 months and then randomly thereafter

4) The Dietary Manager/designee will provide a report monthly to the Administrator on the findings of the kitchen audit. The Administrator will report to QAPI monthly for three months the findings of the Dietary /kitchen Audit to assure and maintain compliance.
5) The Date of Compliance is Sept 7th, 2018

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F 812	Continued From page 28 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy review, the facility failed to maintain sanitary conditions for the preparation of food, and failed to properly discard foods on or before the discard dates. The facility staff failed to maintain sanitary conditions of the oven, tilt skillet, for the preparation of food, and failed to properly discard foods on or before the discard dates. On 08/07/18 at 12:45 PM Initial tour of the kitchen was conducted accompanied by the food service director and chef. On 8/7/18 at 1:00 PM a tour of the produce walk-in cooler was conducted. Located on the wire rack was a covered bowl of tomato soup with an orange sticker. The sticker noted: prepared "today" date of 8/3/18 and "use by" date of 8/6/18. The director was asked to explain his expectation for the safe storage of food prepared for residents. The director explained that the orange sticker on the food products indicated to kitchen staff "the first date [on the orange sticker] the food product is opened or prepared and the second date is the discard date". He stated that "the soup should have been discarded on the 6th."	F 812		

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F 812	Continued From page 29 On 8/7/18 at 1:10 PM a tour of the meat walk-in refrigerator noted a plastic tub container of banana muffin batter with an orange sticker which noted "opened" on 7/5/18 and "use by" date of 8/5/18. Asked the director what his expectation was for the safe storage of open food and he responded that the muffin batter "should have been discarded on the 5th". During the same tour of the kitchen a large amount of built up, of brown and black grease was noted on the oven walls, oven racks, and doors. An examination of the tilt skillet (large pan used in industrial kitchens to braise food) noted dark brown grease completely covering the two hinges at the rear of the skillet lid and dripping grease build up along the front panel. The director was asked to explain the process for cleaning these pieces of food preparing equipment. He stated he "hires someone to come in every 2 weeks to do a deep cleaning of the bigger equipment like the ovens and tilt skillet". When we looked together at the oven and skillet he acknowledged there is significant buildup of grease. The director and chef sated it looks like "more than 2 weeks' worth of grease". On 8/7/18 at 1:40 PM during the same tour the floor around the oven and tilt skillet was noted to have a significant amount of food particles, and dirt which was build up on the floor and the wall behind the equipment. When the director was asked about the cleaning schedule for the kitchen floor he stated "they are buying a floor machine to use daily." He acknowledged that the floor was dirty. He stated the floors get cleaned daily between 4-4:30 PM daily. The chef moved a table away from the wall and stated" this is old dirt, the food on the floor is from today, we had	F 812		

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F 812	Continued From page 30 fajitas." 08/08/18 1:24 PM a review of the facility kitchen policy #B004 titled: PRODUCTION, PURCHASING, STORAGE with the revision date 1/2014. Subject: "Most products contain an expiration date. The words "sell by" or "use by" should precede the date. The "sell by" date is the last date that the food can be sold; do not sell products in the retail areas or place on patient trays/resident plates past the date on the product." "Cover, label, and date unused portions and open packages. Use the [facility contracted food service company] orange label; complete all sections on the label." Refer to the Food Storage Chart in this policy to determine discard dates for food items." A review of the Food Storage Chart noted the following: "Unused portions of food prepared on site that are reheated for service, such as rice, vegetables, soups, gravies, and meat sauces - discard after 3 days." An exit conference with the administrator and DON was conducted on 8/9/18 at 4:50 PM and no further information was provided.	F 812		

Bon Secours

Bon Secours
DePaul Medical Center

August 23, 2018

Ms. Veuhoff,

Enclosed is our plan of correction for our most recent unannounced annual state survey. If you have any questions or concerns please let me know. I can be reached directly at 757-889-5875 or by e-mail at tyler_young@bshsi.org . Thank you for your assistance.

Sincerely,

Tyler Young, Administrator

Transitional Care Unit
150 Kingsley Lane
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p: 757-889-3200 f: 757-889-3288