AND PLAN O	IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		495346	B. WING			8/00/2040
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505		8/09/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 015 SS=C	survey was conduct Corrections are req CFR Part 483.73, R Care Facilities. No complaints were inv Subsistence Needs CFR(s): 483.73(b)(1) [(b) Policies and prodevelop and implem policies and procediplan set forth in para assessment at para and the communica this section. The poreviewed and update minimum, the policies address the following: (1) The provision of and patients whether place, include, but an (i) Food, water, med supplies (ii) Alternate sources following: (A) Temperatures safety and for the safety and for the safety and for the safety and for the safety and some supplies. (B) Emergency lig (C) Fire detection, systems. (D) Sewage and v	procedures. [Facilities] must be nent emergency preparedness sures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be end at least annually.] At a less and procedures must g: subsistence needs for staff or they evacuate or shelter in the net limited to the following: ical and pharmaceutical is of energy to maintain the to protect patient health and fe and sanitary storage of htting. extinguishing, and alarm waste disposal.	E 01	The statements made on this pla are not an admission to and do n agreement with the alleged defici. To remain in compliance with all federal regulations, the center ha actions set forth in the following procorrection. The following plan of constitutes the centers allegations compliance. All alleged deficienci or will be corrected by the date in the could potentially be affected practice. 1. No residents were affected practice. 2. Residents residing in the faculd potentially be affected practice. 3. The emergency preparedness reviewed and updated Administrator to ensure: a) A system was in place communicating provision subsistence needs for individuals. b) A process was determined ocumented and implest to determine supply nealternate energy source outlined in this regulation. c) The Emergency Preparage Safety team reviewed a approved these updates required in this regulation. d) The Emergency Preparage plan was submitted and approved with these adapproved with the committee. 4. The Administrator will be responsible to report and upmonthly at the QAPI committee. 4. The Administrator will be responsible to report and upmonthly at the CAPI committee. 5. Date of Compliance Sept 14	ot constitute an encies herein. state and state and staken the plan of correction s of es have been dicated by this ess plan by the for on of staff and es as on. aredness and es as on. redness diditional podate aff and aftes	RECEIVED AUG 24 2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES 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

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

Event ID: EBOI11

Facility ID: VA0295

If continuation sheet Page 1 of 31

PRINTED: 08/17/2018

FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495346		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BON SECOURS DEPAUL,TCC		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505	0	08/09/2018	
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING IN	ED BY ELLI	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	IOUI D BE	(X5) COMPLETION DATE	
Continued From page 1 (6) The following are additional requir hospice-operated inpatient care facilit The policies and procedures must additional following: (iii) The provision of subsistence need hospice employees and patients, whe evacuate or shelter in place, include, it limited to the following: (A) Food, water, medical, and pharm supplies. (B) Alternate sources of energy to not following: (1) Temperatures to protect patient and safety and for the safe and sanitary of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, a systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as eviby: Based on review of the facility's emergency preparedness plan and staff interview, staff failed to ensure policies were in ple provision of subsistence needs for staff individuals. The facility staff failed to document their needs and alternate energy sources nemaintain temperatures to protect patient and safety, lighting, fire detection, the asystem, sewage and waste disposal duemergency. The findings included: An interview was conducted on 8/8/18 a.m., with the Administrator and Emergency. The paredness (EP) Director. There was	dress the dress	EO	15			



STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MILL	TIDI E AGUI		OMB N	O. 0938-039
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		495346	B. WING				
BON SECOURS DEPAUL,TCC			150 KIN	ADDRESS, CITY, STATE, ZIP CODE	08	3/09/2018	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		NORFO	DLK, VA 23505		
PRÉFIX TAG	(EACH DELICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
E 018	systems as well as se The Administrator stat would deliver more fue 2.5 days' worth of fuel has, however there was support what was state	nonstrate their supply seuticals, medical supplies, g extinguishing and alarm wage and waste disposal. ted (name of fuel supplier) el prior to exhausting the the generator currently as no documentation to		015 18 E 018			
i i i i i i i i i i i i i i i i i i i	policies and procedure plan set forth in paragra assessment at paragra and the communication this section. The policies reviewed and updated minimum, the policies address the following: (2) A system to track the and sheltered patients is an emergency. If on-dubatients are relocated difficultity] must document ocation of the receiving [For PRTFs at §441.18 CF/IIDs at §483.475(b) Policies and procedures ocation of on-duty staff the [PRTF's, LTC, ICF/I and after an emergency sheltered residents are	e location of on-duty staff in the [facility's] care during ty staff and sheltered luring the emergency, the ithe specific name and ifacility or other location. 64(b), LTC at §483.73(b), , PACE at §460.84(b):] is. (2) A system to track the and sheltered residents in ID or PACE] care during if on-duty staff and		1) 2) 3)	this practice. Residents residing in the facility could potentially be affected by this practice. A policy was developed to include following requirements as outline specified in this regulation to include 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.	d and lude	



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	PRINTED: 08/17/2018 FORM APPROVED
	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 14 th , 2018

AND PLAN O	N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF F	DDOU/DED OF OUTPUT	495346	B. WING_			08/09/2018
BON SEC	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 150 KINGSLEY LANE NORFOLK, VA 23505	DE	00/00/2010
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	must document the sign the receiving facility of the receiving facilities; transpersation of the receiving facilities; transpevacuation location of the receiving facilities of the receiving faci	pecific name and location of or other location. De at §418.113(b)(6):] Tres.	EC	018		



PRINTED: 08/17/2018 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(2/0) 10 11		OME	NO. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495346	B. WING			00/00/0040
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 150 KINGSLEY LANE NORFOLK, VA 23505	Œ	08/09/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION DATE
E 018	facility, which include needs of the patients This REQUIREMENT by: Based on review of t preparedness plan ar staff failed to develop and on-duty staff in the emergency event. The facility staff failed place to track the local sheltered individuals we emergency. The findings included An interview was conda.m., with the Administ Preparedness Director their system was through Alerting & Status System Administrator stated information in the VHA time the event occurs however, there was not tracking system. *VHASS OVERVIEW:	is not met as evidenced the facility's emergency and staff interview, the facility a policy to track individuals the facility's care during an all to ensure a policy was in ation of on-duty staff and who are relocated during the ducted on 8/8/18 at 10:15 strator and Emergency for. The Administrator stated, sugh The Virginia Healthcare them (VHASS)*. The the would enter the ASS tracking system at the for print a face sheet, to policy that included the ci.org) was created to application functionality, them information, it is not the to access the VHASS A-MCI.org Download verview	E 018			

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

Event ID: EBOI11

Facility ID: VA0295

If continuation sheet Page 6 of 31



I IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495346	B. WING _			09/09/2049
NAME OF PROVIDER OR SUPPLIER BON SECOURS DEPAUL,TCC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP COI 150 KINGSLEY LANE NORFOLK, VA 23505		08/09/2018	
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	management system streamline individual response to all haza-in modules "handsh save time, reduce contelligent real-time response to all haza-in modules "handsh save time, reduce contelligent real-time response to all haza-in modules "handsh save time, reduce contelligent real-time response to an all the distribution of critical management information hospitals and health these entities better mass casualty incided. The project has been (HRSA/ASPR prograte coordination/collabor Department of Health and Healthcare Associated to the system and healthcare worked involved in hospital experiments. The system was communication and one meeds, requirements and one meeds, requirements. The system was common re-deployed in 2017. Events and Situation VA Dept. of Public Hecollaborate and shared Dept. of Management updates to existing medical situation of the system was compared to the	and regional health care rds. Fully interoperable, built ake" with one another to onfusion and provide esponses. It began early in 2002 with eral government to enhance tical emergency ation needed by Virginia care providers and to help prepare for and manage ents. In funded by HHS/AHRQ ams) and managed by a ration between the Virginia and the Virginia Hospital ciation. In cused on the need for a collaboration tool for hospital ers involved or potentially mergency preparedness and has grown since that time and now ASPR, going user/organization and suggestions. In pletely re-written and The new system includes an Reporting module to allow ealth and VHHA members to expect the properties of the responsive design for	EO	18		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495346	B. WING		0.0	10010010
NAME OF PROVIDER OR SUPPLIER BON SECOURS DEPAUL, TCC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	STREET ADDRESS, CITY, STATE 150 KINGSLEY LANE NORFOLK, VA 23505	, ZIP CODE	3/09/2018	
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E 018	The system is a robu helps the Virginia hos infrastructure better p	est multifaceted system that spital and healthcare prepare, communicate, ort conditions and statuses	E 0			
SS=C	CFR(s): 483.73(b)(3) [(b) Policies and procedure policies and procedure plan set forth in paragrament at parag	redures. 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 cies and procedures must be d at least annually. At a sand procedures must if the [facility], which includes and treatment needs of insibilities; transportation; ation location(s); and means of communication of assistance. 748(b)(3) and ASCs at the [RNHCI or ASC] which includes and treatment incomplete inco		practice. 2. Residents residi potentially be aff as The Administrate Emergency Prepolicies as outlininclude: a) Documental preparedner policy and pevacuation required in the boundary of the Emergency Safety tear approved the required in the control of the Emergency plan was sure with these and the QAPI control of the QAPI commining changes or need process or policie evacuation from in this regulation.	paredness plan and ned in this regulation to the din this regulation to the din this regulation to the safe from the facility as this regulation. The properties and the safe from the facility as this regulation. The properties and the safe provided and the safe from the facility as required to the facil	



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	l l l l l l l l l l l l l l l l l l l	A. BUILD	ING		MPLETED	
NAME OF PROVIDER OR SUPPLIER		B. WING			08/00/0040	
BON SECOURS DEPAUL,TCC			STREET ADDRESS, CITY, STATE 150 KINGSLEY LANE NORFOLK, VA 23505	TE, ZIP CODE	08/09/2018	
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* [For RHCs/FQHCs a evacuation from the R appropriate placement responsibilities and ne This REQUIREMENT by: Based on record revie facility staff failed to ha emergency preparedne and procedures for the facility. The findings included: An interview was condua.m., with the Administr Preparedness Director. asked for documentatic safely evacuate the pat how transportation, ideal locations, care for the remeans of communication and staff responsibilities Emergency Preparednese levators are down they down the stairway and	the [CORF; Clinics, es, and Public Health of Outpatient Physical Language Pathology Facilities], which includes and needs of the patients. At §491.12(b)(1):] Safe CHC/FQHC, which includes to fexit signs; staff eds of the patients. At safe sevidenced EW and staff interview, the ave documentation that the ess plan included policy as afe evacuation from the sex of how the facility and intification of evacuation esidents, and alternate on with external resources is would be managed. The ess Director stated if the yould sled the patient's	E	020			

NAME OF PROVIDER OR SUPPLIER #95346 #95346 **BUILDING** A. BUILDING** A. BUILDING** A. BUILDING** A. BUILDING** STREET ADDRESS, CITY, STATE, ZIP CODE 190 KINGSLEY LANE **NORPOLK, VA 23805 PROVIDER'S ILAN OF CORRECTIVE ADTON POLICE (EACH OPERCIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 031 E 031 E 031 E 031 E 031 I. No residents were affected by this practice. CFR(s): 483.73(c)(2) E 031 E 031 I. No residents were affected by this practice. The Administrator updated the Emergency Preparedness and soutlined in this regulation as well to include 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: 10	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII T	IDI E OOUE		OMB N	IO. 0938-039	
BON SECOURS DEPAUL, TCC BUMMARY STATEMENT OF DEFICIENCIES PREDIX SUMMARY STATEMENT OF DEFICIENCIES PREDIX SUMMARY STATEMENT OF DEFICIENCIES PREDIX SUMMARY STATEMENT OF DEFICIENCIES PREDIX REGULATORY OR LSC IDENTIFYING INFORMATION) 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 031 Emergency Officials Contact Information SS=C 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: **The facility assessable to staff in the event of an emergency. **The Administrator updated the communication plan and necessary information included in the communication plan and necessary information was readily assessable to staff in the event of an emergency. **The Administration and the required emergency preparedness and staff in the event of an emergency. **The Administration develop and maintain an emergency preparedness staff. (ii) Other sources of assistance.	THE STATE OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
BON SECOURS DEPAUL,TCC (24) ID PREFIX TAGS SUMMARY STATEMENT OF DEFICIENCIES (PREFIX NOTES) EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) 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 031 Emergency Officials Contact Information CFR(s): 483.73(c)(2) E mergency 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: (3) 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: 10) The Emergency Preparedness and services during an emergency. 11) No residents were affected by this practice. 22. 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: (2) Contact information for the following: (3) Documentation that required emergency preparedness staff. (ii) Other sources of assistance.	NAME OF	DDO/ (DDD)	495346	B. WING _					
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 preparedness plan included policy and procedures for the safe evacuation from the facility. E 031 E(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: (3) Contact information for the following: (4) Contact information for the following: (5) Contact information for the following: (6) Federal, State, tribal, regional, and local emergency preparedness staff. (6) Other sources of assistance. (7) For LTC Facilities at §483.73(c):] (2) Contact information for the following: (8) Contact information for the following: (9) The Emergency Preparedness and information for the following: (10) The Facilities at §483.73(c):] (2) Contact information for the following: (11) PREFIX PREFIX DEMCHORECTOR (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO HEAPPROPRIATE (12) PREFIX PREFIX DEMCHORECTOR (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (12) PREFIX PREFIX DEMCHORECTOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (13) PREFIX PREFIX PROPRIATE (14) PREFIX PROPRIATE (15) CONTACT PROPRIATE (16) PREFIX PROPRIATE (17) PREFIX PROPRIATE (18) PREFIX PROPRIATE (18) PREFIX PROPRIATE (18) PROPRIATE APPROPRIATE (18) PREFIX PROPRIATE (18) PROPRIATE APPROPRIATE (18) PREFIX PROPRIATE (18) PROPRIATE APPROPRIATE (18) CONTACT PROPRIATE (18) PREFIX PROPRIATE (18) PREFIX PROPRIATE (18) PROPRIATE APPROPRIATE (18) PROPRIATE					150 KING	GSLEY LANE	08	3/09/2018	
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 031 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. Terro LTC Facilities at §483.73(c):] (2) Contact information for the following: The Emergency Preparedness and SEO 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. The Emergency Preparedness and The Emergency Preparedness and	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY ELLI	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) DE	(X5) COMPLETION DATE	
(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: *Catety 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	E 031 SS=C	others who can access Preparedness Direct the command center. The Emergency Preparedness Direct the command center. The Emergency Preparedness during an their patients but a conformation for services during and their patients but a conformation for services during and procedures for the emergency preparedness of the emergency Officials (CFR(s): 483.73(c)(2)) [(c) The [facility] must emergency preparedness with Fedand must be reviewed annually.] The communall of the following: (2) Contact information (i) Federal, State, tremergency preparedness at information for the following transported in the state Licensing (iii) The State Licensing (iii) The Office of the Sombudsman. (iv) Other sources of a *[For ICF/IIDs at §483.*	ept them. The Emergency for escorted the surveyor to where one sled is located. Daredness Director stated the may is expected to transport contract has not been made in emergency. If to have documentation that predness plan included policy he safe evacuation from the contact Information Idevelop and maintain an included policy he safe evacuation plan deral, State and local laws and updated at least unication plan must include in for the following: If assistance. §483.73(c):] (2) Contact cowing: If, regional, or local ess staff. If and Certification Agency. Itate Long-Term Care sesistance. 475(c):] (2) Contact		1 1. 2. 3.	No residents were affected by practice. Residents residing in the facility potentially be affected by this p The Administrator updated the Emergency Preparedness plan include the requirements as out this regulation as well to includ following: a) Documentation that require emergency official's contact information included in the communication plan and not information was readily asset to staff in the event of an emergency. b) The Emergency Preparedness these policies and approve updates as required in this regulation. c) The Emergency Preparedness these policies were subrand approved with these accupdates by the QAPi communication will be	to to tlined in le the ed ets ecessary sessable ness and plan and d these ess mitted dditional nittee.		



DEPARTMENT OF HEALTH AND HUMAN SERVICES		PRINTED: 08/17/2018 FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES	on any ongoing changes or policy needs related to contacting emergency officials and staff during an emergency. 5. Date of Compliance Sept 14 th , 2018	MB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495346 NAME OF PROVIDER OR SUPPLIER BON SECOURS DEPAUL,TCC			(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		B. WING _	STREET ADDRESS, CITY, STATE, ZIP (CODE	08/09/2018	
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	(i) Federal, State, the emergency prepared (ii) Other sources of (iii) The State Licer (iv) The State Protest This REQUIREMENDE (iv) The State Protest This REQUIREMEND (iv) The State Protest This REQUIREMEND (iv) The State of the communication assessable to staff The findings included An interview was considered as a.m., with the Admin Preparedness Direct a card with emerge by VHASS and state stated to keep the intelephone in his official by the surveyor. At 4:20 P.M., the Adsupervisor would have Preparedness inform present. An interview nurse supervisor an Administrator. The Administrator administrator. The Administrator administrator.	ribal, regional, and local edness staff. of assistance. In a sing and Certification Agency. Section and Advocacy Agency. In it is not met as evidenced of the facility's emergency and staff interview, the facility cumentation that all required is contacts information included on plan and was readily in the event of an emergency of it. The Administrator present included ed the VHASS representative information beside his ince and it would be accepted descended by the intervence of the was contacted by the individual ed the was contacted by the intervence of the included in the included	EOO	31		
. 550	COMMENT	<u> </u>	F 000	U		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495346	B. WING		0/00/0040		
	NAME OF PROVIDER OR SUPPLIER BON SECOURS DEPAUL,TCC			50 KING	ADDRESS, CITY, STATE, ZIP CODE SSLEY LANE LK, VA 23505	0	8/09/2018
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F 656 SS=D	An unannounced Me survey was conducted Corrections are requirements. The Life survey/report will folk investigated during the The census in this 24 at the time of survey, consisted of 9 Currer (Residents #2, #5, #7 and #69) and 3 close #17 through 19). Develop/Implement CCFR(s): 483.21(b)(1)	edicare/Medicaid standard and 8/7/18 through 8/9/17. ired for compliance with 42 al Long Term Care fe Safety Code ow. No complaints were ne survey. I certified bed facility was 16 The survey sample at Resident reviews 7, #8, #11, #12, #15, #67, doi: 10.000 reviews (Residents Comprehensive Care Plan	F 000	1)	Resident #11, Resident #12, a Resident #2's care plans were		
	§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			3)	could potentially be affected by this practice. a) Care plans were reviewed and updated as needed fo those residents currently residing in the facility to include person centered-comprehensive care plans activities.	ty r in	





DEPARTMENT OF HEALTH AND HUMAN SERVICES				
CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICES	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. The Date of Compliance is Sept, 7 th , 2018			

AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	0	X3) DATE COMPI	SURVEY LETED
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	rehabilitative services provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv) In consultation with resident's representation (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was assess local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, i requirements set forth section. This REQUIREMENT by: Based on medical recand facility document to ensure the Person-Care Plan was completed of 12 Residents in the #7, Resident #8, Resident #2. 1. The facility staff fail #7's Person-Centered dated 7/25/18 was cord. 2. The facility staff fail #8's Person-Centered dated 7/25/18 was cord. 3. The facility staff fail.	s the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and eference and potential for illities must document is desire to return to the ssed and any referrals to is and/or other appropriate	F6	56			

IDENTIFICATION NUMBER:		4000 0000000000000000000000000000000000	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495346	B. WING_			08/09/2018	
BON SEC	OURS DEPAUL,TCC			STREET ADDRESS, CITY, STAT 150 KINGSLEY LANE NORFOLK, VA 23505	TE, ZIP CODE	00/03/2010	
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	Activities. 4. The facility staff fa #12's Person-Centered Plan dated 7/24/18 who Activities. 5. The facility staff fa #2's Person-Centered dated 6/26/18 was contained to the findings included. The findings included 1. Resident #7 was a on 7/13/18 with diagnicated by the findings included. The most recent composet (MDS) assessment F7/20/18. The Brief Interpretable of daily discontained that Resider and capable of daily discontained that Resider and Capable of daily discontained that Resider and Activities Resider "Very Important" to he listening to music she keeping up with the negroups pf people, doir going outside for fresh Preferences for Custo Resident #7 was code Important" to her for the having books, newsparead, and to participate	iled to ensure that Resident ed Comprehensive Care as complete to include illed to ensure that Resident illed illed to ensure that Resident illed ill	F 6	356			

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 A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER		STR 150	EET ADDRESS, CITY, STATE, ZIP CODE KINGSLEY LANE RFOLK, VA 23505		3/09/2018
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	Care Plan dated 7/28 was no Activity focus interventions initiated Person-Centered Co On 08/08/18 5:15 PM conducted with the M Resident #7's Person Care Plan dated 7/28 was asked if a activiti initiated for the reside stated, "I do not see a comprehensive care who was responsible care plan for the reside Coordinator stated, "I before she left and I before she left and I before she left and I before she left. Activities she Comprehensive care On 08/08/18 at 5:35 F conducted with the D Director of Nursing we Person-Centered Corshould have included Nursing stated, "Yes, on the care plan." The facility policy title Centered" effective dand is documented in Purpose: To provide and in the highest pand psychosocial well resident comprehensi	5/18 was reviewed. There 6, goal, or planned 8 on Resident #7's mprehensive Care Plan. M An interview was IDS Coordinator regarding n-Centered Comprehensive 6/18. The MDS Coordinator resides care plan had been ent. The MDS Coordinator a activity care plan in their plan." Surveyor then asked for initiating the activities dents. The MDS The Activities Director did it was supposed to be the Activities care plan after ould be included in the plan." P.M. and interview was irector of Nursing. The as asked if Resident #7's inprehensive Care Plan activities. The Director of activities should be included d, "Care Plans-Resident ate May 2018 was reviewed part, as follows: hecessary care planning	F 656			

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

Event ID: EBOI11

Facility ID: VA0295

If continuation sheet Page 17 of 31





	AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DA	NO. 0938-039° ATE SURVEY	
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ı	NAME OF P	ROVIDER OR SUPPLIER	490040	B. WING	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		08/09/2018	
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	the state of the s	2016 Final Rule. Procedure: 1. The care plan will be resident issues and counique characteristics. 4. The care plan will inneeded to provide effecare of the resident that standards of quality cates. 8. A comprehensive period within the comprehensive as include measurable objument a resident's medicosychosocial needs that comprehensive assess. 9. The care plan will be the interdisciplinary tean tot limited to: a register esponsibility for the resesponsibility for	be driven by identified conditions and by resident's and needs. Include the instructions active and person-centered at meet professional are. Berson-centered care plan of a days after completion assessment and will jectives and timeframes to cal, nursing, mental and at are identified in the ment. Be prepared with the input of m which includes but is red nurse with sident, a nurse aide with sident, a case manager or ding physician, a member revices staff and a member are conducted on 8/9/18 at inistrator and the Director cove information was mation was provided by	F	656				

PRINTED: 08/17/2018 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	100000000000000000000000000000000000000		OM	IB NO. 0938-0391
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	(X3)) DATE SURVEY COMPLETED
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BON SEC	COURS DEPAUL,TCC			150 KINGSLEY LANE NORFOLK, VA 23505	ZIP CODE	
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	The most recent comes of (MDS) assessment Referent The Brief Interview for a 15 out of a possible Resident #8 was cognicity decision making Preferences for Custon Resident #8 was code to her for the following music she liked, being with the news, doing the doing favorite activities services and going out Section F Preferences and Activities Resident "Somewhat Important activities: having book magazines to read. Resident #8's Person-Care Plan dated 7/25/was no Activity focus, interventions initiated of Person-Centered Comes and Conference of the resident #8's Person-Care Plan dated 7/25/was asked if a activitie initiated for the resident stated, "I do not see a comprehensive care plan for the residence of the resident plan for the residence of the resident plan for the residence of the plan for the plan fo	aprehensive Minimum Data ent was an Admission with a ce Date (ARD) of 7/24/18. For Mental Status (BIMS) was a 15 which indicated that initively intact and capable of a Under Section Formary Routine and Activities ed as being "VeryImportant" gractivities: listening to graound pets, keeping up hings with groups pf people, es, to participate in religious atside for fresh air. Under so for Customary Routine and #8 was coded as being "to her for the following as, newspapers, and "Centered Comprehensive (18 was reviewed. There goal, or planned on Resident #8's aprehensive Care Plan. An interview was DS Coordinator regarding Centered Comprehensive (18. The MDS Coordinator activity care plan in their an." Surveyor then asked or initiating the activities ents. The MDS in Activities Director did it	F6			
	cahoriainie ioi doilid ti	ie Activities care plan after				

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

Event ID: EBOI11

Facility ID: VA0295

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	she left. Activities she Comprehensive care On 08/08/18 at 5:35 conducted with the I Director of Nursing of Person-Centered Coshould have include Nursing stated, "Yes on the care plan." A pre-exit debriefing 4:50 P.M. with the A of Nursing where the shared. No further in the facility. 3. Resident #11 was on 7/11/18 with diag Wrist Fracture and (2) The most recent con Set (MDS) assessment References (MDS) assessment References for Cust Resident #11 was confidally decision make Preferences for Cust Resident #11 was confidally decision make Preferences for Cust Resident #11 was confidally decision make Preferences for Cust Resident #11 was confidally decision make Preferences for Cust Resident #11 was confidally decision make Preferences for Cust Resident #11 was confident #11	prould be included in the e plan." P.M. and interview was Director of Nursing. The was asked if Resident #8's emprehensive Care Plan d activities. The Director of s, activities should be included was conducted on 8/9/18 at dministrator and the Director e above information was aformation was provided by a 54 year admitted to facility moses to include (1.) Right 2.) Hypertension. Inprehensive Minimum Data ent was an Admission with a nace Date (ARD) of 7/12/18. For Mental Status (BIMS) was a 15 which indicated that agnitively intact and capable sing. Under Section Formary Routine and Activities ded as being "Very the following activities: being a up with the news, doing people, doing favorite outside for fresh air. Under se for Customary Routine ent #11 was coded as being t" to her for the following	F	656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495346	B. WING			08/09/2018	
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	participate in religious Resident #11's Perso Care Plan dated 7/31 was no Activity focus interventions initiated Person-Centered Con On 08/08/18 5:15 PM conducted with the M Resident #11's Perso Care Plan dated 7/31 was asked if a activiti initiated for the reside stated, "I do not see a comprehensive care p who was responsible care plan for the reside stated, "I do not see a comprehensive care p who was responsible care plan for the reside c	on-Centered Comprehensive 1/18 was reviewed. There , goal, or planned I on Resident #11's imprehensive Care Plan. I An interview was DS Coordinator regarding in-Centered Comprehensive /18. The MDS Coordinator es care plan had been ent. The MDS Coordinator a activity care plan in their plan." Surveyor then asked for initiating the activities lents. The MDS The Activities Director did it was supposed to be the Activities care plan after uld be included in the plan." I.M. and interview was rector of Nursing. The is asked if Resident # 11's imprehensive Care Plan activities. The Director of activities should be included was conducted on 8/9/18 at ininistrator and the Director	F 656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) D/	(X3) DATE SURVEY COMPLETED	
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		ROVIDER OR SUPPLIER OURS DEPAUL,TCC			STREET ADDRESS, CITY, STATE, ZI 150 KINGSLEY LANE NORFOLK, VA 23505	P CODE	08/09/2018	
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		on 7/5/18 with diagnormal most recent commodellitus and (2.) Hypormal most recent commoder (MDS) assessments of the status (BIMS) was a which indicated that in the status (BIMS) was a which indicated that intact and capable of Under Section F Preferences and Activities being "Very Important activities: having book magazines to read, list doing things with groun activities, to participat going outside for fresh Preferences for Custor Resident #8 was code Important" to her for the around pets and keep Resident #12's Person Care Plan dated 7/24/was no Activity focus, interventions initiated of Person-Centered Common 08/08/18 5:15 PM conducted with the MD Resident #12's Person Care Plan dated 7/24/was asked if a activitie initiated for the resident stated, "I do not see a comprehensive care plans asked in the most resident stated, "I do not see a comprehensive care plans asked in the most resident stated, "I do not see a comprehensive care plans asked in the most resident stated, "I do not see a comprehensive care plans asked in the most resident stated, "I do not see a comprehensive care plans asked in the most resident stated, "I do not see a comprehensive care plans asked in the most resident stated, "I do not see a comprehensive care plans asked in the most resident stated, "I do not see a comprehensive care plans asked in the most resident stated."	prehensive Minimum Data ent was an Admission with a sment Reference Date entered Enterview for Mental 15 out of a possible 15 desident #12 was cognitively daily decision making. Everences for Customary entered Enterview for Hollowing entered Enterview for Mental 15 out of a possible 15 desident #12 was coded as everences for Customary entered Enterview for Hollowing entered Enterview for the following entering to music she liked, ups pf people, doing favorite entered in religious services and entering to music she liked, ups pf people, doing favorite entered in religious services and entered Enterview and Activities entered Entered Enterview was entered	F 6	156			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495346	B. WING				
	PROVIDER OR SUPPLIER			150	EET ADDRESS, CITY, STATE, ZIP CODE KINGSLEY LANE RFOLK, VA 23505	0	8/09/2018
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F 656	Coordinator stated, "before she left and I versponsible for doing she left. Activities sho Comprehensive care On 08/08/18 at 5:35 Foonducted with the Didirector of Nursing was Person-Centered Corshould have included Nursing stated, "Yes, on the care plan." A pre-exit debriefing was 4:50 P.M. with the Ad of Nursing where the shared. No further infetthe facility. 5. Resident #2 was ac 6/26/18 with diagnose limited to laminectomy procedure to fuse the spine), Multiple sclero Type 2, and hypertens A comprehensive MDS was completed with an Reference Date) of 7/3 BIMS (Brief Interview Resident #2 with no content was a list of Resident #2's responsimportant" to have boom agazines to read, list around animals such a groups of people, do y	The Activities Director did it was supposed to be the Activities care plan after ould be included in the plan." P.M. and interview was irector of Nursing. The as asked if Resident #12's imprehensive Care Plan activities. The Director of activities should be included was conducted on 8/9/18 at iministrator and the Director above information was ormation was provided by dimitted to the facility on its that include but are not a with spinal fusion (surgical some of the bones of the sis, low back pain, diabetes sion (high blood pressure). S 3.0 (Minimum Data Set) in ARD (Assessment 3/18 for Resident #2. A for Mental Status) coded cognitive impairment. Under irences and Customary activity preferences: es were coded as "very oks, newspapers, and ten to music you like, be	F	656			

STATEMENT AND PLAN OF	OF DEFICIENCIES F CORRECTION	I IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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	OURS DEPAUL,TCC		STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505					
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; ; ;	A review of Resident prepared on 6/26/18 implementation strate activities to enhance On 8/8/18 at 5:09 PM interviewed. MDS cook the comprehensive cashe stated "there is nearly includes for preparing plan she stated "the periodid the activities care was supposed to write now. I failed to put an place." When asked he person centered need MDS, and "if it didn't to the Area Assessment- included during the activitied during the activitied during the activitied during the activities and he should activities and he should activities and he should are view of the facility Resident Centered, effincluded: Purpose: To provide nethat results in care and	#2's care plan which was noted no problems, goals, or egies, to address needs for his psychosocial well-being. I MDS RN# 1 was ordinator RN# 1 reviewed are plan for Resident #2. To activities care plan for asked what the process of the person centered care previous activities director plan," and when she left "I se the activities care plan in now she identifies the less she stated it is on the rigger in the CAA's [Care dicated the need for the based on problems assessment, known as don't trigger for activities." an interview with the DON ras conducted. When ent #2's care plan, she oesn't have a care plan for dhave one." policy titled Care Plans fective date May 2018	F	356	RECEIVED AUG 2 4 2018			
8	and psychosocial well-	being consistent with the			VDH/OLC			

IDENTIFICATION NUMBER		(X2) MULTI A. BUILDIN	PLE CONST G	(X3) DATE SURVEY COMPLETED		
NAME OF S		495346	B. WING			08/09/2018
Mark College Co. N Philos St. 1987	PROVIDER OR SUPPLIER			150 KING	ADDRESS, CITY, STATE, ZIP CODE SLEY LANE LK, VA 23505	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 656	resident comprehens care and based on re 2016 Final Rule. Procedure: 1. The care plan will resident issues and cunique characteristics. 4. The care plan will inneeded to provide efficare of the resident the standards of quality of the comprehensive will be developed with of the comprehensive include measurable of meet a resident's	de driven by identified conditions and by resident's se, strengths and needs. Include the instructions fective and person-centered nat meet professional care. Include the instructions fective and person-dentered nat meet professional care. Include the instructions fective and person-dentered nat meet professional care. Include the instructions fective and person-dentered care plan nin 7 days after completion assessment and will bjectives and timeframes to dical, nursing, mental and nat are identified in the assment. Include the instructions fective and person-centered care plan nin 7 days after completion assessment and will bjectives and timeframes to dical, nursing, mental and nat are identified in the assment. Include the instructions fective and will be person-centered care plan nin 7 days after completion assessment and will bjectives and timeframes to dical, nursing, mental and nat are identified in the assment. Include the instructions fective and will be person-centered care plan nin 7 days after completion assessment and will bjectives and timeframes to dical, nursing, mental and nat are identified in the assment. Include the instructions fective and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be person-centered care plan nin 7 days after completion assessment and will be perso	F 6	56		
F 680 SS=E	further information wa Qualifications of Activ CFR(s): 483.24(c)(2)(ity Professional	F 68	0 1.	cited in this regulation.	
	§483.24(c)(2) The act	ivities program must be			 A Qualified Activity Profess has since been hired and is staff at the facility. The Qua Activity Professional/Director 	on dified

DEPARTMENT OF HEALTH AND HUMAN SERVICES	PRINTED: 08/17/2018
CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES	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 7 th , 2018.

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
		495346	B. WING	,		010010040
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 150 KINGSLEY LANE NORFOLK, VA 23505	ZIP CODE	8/09/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
	directed by a qualific qualified therapeutic activities profession. (i) Is licensed or registate in which practic (ii) Is: (A) Eligible for certific recreation specialist professional by a recor after October 1, 1 (B) Has 2 years of expeciation and program of which was full-time program; or (C) Is a qualified occoccupational therapy (D) Has completed at the State. This REQUIREMENT by: Based on observation interviews, and facility staff failed to exprogram was being deprofessional. The facility staff failed to exprogram was directed recreation specialist of who-Is licensed or restate in which practic certification as a thereor as an activities professional program of which was full-time program; or (C) Is a qualified to get the state of the st	ed professional who is a crecreation specialist or an all whostered, if applicable, by the icing; and cation as a therapeutic or as an activities cognized accrediting body on 990; or experience in a social or a within the last 5 years, one in a therapeutic activities compared the provided accrediting body on 990; or experience in a social or a within the last 5 years, one in a therapeutic activities compared by a sistent; or a training course approved by a provided compared by a qualified compared by a qualified therapeutic correct that their activities directed by a qualified therapeutic correct activities or an activities professional gistered, if applicable, by the compared by a recognized or after October 1, 1990; or perience in a social or within the last 5 years, one in a therapeutic activities	F	580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495346	B. WING			9/00/2040
	DF PROVIDER OR SUPPLIER BECOURS DEPAUL,TCC			STREET ADDRESS, CITY, STATE, ZIP CO. 150 KINGSLEY LANE NORFOLK, VA 23505	DE O	8/09/2018
(X4) I PREF TAG	IX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 6	Has completed a transtate. The findings include During the initial tou was observed in sor large bulletin board A in the hallway past the August calendar shown of the Activity, When the Activity the alternated of the activity times noted. The Activity the the Activity the Administrator stated, Activities Director and yesterday and would week. The Administrator stated, Activities Director and yesterday and would week. The Administrator stated, The last Activity and who had been do residents in the mear stated, The last Activity June and we have have placement. Since see Rehab. (Rehabilitation activities."	aining course approved by the deciding course approved by the deciding and a course are resident rooms and a course activities Calendar was noted the nurse's station. The bowed a daily activity on which was "Music with David from 10 AM to 12 PM was rednesdays from 10 AM to 12 other week between "Coffee the", Thursdays from 10 AM to revery other week between go" with no other planned On Saturday and Sundays sure a la mode" with no time	F 68	30		

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA (X2)		(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391		
AND PLAN O	PLAN OF CORRECTION IDENTIFICATION NUMBER: (A2) MIDENTIFICATION NUMBER: (A2) MIDENTIFICATION NUMBER:		RUCTION	(X3) DATE SURVEY COMPLETED					
		495346	B. WING _				2010010010		
	PROVIDER OR SUPPLIER			150 KING	ADDRESS, CITY, STATE, ZIP CODE SLEY LANE -K, VA 23505		08/09/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE		
	were on Activity Partit Wednesdays, and Fri On 8/8/18 at 2:45 P.M. conducted with the R Administrator present asked verbatim from Manual is she was a recreation specialist of who-Is licensed or registate in which practic certification as a there or as an activities pro accrediting body on o (B) Has 2 years of exprecreational program of which was full-time program; or (C) Is a quite the program; as completed a train State. The Rehab. Te those." Facility documentation Administrator indicate ended employment with and the new facility Adtesting for certification. The facility "Job Description or certification as a follows: II. Employment Qualificate form a collection or an equivalent combe experience is preferred.	cipation Logs for Mondays, idays. M. and Interview was ehab. Tech with the t. The Rehab. Tech was the State Operations qualified therapeutic or an activities professional pistered, if applicable, by the ing; and Is: (A) Eligible for apeutic recreation specialist fessional by a recognized or after October 1, 1990; or perience in a social or within the last 5 years, one in a therapeutic activities ualified occupational nal therapy assistant; or (D) sing course approved by the ch stated, "No, I'm none of the provided from the d the last Activities Director will be on 9/17/18. In provided from the dother last Activities activities Director will be on 9/17/18. In provided from the dother last Activities Director will be on 9/17/18. In provided from the dother last Activities Director will be on 9/17/18.	F 6	80					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495346	B. WING			0/00/00/40	
	PROVIDER OR SUPPLIER			150 KING	ADDRESS, CITY, STATE, ZIP CODE GSLEY LANE LK, VA 23505	0	8/09/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
SS=D	National Certification Professionals will be A pre-exit debriefing of 4:50 P.M. with the Add of Nursing where the shared. No further infithe facility. Label/Store Drugs and CFR(s): 483.45(g)(h)(d) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. §483.45(h) Storage of §483.45(h)(1) In according to the facility biologicals in locked of temperature controls, personnel to have accessory instructional to have	Council for Activity necessary. was conducted on 8/9/18 at Iministrator and the Director above information was ormation was provided by d Biologicals (1)(2) of Drugs and Biologicals used in the facility must be with currently accepted and include the y and cautionary expiration date when Torugs and Biologicals cautionary expiration date when Torugs and Biologicals rdance with State and ity must store all drugs and compartments under proper and permit only authorized	F 7	61 1) 2) 3)	cited in this citation. a) All identified medications were immediately remove and disposed of according to regulation to assure appropriate labeling and storage as identified in the regulation. Residents residing in the faci could potentially be affected by this practice.	ed e	

DEPARTMENT OF HEALTH AND HUMAN SERVICES	PRINTED: 08/17/2018
CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVED
	for three months to assure and maintain compliance. 5) Date of Compliance Sept 7 th ,
	2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCT	ION	(X3) DATE SURVEY COMPLETED	
		495346	B. WING _	B. WING			
	PROVIDER OR SUPPLIER			STREET ADDRE		0	8/09/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Based on observation manufacture guidelin documentation the fathat 3 medications we manufacture recomm The facility staff failed 0.005% ophthalmic sensure they would be based on manufacture. The findings included On 08/08/18 at 9:46 Amedication room was refrigerator 3 open be ophthalmic solution Linot dated. The Pharm room and was asked dating the bottles whe stated, "The nurse the responsible for dating was asked when and Xalatan 0.005% ophth Director of Nursing state the bottle should date.	es and facility cility staff failed to ensure ere stored according to endations. It to date 3 bottles of Xalatan colution when opened to ediscarded within 6 weeks er recommendations. AM the the facility's only inspected. In the locked attles of Xalatan 0.005% of# 292601F were observed eacist was in the medication who was responsible for en opened. The Pharmacist at opens the bottle is it." The Director of Nursing who should have dated the each in the nurse that opens it when she opens it."	F 7	61			
	Once a bottle is opened at room temperature used weeks.	ed for use, it may be stored up to 25 degrees Celsius for			AUG 24 2018		
	The facility policy titled Security of Medication was reviewed and is d follows:	s" last revised on 1/2016			VDH/OLC		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION	(X3) DATI	O. 0938-0391 E SURVEY PLETED
		495346	B. WING		0.0	10010010	
	PROVIDER OR SUPPLIER			150 KIN	FADDRESS, CITY, STATE, ZIP CODE IGSLEY LANE OLK, VA 23505	08	/09/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBF	(X5) COMPLETION DATE
F 761	Purpose: To ensure pof medications under recommended conditions. Policy: All medication Name" must be procumonitored and disposs State, Local guideline standards of accrediting carried out by all faculd dispense, and administ Procedure: 6. Medications are stoutable for product standards. No medications are stoutable for product standards. No further as shared. No further inforthe facility staff.	proper security and storage proper manufacturer ons to ensure stability. Is throughout "Facility ared, stored, administered, ed of according to Federal, as and laws as well as an institutions. This is to be alty and staff who order, after medications to patients. Direct under conditions ability. It is expired. It is a conducted on 8/9/18 at ministrator and the Director	F 7				
SS=F	CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety The facility must - §483.60(i)(1) - Procure approved or considere state or local authoritie (i) This may include foo from local producers, s and local laws or regula (ii) This provision does facilities from using pro-	requirements. food from sources d satisfactory by federal, s. od items obtained directly ubject to applicable State ations. not prohibit or prevent		2) 3)	There were no residents ident citation. a) The food that was identificitation was immediately and disposed of. b) The areas identified for accleaning were scheduled immediate cleaning. Residents residing in the facilic potentially be affected by this An audit was developed and we conducted by Dietary manage designee to include: a) Walk through validate food storage/dispossing according to dates with a months and then in the food storage identication.	ed in this removed dditional for ty could practice. vill be r or tition of al weekly for	

DEPARTMENT OF HEALTH AND HUMAN SERVICES	PRINTED: 08/17/2018
CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES	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 7 th , 2018



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		B) DATE SURVEY COMPLETED
		495346	B. WING			08/00/2049
BON SEC	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 150 KINGSLEY LANE NORFOLK, VA 23505	E	08/09/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	(iii) This provision do from consuming foo \$483.60(i)(2) - Store serve food in accord standards for food s This REQUIREMEN by: Based on observating facility policy review, sanitary conditions of and failed to properly the discard dates. The facility staff failed conditions of the overpreparation of food, a foods on or before the On 08/07/18 at 12:45 was conducted accordirector and chef. On 8/7/18 at 1:00 PN walk-in cooler was accordirector and chef. On 8/7/18 at 1:00 PN walk-in cooler was accordirector and chef. The director was ask for the safe storage of residents. The director sticker on the food prostaff "the first date [or food product is opened second date is the disserted strength of the director sticker on the food product is opened second date is the disserted strength of the safe storage of food product is opened second date is the disserted strength of the safe storage of the s	od-handling practices. Des not preclude residents dis not procured by the facility. It is prepare, distribute and lance with professional ervice safety. T is not met as evidenced ons, staff interviews and the facility failed to maintain or the preparation of food, y discard foods on or before discard foods on or before and failed to properly discard die discard dates. EM Initial tour of the kitchen impanied by the food service onducted. Located on the red bowl of tomato soup with the sticker noted: prepared and "use by" date of 8/6/18. The discard has expectation of the exp	F 81	2		

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA			OMB I	OMB NO. 0938-0391		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
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		495346	B. WING _			20000000		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	8/09/2018		
BON SEC	COURS DEPAUL,TCC			150 KINGSLEY LANE				
27.0.15				NORFOLK, VA 23505				
PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 812	refrigerator noted a p banana muffin batter noted "opened" on 7/8/5/18. Asked the dire was for the safe stora responded that the m been discarded on the During the same tour amount of built up, of was noted on the over doors. An examination used in industrial kitch dark brown grease cohinges at the rear of the grease build up along director was asked to cleaning these pieces equipment. He stated come in every 2 week the bigger equipment skillet". When we look and skillet he acknowled buildup of grease. The looks like "more than 2". On 8/7/18 at 1:40 PM floor around the oven have a significant amount of the equipment.	la a tour of the meat walk-in lastic tub container of with an orange sticker which 5/18 and "use by" date of ector what his expectation age of open food and he suffin batter "should have e 5th". of the kitchen a large brown and black grease in walls, oven racks, and in of the tilt skillet (large panners to braise food) noted empletely covering the two he skillet lid and dripping the front panel. The explain the process for of food preparing he "hires someone to is to do a deep cleaning of like the ovens and tilt ed together at the oven ledged there is significant to director and chef sated it is weeks' worth of grease". during the same tour the and tilt skillet was noted to ount of food particles, and to on the floor and the wall. When the director was	F 81					
	floor he stated "they ar			AUG 2	4 2018			
	table away from the wa	all and stated" this is old		VDH	OLC			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495346	B. WING		08/09/2018	
NAME OF PROVIDER OR SUPPLIER BON SECOURS DEPAUL,TCC				STREET ADDRESS, CITY, STATE, ZIP CODE 150 KINGSLEY LANE NORFOLK, VA 23505	1 00/0	3312016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	
	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 8:	12		
				RECEIVED AUG 24 2018 VDH/OLC		





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

AUG 24 2018 VDH/OLC