October 4, 2019

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

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

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 _____	09/26/2019

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 9/25/19 through 9/26/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement 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 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 sewage and waste disposal 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 sewage and waste disposal as required in this regulation. 5. Date of Compliance October 11, 2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10-4-19

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 record review and staff interview, the facility staff failed to have documentation that the Emergency Preparedness Plan addressed procedures for sewage and waste disposal. The findings included: During the Emergency Preparedness Review on 09/26/19 at 1:10 P.M., procedures for sewage and waste disposal were discussed. The Administrator stated, there were no vendor contracts for sewage and waste disposal. No further information was provided by the facility staff.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)	E 018		

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E 018	Continued From page 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] 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	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. e) 100% of staff to be educated on policy, procedure, and forms to be used in a situation requiring evacuation. 4). The Administrator will be responsible to report and	

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E 018	Continued From page 3 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 facility, which includes 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 ensure staff were trained in the facility's Emergency Preparedness tracking system. The findings included: During an interview on 09/26/19 at 1:24 P.M. with	E 018	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 October 31, 2019	

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E 018	Continued From page 4 the Administrator and the Safety Coordinator, they were asked for documentation of the facility's Emergency Preparedness tracking system in the event Residents and staff were relocated during an emergency. The staff stated, they did not have documentation of the facility's tracking system and staff training. Random interviews with a Certified Nursing Assistant (CNA), a Housekeeper and a Licensed Practical Nurse (LPN) were conducted and they indicated that they had not been trained. A review of three Nursing staff employee records did not indicate staff were trained in the facility's emergency preparedness tracking system.	E 018		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(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:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and	E 023	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 preserving of patient information in the emergency preparedness plan 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.	

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E 023	Continued From page 5 procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have verification for preserving patient information in the Emergency Preparedness Plan. The findings included: During an interview on 09/26/19 at 1:45 P.M. with the Administrator and the Safety Coordinator, the Administrator was asked for documentation the Emergency Preparedness Plan to protect confidentiality of patient information and maintain the availability of resident records. The Administrator stated, he did not have documentation to ensure patient records were secure and readily available to support the continuity of care for residents during an emergency.	E 023	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 preservation of patient information as required in this regulation. 5. Date of Compliance October 11, 2019	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan	E 033		

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E 033	Continued From page 6 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: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the	E 033	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 sharing information and medical documentation to maintain continuity of care in the emergency preparedness plan 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. d) e) 100% of staff to be educated on policy, procedure, and forms regarding this requirement. 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 sharing of information and medical documentation to maintain	

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E 033	Continued From page 7 communication plan included a method for sharing information and medical documentation to maintain continuity of care in the Emergency Preparedness Plan. The findings included: During an interview on 09/26/19 at 1: 35 P.M. with the Administrator and Safety Coordinator, the Administrator was asked for evidence that the facility had a method for sharing information and medical care for residents with other health care providers to maintain continuity of care in the Emergency Preparedness Plan. The Administrator stated, he did not have documentation for sharing information and medical care needs for residents in an alternate care site. Random interviews of a Certified Nursing Assistant (CNA), a House keeper and a Licensee Practical Nurse (LPN) were conducted and they indicated that they had not been trained in providing care at alternate care sites. A review of three Nursing staff employee records did not indicate staff were trained in emergency preparedness.	E 033	continuity of care as required in this regulation. 5. Date of Compliance October 31, 2019	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(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: (7) [(5) or (6)] A means of providing information	E 034	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	

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E 034	Continued From page 8 about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation concerning the facility's occupancy, needs, and its ability to provide assistance in the Emergency Preparedness Plan. The findings included: During an interview on 09/26/19 at 1:56 P.M. with the Administrator and the Safety Coordinator, they were asked for documentation for identifying the needs of the facility, and occupancy in the Emergency Preparedness Plan. The Administrator stated, the facility had not identified in it's policy the occupancy needs of the facility.	E 034	procedures for documenting the facility's occupancy, needs, and its ability to provide assistance 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 documenting the facility's occupancy, needs, and its ability to provide assistance as required in this regulation. 5. Date of Compliance October 11, 2019	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must	E 036	1. No residents were affected by this practice. 2. Residents residing in the facility could potentially be affected by this practice.	

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E 036	Continued From page 9 develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	E 036	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 maintaining a written training and testing program for the emergency preparedness plan training at least annually 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 the training and testing program as required in this regulation. 5. Date of Compliance October 11, 2019	

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E 036	Continued From page 10 facility staff failed to maintain a written training and testing program for Emergency Preparedness Plan training at least annually. The findings included: During the Emergency Preparedness review on 09/26/19 at 1:40 P.M. with the Administrator and the Safety Coordinator were asked for the annual testing and training in the Emergency Preparedness Program. The Administrator stated he trained staff on Emergency Preparedness. When asked for test and subject training material, the Administrator was not able to produce any documents.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037	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 providing emergency preparedness training at least annually 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.	

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(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 037	Continued From page 11 arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency	E 037	D) e) 100% of staff to be educated on policy, procedure, and forms regarding this requirement. Individuals providing services other than staff and volunteers will also be in-serviced and trained at least annually. 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 training of staff at least annually on emergency preparedness as required in this regulation. 5. Date of Compliance October 31, 2019	

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	495346	A. BUILDING _____ B. WING _____	09/26/2019

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E 037	Continued From page 12 preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:	E 037		

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E 037	Continued From page 13 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests. fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide Emergency Preparedness Plan training at least annually. The findings included: During the Emergency Preparedness review on 09/26/19 at 1:40 P.M. with the Administrator and the Safety Coordinator were asked for the annual	E 037		

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E 037	Continued From page 14 training in Emergency Preparedness Plan policies and procedures to all new and existing staff. The Administrator stated he trained staff on Emergency Preparedness. When asked for test and subject training material, the Administrator was not able to produce any documents. A review of three Nursing staff employee records did not indicate staff were trained in the facility's Emergency Preparedness Plan.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/25/19 through 09/26/19. 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 14 at the time of the survey. The survey sample consisted of 9 current Resident reviews and 6 closed record reviews.	F 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	
F 641 SS=C	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility record review and clinical record review it was determined that facility staff failed to ensure an accurate MDS (Minimum Data Set) assessment for one of 15 residents in the survey sample, Resident #12.	F 641	1. Resident #12 had no ill-effect related to this coding inaccuracy. The MDS Coordinator will make a correction to the MDS to correct the discharge location. 2. Those residents who discharge from the facility are at risk for this coding inaccuracy occurring. 3. The DON will audit weekly those residents that were discharged for accuracy in MDS coding. 4. The DON will report to QAPI (Quality Assurance and Performance Improvement) monthly	

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F 641	Continued From page 15 The findings included: Resident #12 was admitted to the facility on 6/25/19 with diagnoses that included but were not limited to acute on chronic systolic CHF (congestive heart failure), post stroke, acute cystitis (bladder inflammation) without hematuria (blood in urine), and high blood pressure. Resident #12's most recent MDS (minimum data set) assessment was a discharge assessment with an ARD (assessment reference date) of 7/25/19. Resident #12 was coded as being intact in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #12's clinical record revealed that she was discharged home on 7/24/19 with home health services. Her discharge assessment documented the following: "Discharge To: Home with HH (home health)." Review of Resident 12's discharge MDS assessment with an ARD (assessment reference date) of 7/25/19 coded Resident #12 in Section A2100. (Discharge Status), as being sent to an acute hospital. On 9/24/19 at 2:10 p.m., an interview was conducted with RN (Registered Nurse) #1, the MDS coordinator. When asked how to fill out Section A2100. of the MDS, RN #1 stated that she will code the resident based on their discharge status (home, transferred to hospital, expired). When asked if Resident #12 was discharged home, RN #1 stated, "She went home." When asked why she had coded that Resident #12 went to the hospital, RN #2 stated that the MDS was coded in error. RN #1 stated	F 641	x3 months the results of the MDS audits. The DON will monitor the results to assure compliance. 5. Date of Compliance 10/11/19	

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F 641	Continued From page 16 that she uses the RAI (resident assessment instrument manual) as a reference when completing the MDS. On 9/24/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the above concerns. No further information was presented prior to exit.	F 641		
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 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.	F 656	1. Residents # 9, 65 and 10 had no ill -effects related to this care planning oversight. Those residents care plans (#9,#65 and #10)were updated to accurately reflect each residents individual care needs which were an antidepressant/ depression diagnosis , anticoagulant and suprapubic catheter as identified in this citation. 2. Those residents with care planning of needs could potentially be at risk for this care planning oversight. 3. The DON will audit 50% of care plans weekly to check for care planning accuracy according to the resident's individual needs. 4. The DON will report to QAPI (Quality Assurance and Performance Improvement) monthly x3 months the results of this care plan audit. The DON will audit and monitor the results to assure compliance. 5. Date of Compliance 10/11/19.	

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F 656	Continued From page 17 (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 staff interviews, clinical record review and facility documentation the facility staff failed to develop three of 15 residents (Resident #9, #65 and #10) comprehensive person centered care plan in the survey sample. The findings included: 1. For Resident #9, the facility staff failed to develop a person-centered care plan to include the diagnosis of Depression with the use of a psychoactive medication (*Zoloft). Resident #9 was admitted to the nursing facility on 09/08/19. Current diagnosis for Resident #9 included but not limited to *Depressive Disorder. The current Minimum Data Set (MDS) a 14-day Assessment Reference Date (ARD) of 09/15/19 coded the resident with a 08 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The residents MDS was coded for the usage of antidepressant medication. The	F 656		

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F 656	Continued From page 18 section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving an antidepressant for 7 days. The review of Resident #9's Resident Medication Profile indicated the following antidepressant order: Sertraline 100 mg (1) tablet daily starting on 09/09/19. The review of the Resident #9's comprehensive care plan did not include a care plan for a diagnosis of depression with use a psychoactive medication. An interview was conducted with the MDS Coordinator on 09/26/19 at approximately 11:30 a.m. The surveyor asked, "Should Resident #9's person-centered care plan include the diagnosis of depression with the use of an antidepressant?" The MDS Coordinator reviewed Resident #9's orders and her care plan then stated, "Yes, she is on Zoloft; I usually put the use of an antidepressant on their care plan." She said, "Apparently I left it off, the use of an antidepressant should have been care planned; it was an oversight." On 09/26/19 at approximately 11:50 a.m., a psychoactive medication care plan on Resident #9 was given to the surveyor. The care plan was created on 09/26/19, but only created after it was requested by the surveyor. The review of the psychoactive care plan included but not limited to the following information: Resident receives antidepressant medication therapy and is at risk of the adverse effects of the medications. Goal: will feel more peaceful and at ease with improved	F 656		

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F 656	Continued From page 19 quality of life. Some of the intervention/approaches to manage goal included identify potential side effects of the selected medication and monitor for clinical appearance (i.e.: falls, lethargy, cognitive decline, physical decline, etc), notify MD as needed for acute changes and psychiatric consult and therapy as needed. The Administrator and Director of Nursing were informed of the finding during a briefing on 09/26/19 at approximately 3:53 p.m. The facility did not present any further information about the findings. The facility's policy titled Care Plan-Resident Centered (Last reviewed June 2018). -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 are and based on regulations as outlined in the 2016 Final Rule. Definitions: -Zoloft is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Zoloft affects chemicals in the brain that may be unbalanced in people with depression, panic, anxiety, or obsessive-compulsive symptoms (www.drugs.com). -Depression disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary Medicine, Nursing & Health Professions 7th edition).	F 656		

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F 656	Continued From page 20 2. The facility staff failed to develop a care plan for the use of a suprapubic catheter for Resident #65. Resident #65 was admitted to the facility on 09/11/19. Admitting diagnoses included urinary tract infection with sepsis, left ankle fracture, chronic kidney disease, retention of urine, and neurogenic bladder. An admission physician's order dated 09/11/19 included: Consult urology for suprapubic catheter changes every 3 weeks. Resident #65 was observed through out the survey in his room seated in a wheelchair with a suprapubic catheter covered in a bag. A nursing note dated 09/23/19 at 5:41 AM indicated: "Suprapubic catheter in intact and draining clear yellow urine, no c/o pain and no visual signs of pain noted." Review of an initial Care Plan dated 09/12/19 and revised on 09/23/19 did not include goals and interventions for the use of a suprapubic catheter. During an interview on 09/26/19 at 10:30 A.M. with the Minimum Data Set (MDS)/Care Plan Coordinator she stated, the comprehensive care plan did not include goals and interventions for the use of a suprapubic catheter. 3. For Resident #10, facility staff failed to develop a care plan to reflect the use of anticoagulants. Resident #10 was admitted to the facility on 9/10/19 with diagnoses that included but were not limited to fracture of the shaft of the right tibia, high blood pressure and muscle weakness.	F 656		

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F 656	Continued From page 21 Resident #10's most recent MDS (Minimum Data Set) assessment was an admission assessment with an ARD (assessment reference date) of 9/17/18. Resident #10 was coded as being intact in cognitive function scoring 14 out of possible 15 on the BIMS (brief interview for mental status) exam. Resident #10 was coded in Section N (Medications), as receiving an anticoagulant (blood thinner). Review of Resident #10's physician order summary (POS) dated September 2019, documented the following order: "Heparin (1) injection 5,000 units every 12 hours." This order was initiated on 9/12/19. Review of Resident #10's comprehensive care plan dated 9/11/19 and revised on 9/20/19 failed to reflect that she was taking anticoagulants. On 9/24/19 at 2:10 p.m., an interview was conducted with RN (Registered Nurse) #1, the MDS coordinator. When asked who was responsible for developing the comprehensive care plan, RN #1 stated that she was responsible. When asked when the comprehensive care plan was developed, RN #1 stated that the comprehensive care plan was developed 21 days after admission or sooner. When asked if Resident #10's care plan was a comprehensive care plan, RN #1 stated that it was. When asked what was on the comprehensive care plan, RN #1 stated that the comprehensive care plan should reflect medications such as antidepressants, antibiotics; ADL (activities of daily living), pain etc. When asked if a resident was receiving an anticoagulant if that she be reflected on the care plan, RN #1 stated that it should. When asked if Resident #10 received an anticoagulant, RN #1	F 656		

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F 656	Continued From page 22 stated that she received an injection. When asked the purpose of the care plan, RN #1 stated that the purpose of the care plan was to serve as a guide on how to care for the resident. When asked if it should be accurate, RN #1 stated that it should because the the care plan was a reference for the IDT (interdisciplinary team). RN #1 confirmed that Resident #10 did not have a care plan reflecting the use of an anticoagulant. On 9/24/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing, were made aware of the above concerns. No further information was presented prior to exit. (1) Heparin is an anticoagulant used for the following reasons: Prevention of postoperative deep venous thrombosis and pulmonary embolism in patients undergoing major abdominothoracic surgery or who, for other reasons, are at risk of developing thromboembolic disease;Atrial fibrillation with embolization;Treatment of acute and chronic consumptive coagulopathies (disseminated intravascular coagulation);Prevention of clotting in arterial and cardiac surgery; Prophylaxis and treatment of peripheral arterial embolism. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=88114716-5759-4bc9-8a85-d28da12962cc.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657	1. Resident # 4 had no ill effect related to this care planning oversight. Resident's #4's care plan was updated to accurately reflect the residents care needs.	

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F 657	Continued From page 23 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to revise one of 15 residents (Resident #4) in the survey sample comprehensive person-centered care plan. The findings included: The facility staff failed to revise Resident #4's comprehensive person-centered care plan to include the removal of a stage 2 pressure ulcer to	F 657	2. Those residents who have individual care needs to be care planned could be at risk due to this care planning oversight. 3. The DON will audit 50% care plans weekly to assure compliance of the care plan to indicate the resident's individual needs as outlined in the regulatory requirement. 4. The DON will report monthly to QAPI the findings of the care plan audits for 3 months. The DON will assure compliance monthly. 5. Date of Compliance 10/11/19.	

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 _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS DEPAUL,TCC	160 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
F 657	Continued From page 24 the left foot second digit. Resident #4 was admitted to the facility on 08/21/19. Current diagnoses included but are not limited to, muscle weakness. Resident #4's Minimum Data Set (MDS-an assessment protocol), a 14 day-PPS with an Assessment Reference Date (ARD) coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #4 extensive assistance of one with transfer, hygiene and bed mobility, limited assistance of one with dressing, eating and bathing. Resident #4's person-centered comprehensive care plan with a revision date of 09/18/19 documented Resident #4 with a stage 2-pressure ulcer to her left foot. The goal: prevent pressure ulcer from worsening. Some of the intervention/approaches to manage goal included pressure ulcer care per order, to assess for sign/symptom (s/s) of infection and notify the physician as needed for acute changes. Review of Resident #4's podiatry note written on 09/10/19 included the following under skin: positive for wound to left second toe, there is a grade 2 ulcer medial with erythema (redness and edema.) No treatment recommended. Review of clinical note written on Resident dated 09/11/19 included but not limited too: left toe open to air (OTA). Review of Resident #4's Wound Care Flow Sheets from 09/15/19-09/26/19; did not include a wound to Resident #4's left foot (second digit.)	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496346	A. BUILDING _____ B. WING _____	09/26/2019

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
F 657	Continued From page 25 On 09/26/19 at approximately 10:05 a.m., the Director of Nursing (DON) completed a skin assessment on Resident #4's left foot (second digit) with the surveyor present. The skin to the left foot (second toe) intact with no skin impairment. On the same day at approximately 3:03 p.m., the care plan was reviewed with the DON, who stated, "Resident #4's care plan should have been revised to remove the stage II pressure ulcer from left foot second digit." The Administrator and Director of Nursing was informed of the finding during a briefing on 09/26/19 at approximately 3:53 p.m. The facility did not present any further information about the findings. The facility's policy titled Care Plan-Resident Centered (Last reviewed June 2018). -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 are and based on regulations as outlined in the 2016 Final Rule. -Procedure to include but not limited to: 11. Care plans will be revised in the interim by the interdisciplinary team as changes occur.	F 657		