STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	495206	A. BUILDING: _____ B. WING _____	10/3/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	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 and clinical record review the facility staff failed to ensure that the discharge assessment was accurately coded for 1 of 42 residents (Resident #87) in the survey sample. The findings included: Resident #87 was admitted to the facility on 07/26/2019 and discharged home on 08/09/2019. Diagnoses included but were not limited to, Pneumonia and Atrial Fibrillation. Resident #87's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 08/02/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. On 10/03/2019 Resident #87's closed record was reviewed and revealed the following: Resident #87's 14-day MDS (Minimum Data Set) with an Assessment Reference Date of 08/09/2019, Section A2100 Discharge Status, coded Resident #87 as discharged to "acute hospital." Review of Progress Notes revealed the following: Discharge Planning Note dated 08/08/2019 time 7:01 p.m., revealed the following: "Discharge will be to a private residence." Discharge Planning Note dated 08/09/2019 time 8:30 a.m., revealed the following: "Resident discharged home....." On 10/03/2019 at approximately 5:30 p.m., an interview was conducted with Registered Nurse (RN) #4 and she was asked, "Was Resident #87 discharged home?" RN #4 stated, "Yes." RN #4 was asked, "What does the MDS Discharge Assessment state?" RN #4 stated, "Discharged to the hospital." RN #4 was asked, "Is this a inaccurate assessment?" RN #4 stated, "Yes. It was a data entry error." RN #4 stated, "I will complete a modification and send to CMS (Centers for Medicare and Medicaid Services)." On 10/03/2019 at approximately 5:40 p.m., RN #4 provided the surveyor a copy of the modified MDS. The surveyor was also provided a copy of the MDS 3.0 Final Validation Report dated 10/03/2019 time 5:47 p.m. On 10/03/2019 at approximately 7:30 p.m., the Administrator and Director of Nursing were made aware of the finding at the pre-exit meeting. The facility staff did not present any further information. 10/25/2019

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 10/1/19 through 10/3/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	F554 1. For resident #7, a medication self-administration safety screen was performed to indicate resident is safe to self administer the following medications, per physician order: asperflex, simethicone, and eyedrops. Resident #7's care plan was updated. 2. Residents capable of self-administration of medications have the potential to be affected. 3. A. Nurses educated on the facility's policy/procedure regarding resident self-administration of medications. B. Audit performed by Clinical Managers to assess each resident's ability to self administer medications. C. Clinical documentation for all residents that self-administer medications reviewed to ensure compliance with facility policy/procedure, physician orders, and regulatory standards. D. Medication self-administration safety screening to be performed quarterly and as needed on residents capable of self-administration.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/01/2019 through 10/03/2019. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 3 complaints were investigated during the survey. The census in this 120 certified bed facility was 96 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 7 closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, clinical record review and facility document review, the facility staff failed to determine that it was safe for one of 42 residents in the survey sample to self-administer medications, Resident #7. The findings include:	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Exec. Admin — (X6) DATE: 10/25/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 554	Continued From page 1 Resident #7 was admitted to the facility on 5/29/18 with diagnoses to include but not limited to, unspecified dementia, gastro-esophageal reflux disease (GERD), anxiety disorder, major depression and chronic pain syndrome. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 9/23/19, coded Resident #7 as scoring a 15 out of a possible 15, indicating the resident's cognition was intact. The resident required supervision for all activities of daily living. The pain assessment coded the resident as having experienced pain almost constantly making it difficult to sleep at night and limiting day-to-day activities with a pain level score of 10 out of a possible 10 (zero being no pain and ten as the worst pain you can imagine.) A physician order dated 7/10/18 included: Asper-Flex Cream 10% apply to affected area topically as needed for joint pain twice daily/patient may keep at bedside and administer (self-administer). Physician orders dated 11/19/18 included: Simethicone Tablet 80 mg (milligrams) give 2 tablets by mouth before meals for heartburn/gas (1 hour before meals) unsupervised self-administration. On initial tour conducted 10/1/19 at 1:10 p.m., the Resident #7 was observed sitting up in a wheelchair at the bedside. A blister pack of medication was observed stored inside a plastic three drawer bin. The medication was labeled as MI acid 80 mg tabs chew, take two tablets by mouth before meals-unsupervised self administration. The resident stated she takes these before meals for her reflux, and stated she also applies a cream to her knee when she needs it. She then took out a tube of Arthricream stored	F 554	4. Audits and Pharmacy Consultant's report to be reviewed by Pharmacy Consultant (or designee) at monthly QAPI committee meeting for the next three months. 5. Completion date: 11/15/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 554	Continued From page 2 inside the top drawer of the bedside drawer, when asked when was the last time she applied the cream, she stated, "Last night around 11 or 12 for my right knee." When asked to rate the pain to her right knee at that time she said, "9." The resident then took out from the same drawer a small vial of refresh eye drops with instructions to apply two drops to both eyes as needed. She stated she has had multiple eye surgeries for cataracts and the drops help. A second review of the physician orders included one dated 1/28/19 for LiquiTears Solution 1.4% instill 1 drop in both eyes every 6 hours as needed for dry eyes, but did not include an order for unsupervised self-administration. The clinical record failed to evidence that an assessment for self-administration of medications was conducted for Resident #7. Also, there was no revision of the comprehensive person-centered care plan to include self-administration of medications. On 10/3/19 at approximately 3:30 p.m., the Licensed Practical Nurse (LPN) Nansemond unit manager and the Registered Nurse (RN#2) who was orientating the LPN unit manager were interviewed. When asked about the self-administration of medication assessment for residents RN #2 stated, "We educate them for right med, right time, how and when to notify staff of side effects, we do an observation of the resident administering the medication." When asked if they were aware of a self-administration assessment, they could not provide information of where this could be found. When asked if they where aware of the three medications Resident #7 self-administered unsupervised, the RN	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 554	Continued From page 3 stated, "I was aware of the cream to her knees." The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting on 10/3/19 at 7:30 p.m. Prior to exit the facility provided a copy of a completed Self Administration Safety Screen for Resident #7 dated 10/3/19. The facility policy titled Medication-Resident Self-Administration dated May 2018 read, in part: * The competency of the resident is assessed prior to allowing the resident to self-administer medications. A resident felt to be mentally or physically incompetent or incapacitated shall not be allowed to self-administer medications. Periodic re-evaluation of the resident shall be performed. *Specific orders for self-administration of medication by the resident must be documented in the resident's medical record and care plan. Tool to assess resident's competency to self administer medications is located in Point Click Care (PCC) EMR (electronic medical record) and is titled "Medication:BSHSI Self Administration Safety Screen.	F 554		
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	F 656	F656 1. For resident #7, the care plan has been revised to include medication self-administration. 2. Residents capable of self-administration of medications have the potential to be affected. 3. A. The facility's Clinical Assessment Coordinators have been educated on the facility's policy/procedure regarding care planning and medication self-administration. B. Clinical documentation to be audited monthly for the next three months for residents capable of self-administration of medications. Audit to be comprised of physician order verification, review of self-administration safety screen, and review of care plan. 4. Audit results to be reported and reviewed at monthly QAPI committee meeting for the next three months. 5. Completion date: 11/15/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 656	Continued From page 4 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. (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 observation, resident interview, staff interviews, clinical record review and facility document review the facility staff failed to revise the comprehensive person-centered care plan to include medication self-administration for one of	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 656	Continued From page 5 42 residents in the survey sample, Resident #7. The findings include: Resident #7 was admitted to the facility on 5/29/18 with diagnoses to include but not limited to, unspecified dementia, gastro-esophageal reflux disease (GERD), anxiety disorder, major depression and chronic pain syndrome. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 9/23/19 coded the resident as scoring a 15 out of a possible 15, indicating the resident's cognition was intact. The resident required supervision for all activities of daily living. The pain assessment coded the resident as having experienced pain almost constantly making it difficult to sleep at night and limiting day-to-day activities with a pain level score of 10 out of a possible 10 (zero being no pain and ten as the worst pain you can imagine.) A physician's order dated 7/10/18 was for Asper-Flex Cream 10% apply to affected area topically as needed for joint pain twice daily/patient may keep at bedside and administer (self-administer). A physician's order dated 11/19/18, was for Simethicone Tablet 80 mg (milligrams) give 2 tablets by mouth before meals for heartburn/gas (1 hour before meals) unsupervised self-administration. On initial tour conducted 10/1/19 at 1:10 p.m., Resident #7 was observed sitting up in a wheelchair at the bedside. A blister pack of medication was observed stored inside a plastic three drawer bin. The medication was labeled as MI acid 80 mg tabs chew, take two tablets by mouth before meals-unsupervised self administration. The resident stated she takes	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 656	Continued From page 6 these before meals for her reflux, the resident stated she also applies a cream to her knee when she needs it. She then took out a tube of Arthricream stored inside the top drawer of the bedside drawer, when asked when was the last time she applied the cream, she stated, "Last night around 11 or 12 for my right knee." When asked to rate the pain to her right knee at that time she said, "9." The resident then took out from the same drawer, a small vial of refresh eye drops with instructions to apply two drops to both eyes as needed. She stated she has had multiple eye surgeries for cataracts and the drops help. A second review of the physician orders included one dated 1/28/19 for LiquiTears Solution 1.4% instill 1 drop in both eyes every 6 hours as needed for dry eyes, but did not include an order for unsupervised self-administration. The clinical record failed to evidence that Resident #7's comprehensive person-centered care plan was revised to include self-administration of medications. On 10/3/19 at approximately 2:00 p.m., the MDS Coordinator, Registered Nurse #4 was interviewed. When asked who was responsible for the revision of care plans she stated the MDS Coordinators and unit managers. The MDS Coordinator was asked to review the care plan for Resident #7 to find a revision to include the self-administration of medications. After reviewing the care plan she stated "It's not there, I'll do it now." She also stated that she was not aware that the resident was self-administering medications.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 656	Continued From page 7 The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting on 10/3/19 at 7:30 p.m. The facility policy titled Medication-Resident Self-Administration dated May 2018 read, in part: *Specific orders for self-administration of medication by the resident must be documented in the resident's medical record and care plan.	F 656	F 658 1. Resident #25 received one administration of medications in error. Resident's attending physician and legal representative notified. Resident condition was monitored, with no negative effects observed.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to meet professional standards for the administration of medications for 1 of 42 residents (Resident #25) in the survey sample. Resident #25 was administered her roommate's medications in error. The findings included: Resident #25 was admitted to the facility on 11/21/18 with diagnoses to include Type II Diabetes and Depressive Disorder. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/29/19, coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.	F 658	2. Residents that receive medications administered by facility nurses could have the potential of being affected. 3. A. The Pharmacy Consultant's "medication pass inspection report" has been revised to include verification of proper identification of residents by both the nurse AND pharmacist. B. Pharmacy Consultant to perform two medication pass observations per month and report findings to the Director of Nursing. C. Nurses educated on the facility's policy/procedure on medication administration. D. Pharmacy Consultant educated on facility's policy/procedure regarding medication administration and the importance of her role to intervene to avoid medication errors during med pass observations. →	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 658	Continued From page 8 During the Resident Council Meeting held on 10/02/19 at approximately 10:00 a.m., Resident #25 reported she was given her roommates medication. An interview was conducted with the Director of Nursing (DON) on 10/03/19 at approximately 10:05 a.m. The DON said she completed a Medication Error Report on Resident #25; the nurse Registered Nurse (RN) #1 gave Resident #25 her roommate's medication while being observed by the pharmacist. The surveyor requested the Medication Error Report that was completed on Resident #25. On the same day, the DON presented the following documents dated 08/21/19: 1. Review of the Medication Error Report completed by the DON included the following documentation: Medication Error report: When passing medication identification of a resident should be by two forms of identity, picture/name band. This nurse failed to double check that she was giving medications to the correct resident. RN #1 will remain on orientation to continue proper medication administration and will be checked off by the pharmacist before passing medications independently. The RN will be placed back into orientation for 2 more weeks but this could change based on her success to pass. 2. Medication Pass Observation completed by the pharmacist on 08/21/19 included the following documentation: (Meds prepared for patient in A-Bed; given in hallway to patient in B-Bed (Resident #25): -Ensure Plus (used as a nutritional supplement) -Aspirin 81 mg 1 tab (for antithrombotic &	F 658	4. Results of medication pass audits to be reported and reviewed at monthly QAPI committee meeting for the next three months. 5. Completion date: 11/15/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 658	Continued From page 9 anti-inflammatory) -Colace 100 mg 1 tab (for treatment of constipation) -Iron 325 mg 1 tab (used as a supplement) -Tylenol 325 mg 2 tabs (for pain/fever) -Isosorbide 20 mg 1 tab (for treatment of high blood pressure). An interview was conducted with the Director of Nursing (DON) on 10/03/19 at approximately 3:30 p.m. The DON said RN #1 should have rechecked Resident #25's picture that is in the computer and her ID bracelet before giving Resident #25 her medication. On the same day at approximately 3:45 p.m., the surveyor asked the DON, "Was education provided to the other nursing staff on how identify resident prior to administering their medication to ensure the residents are not receiving the wrong medication." The DON reviewed her paperwork but was unable to provide evidence that education was provided to the other nursing staff to include Staffing Resources. The DON said the staff should be checking the resident's armband along with reviewing the picture to make sure the nurses are administering the medication to the right patient. On 10/03/19 at approximately 3:50 p.m., a phone interview was conducted with Registered Nurse (RN) #1. The RN said "I made a medication error on (Resident #25) but not sure of the actual date." RN #1 said she gave Resident #25 her roommate's medications and stated "I mixed up the two residents." The RN said I had mistaken Resident #25 (B-Bed) for the resident in A-Bed. She said when Resident #25 was being rolled out of the room by therapy, "I thought it was the resident in A-bed but it was the resident in B-bed	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 658	Continued From page 10 (Resident #25)." The surveyor asked, "When did you realized the medication you administered to Resident #25 (Bed-B) was prepared for her roommate (Bed-A) she replied, "When the resident stated, I don't drink Ensure my roommate does." The RN said she should have rechecked the resident's ID bracelet and her picture to make sure the right resident received the right medication especially because the resident was removed from the room. The RN said she had just started working at the facility, I did not know the residents so a double check prior to giving the resident could have prevented Resident #25 from receiving the wrong medication. The RN said "The pharmacist was with me when I made the medication error." She said I was placed back on orientation but could not pass medications independently until the pharmacist signed me off. An interview was conducted with Resident #25 on 10/03/19 at approximately 4:10 p.m., who said therapy was rolling me out of my room when the nurse stopped me at the door to give me my morning medication. She said the nurse gave me my medication then offered me some Ensure. The resident said she told the nurse, I do not drink Ensure, my roommate does. The resident said, my daughter called soon after I took my medication and asked if I had taken the wrong medication this morning. The resident said she told her daughter, "I did not take the wrong medications, if anything I was given the wrong medication." The resident said she told her daughter the nurse offered me Ensure to drink and I told her my roommate drinks Ensure; not me, so I guess the nurse then realized she had given me my roommate medications.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 658	Continued From page 11 The Administrator and Director of Nursing were informed of the finding during a briefing on 10/03/19 at approximately 7:35 p.m. The facility did not present any further information about the findings. The facility's policy titled Medication-Administration of Medications (Review date: April 2019). -Policy: Medications shall be administered in a safe and timely manner, and as prescribed. -Scope- Applies to all staff authorized to administer medications to residents. Procedure to include but not limited to: 8. The individual administering medications must verify the resident identify before giving the resident his/her medications. Methods of identifying the resident include: -Checking identification band. -Checking photographs attached to medical record; and -If necessary, verifying resident identification with other facility personnel. 22. Medications ordered for a particular resident may not be administered to another resident.	F 658	F677 1. A. Residents #15 and #57 fingernails have been cleaned and trimmed. B. Resident #288 was offered a shower on 10/3/2019 and declined. He was discharged to home on 10/8/2019 following a successful rehabilitation stay. 2. All residents have the potential to be affected. 3. A. On 10/3/2019, an audit was performed to identify any other residents in need of nail care and/or bathing. B. Clinical Managers (or designee) to perform auditing of resident nail care and bathing weekly for the next twelve weeks, utilizing a newly developed quality monitoring tool and will ensure that follow-up care is provided to residents as needed. C. Nursing staff educated on the facility's policy/procedure regarding nail care and bathing. 4. Audit results to be reported by the Director of Nursing (or designee) and reviewed at the monthly QAPI committee meeting for the next three months. 5. Completion date: 11/15/2019	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and clinical record review the facility	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 677	Continued From page 12 staff failed to ensure 3 residents (Resident #15, #57, #288) out of 42 residents in the survey sample, received the necessary services to maintain good personal hygiene. The findings included: 1. For Resident #15, the facility staff failed to provide fingernail care. Resident #15 was admitted to the facility on 07/09/2019. Diagnosis included but were not limited to, Functional Quadriplegia and Dementia. Resident #15's Admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 07/16/2019 coded Resident #15 with a BIMS (Brief Interview for Mental Status) score of 02 indicating severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #15 as requiring limited assistance of 1 with eating, extensive assistance of 1 with toilet use, extensive assistance of 2 with personal hygiene, dressing, bed mobility and transfer and total dependence of 2 for bathing. During the initial facility tour on 10/01/2019 at 01:27 p.m., Resident #15 was observed lying in bed and her fingernails were noted to be a brownish yellow color and approximately a quarter inch in length past the tip of the fingertips. Resident #15 was asked, "Do you like your fingernails this length?" Resident #15 stated, "No, not this long. They look yellow." On 10/02/2019 at 11:20 a.m., Resident #15's fingernails were observed and they remained unchanged.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 677	Continued From page 13 On 10/03/2019 at 10:45 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #1. The surveyor asked CNA #1 to look at Resident #15's fingernails. CNA #1 was asked, "What do you see?" CNA #1 stated, "Her nails need to be cut." The surveyor asked CNA #1, "What is the process when you notice that a resident needs their fingernails cut?" CNA #1 stated, "I soak the fingernails then clean them and cut them if they are not diabetic." The CNA was asked, "Were you (Resident Name) CNA yesterday?" CNA #1 stated, "Yes. I noticed that her fingernails needed cutting yesterday." On 10/03/2019 at approximately 11:00 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #1. The surveyor asked LPN #1 to look at Resident #15's fingernails. LPN #1 was asked, "What do you see?" LPN #1 stated, "The residents nails need to be cut." LPN #1 was asked, "Does (Residents Name) fingernails look clean or dirty?" LPN #1 stated, "They look yellow." An interview was conducted with the Director of Nursing (DON) on 10/03/2019 at approximately 4:00 p.m. The DON stated, "I expect the staff to provide the residents ADL (Activities of Daily Living) care everyday, clean and trim their nails and file them if they don't want them cut." The Don stated that she would check to ensure that Resident #15's nails had been cut. The surveyor requested a copy of the facility policy and procedure on ADL Care on 10/03/2019. At approximately 5:00 p.m., the DON stated that she was unable to locate a policy on ADL Care.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 677	Continued From page 14 The Administrator and Director of Nursing were made aware of the finding at the pre-exit meeting on 10/03/2019 at approximately 7:30 p.m. The facility did not present any further information about the finding. 2. The facility staff failed to provide fingernail care for Resident #57 who was a dependent resident. Resident #57 was admitted to the facility on 6/6/17 with diagnoses to include but not limited to, traumatic subdural hemorrhage, dysphagia (difficulty swallowing), and functional quadriplegia (paralysis of all four extremities.) The current MDS (Minimum Data Set) an annual with an assessment reference date of 8/26/19 coded the resident as scoring a 2 out of a possible 15 on the brief interview for mental status (BIMS), indicating the resident had severely impaired cognition. The resident was dependent on staff for all activities of daily living (ADL)to include personal hygiene/ grooming such as nail care and dressing. The resident had functional limitation of range of motion to both upper and lower extremities and was bed bound. The resident was dependent on a tube feeding for all nutrition. On 10/1/19 during the initial tour at 12:00 p.m., on 10/2/19 at 1:00 p.m. and on 10/3/19 at 10:30 a.m., the resident was observed in bed and awake. The resident was observed with long jagged fingernails to both hands extending approximately one centimeter past the nail bed, under the second and third finger nail beds on the right hand was a white substance that was similar to the paint chips from the wall where the resident was observed chipping at with her right hand fingernails.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 677	Continued From page 15 Review of the comprehensive person-centered care plan for Resident #57 evidenced an ADL care plan that read; I have ADL Self Care Performance Deficit related to the diagnoses of traumatic subdural hemorrhage, dysphagia (difficulty swallowing), hemiparesis (paralysis). The goal was that the resident would maintain current level of function in ADL care needs through the next review date of 12/5/19. The interventions included toilet use, transfers, bed mobility, personal hygiene/oral care, dressing, and eating. The care plan was not revised to include fingernail care such as trimming/ filing and cleaning under the fingernails as needed. On 10/3/19 at approximately 2:00 p.m., the MDS Coordinator registered nurse #4 was interviewed. When asked who was responsible for the revision of care plans she stated the MDS Coordinators and unit managers. On 10/3/19 at approximately 3:30 p.m.,the above findings was shared with the Licensed Practical Nurse (LPN) Nansemond unit manager and the Registered Nurse (RN#2) who was orientating the LPN unit manager. They escorted this inspector into Resident # 57's room and observed the resident chipping away at the chipped paint with her right hand fingernails. They observed the resident's fingernails and then stated the resident's fingernails would be taking care of right now. On 10/3/19 at 6:00 p.m., the Director of Nursing stated "Everyone should provide ADL care, checking nails every day, clean, trim, file them down, if they don't want them cut we need to care plan that."	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 677	Continued From page 16 The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting on 10/3/19 at 7:30 p.m. The facility policy titled Nail Care dated May 2018 read, in part: The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 3. The facility staff failed to ensure Resident #288 was offered and/or received a scheduled twice-weekly showers to maintain good personal hygiene. The resident's Minimum Data Set (MDS) assessment was not due to be completed. Resident #288 was admitted to the facility on 09/23/19. Diagnosis for Resident #288 included but not limited to *Cerebral Infarction with right hemiplegia. Resident #288 had a Baseline Care Plan completed on 09/2319. The Baseline care Plan under Level of Consciousness/Cognition coded Resident #288 as being alert but cognitively impaired. In addition, under Functional Abilities and Goals-Self Care coded Resident #288 requiring limited assistance of one with eating, personal hygiene, toilet use, dressing, bathing, bed mobility, transfer and ambulation for Activities of Daily Living (ADL). Review of Resident #Admission: Nursing	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 677	Continued From page 17 Admission Assessment completed on 09/23/19 included the following under deficits: -Short term memory loss -Paralysis/paresis -Incoordination -Alteration in sensation -Unsteady Gait An interview was conducted with Resident #288 on 10/01/19 at approximately 1:10 p.m., who stated "I'm not getting my showers; I have not received a shower since I've been here." The surveyor asked, "Do you want showers?" He replied, "Of course I would, they give them to my roommate but no one has offered one to me." The surveyor reviewed the shower schedule for Resident #288. Resident #288 was scheduled for showers twice weekly on Monday and Thursday on the 7 PM-7 AM shift. Review of Resident 288's ADL Verification Worksheet for bathing revealed the following: Showers were not given on the following days: September 2019 (9/23, 9/26 and 9/30/19). A phone interview was conducted with Certified Nursing Assistant (CNA) #2 on 10/02/19 at approximately 8:22 p.m. The CNA said she gave Resident #288 his shower but it will not always show up in the computer as being given. While on the phone with the CNA, she reviewed her shower documentation on Resident #288 for 9/23/19, 9/26/19 and 09/30/19. After she reviewed the documentation the CNA stated, "Oh, I thought because it was PRN (as needed) I did not have to document showers was given but now I know; I have to chart when I give a shower."	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 677	Continued From page 18 An interview was conducted with the Director of Nursing (DON) on 10/03/19 at approximately 3:43 p.m., who stated, "The CNA's are two give showers at least twice a week and more often if requested. The DON also stated, "If a resident refuses their shower, the CNA is inform the nurse of their refusal and document in the refusal in their ADL flow sheet under baths." The Administrator and Director of Nursing were informed of the finding during a briefing on 10/03/19 at approximately 7:35 p.m. The facility did not present any further information about the findings. The facility's policy titled Shower/Tub Bath (Revision 08/2002). Purpose: The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: The following information should be recorded on the resident's ADL record and/or in the resident's medical record included but not limited to: -The date and time the shower/tub bath was performed. -The name and title of the individual(s) who assisted the resident with the shower/tub bath.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 684	Continued From page 19 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and during the course of a complaint investigation the facility staff failed to follow the physician orders for a change in condition for 1 of 42 residents in the survey sample, Resident #237. The facility staff failed to follow the physician order to send the resident to the emergency room if symptoms continued. The symptoms reoccurred on 8/28/18 at 3:30 a.m., the nurse did not send the resident to the ER as ordered, two hours later the resident was deceased, constituting harm. The findings included: Resident #237 was admitted to the facility on 8/10/18 for short-term skilled services with diagnoses of end stage renal disease requiring hemodialysis, seizure disorder, generalized muscle weakness and difficulty walking following a recent hospitalization for metabolic encephalopathy, with the goal to be discharged home on 8/31/18. The admission MDS (Minimum Data Set) with an assessment reference date of 8/23/18, coded the resident as scoring a 15 out of a possible 15, indicating the residents cognition was intact. The resident required limited assistance with one person physical assist with bed mobility, transfers, walking in room and corridor,dressing, toileting, personal hygiene and supervision with set up help only for eating. The	F 684	F684 1. Resident #237 passed away on 8/28/2018. LPN #4 is no longer assigned to work at the facility. 2. All residents have the potential to be affected. 3. A. Nurses educated on the facility's policy/procedure regarding change in resident condition and following physician orders. B. Residents that incur a change in condition will be documented on the "change in condition report" and communicated to the oncoming unit nurse(s) and Clinical Manager (or designee). C. During the daily clinical review meetings, residents with condition changes will be discussed and documentation reviewed to ensure appropriate interventions occurred, adherence to physician orders, and timely reporting to the attending physician and legal representative. 4. Director of Nursing (or designee) will present a report at the monthly QAPI committee meeting for the next three months that identifies residents that encountered a change in condition and compliance with quality standards. 5. Completion date: 11/15/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 684	Continued From page 20 resident was a full code. Resident #237's care plan with an initiated date of 8/13/18 included: I have a seizure disorder; Goal-I will remain free of seizure activity through review date, 11/13/18; I will maintain lab values within therapeutic range per MD, through next review date 11/13/18; Interventions included, but not limited to: Give medications as ordered, seizure documentation, post seizure treatment, seizure precautions. On 8/27/18 the clinical record evidenced the resident had a change in condition that required physician intervention to include evaluation and orders. The nursing health status note dated 8/27/18 timed at 12:09 p.m., read "Res (resident) is very shaky this am. He needed help w/eating (with) breakfast and needed 2 person assist getting out of bed. Dr. (name of physician) saw him and increased his Ativan (anti-anxiety medication) to 3 x day prn (as needed) and said to give him a dose now. He also ordered labs and said that if the shakiness does not improve to send him to the ER. VSS (vital signs stable)." The vital signs obtained closest to this entry were timed for 12:08 p.m., blood pressure 135/66, pulse 57, respirations 16. The physician orders dated 8/27/18 after assessing the resident for this change in condition were as follows: CBC (complete blood count), CMP (comprehensive metabolic panel) and a Keppra level, increase Ativan 0.5 mg (milligrams) three times a day as needed -"give one dose now if still has sx (symptoms) to go to ER", and neurology consult for seizures.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 684	Continued From page 21 The clinical record evidenced on 8/27/18 the resident was administered the "now" dose of Ativan 0.5 mg at 11:58 a.m., and another dose was administered at 8:48 p.m. The 7 a.m.-7 p.m., skilled daily nursing notes dated 8/27/18 at 3:33 p.m., read, in part: Mood Indicator: Tired/has little energy. Staff provided limited assistance with bed mobility. Staff provided set up help only with bed mobility. Resident requires limited assistance from staff for transfers...Neuromuscular status is not within normal clinical limits this shift. Tremors..." The 7 p.m.-7 a.m., skilled daily nursing noted dated 8/27/18 at 10:31 p.m.., read, in part: "...required one person assist with transfers this shift." The clinical record evidenced that early the next morning on 8/28/18, the resident exhibited the "shaking" symptoms; the staff failed to follow the physician orders for the change in condition to send the resident to the ER if still has symptoms. Within two hours of the identified symptoms (shaking) at 3:30 a.m., the resident was deceased. Licensed Practical Nurse (LPN#4) documented the following at 6:41 a.m., on 8/28/18: "@ approximately 03:30 (a.m.), CNA (certified nursing assistant) reported to writer that resident was shaking and was not able to get himself ready as he normally does. Writer went in to assess resident and check his vital signs. Resident was alert, answering questions, speaking coherently. Writer asked resident if he still wanted to go to dialysis or if he would like the MD to be notified. Resident stated he still wanted	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 684	Continued From page 22 to go to dialysis and that he has had "shakes" before. Vital signs were as follow 96.8 axillary, 52, 161/69, 18, 97%. Routine medication was administered, vitals were checked after about 30 minutes and were as follows 97.3 oral, 57, 147/55, 20, 99%. Resident's brothers arrived to transport him to dialysis. Resident's brother stated he wasn't sure if they should transport him and asked him if he wanted to go to the ER instead, resident stated "yes, I'll go to the ER" @ 0500, writer called EMS, gave report @0510. MD was called, answering service stated MD would be notified. @ 0520 EMS arrived, @ 0525 MD called back, report was given, and he stated that resident should go out to ER. Writer informed MD that 911 had already been called and was in room with resident. EMT technician came to desk and requested nursing staff to come to resident's room. CPR (cardiopulmonary resuscitation) was administered by EMS as nursing stood by to assist however needed. Resident was pronounced deceased by EMT at 0540." On 10/3/19 at 11:15 a.m., LPN #4 was interviewed via phone. LPN #4 was asked if she was aware of the physician order to send the resident to the ER if the resident still had symptoms, she stated, "No." She stated the change in condition physician order was not communicated to her during shift change. When asked "If you had been aware of the physician order to send the resident to the ER when he started exhibiting the shaking symptoms at 3:30 a.m., would you have sent him to the ER at that time?" She stated, "Absolutely". On 10/3/19 at 12:00 p.m., the physician was interviewed via phone. He stated he had discussed with the day shift nurse on his order to	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 684	Continued From page 23	F 684		

send the resident to the ER if the resident still had symptoms. When asked if he would have expected the nurse (LPN#4) to have sent the resident to the ER at 3:30 a.m., when the symptoms continued, he stated, "Yes...if he was still having any symptoms any shaking go to the ER." He also stated the nurse could have called him at that time if she had any questions. He also stated that he had a discussion with the nursing staff that his orders have to be passed from one nurse to another.

An interview was conducted on 10/3/19 at 2:45 p.m., with one of two of Resident #237's brothers who was at the bedside on 8/28/18. The brother stated he and his other brother arrived at the facility at approximately 5:00 a.m. on 8/28/18 to transport the resident to dialysis. Upon arrival he noted Resident #237 was not sitting up in the wheelchair at the nurses station as normally expected. They headed to the resident's room and were met by LPN #4. He stated upon entering the resident's room the resident was having a "terrible seizure," the nurse asked if they were going to take the resident to dialysis and he stated "No...he will never make it to dialysis," he stated he told the nurse that she needs to call 911. He stated EMS arrived approximately ten minutes later and began to work on the resident.

The EMS report dated 8/28/18 evidenced the EMS service was dispatched at 5:06 a.m., and made it to Resident #237's bedside at 5:18 a.m. The report read, in part: "M5 arrived scene to find a (age and gender) lying in bed. Patient was pulseless and apenic (not breathing) up (sic) arrival. Skin is warm and dry. Pupils are fixed and dilated. Verified with staff that no DNR (do not resuscitate) was present then began CPR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 684	Continued From page 24 Staff called due to hypertension and tremors. Patient's brothers were present and they stated that he had not been responding to them for about 15 minutes prior to M5 arrival...working through ACLS protocols...airway established...M5 called dispatch for a engine due to cardiac arrest...Epi was given every 3-5 minutes... Initial rhythm was asystole. Rhythm never changed, down time was approximately 15 minutes prior to arrival. Contacted medical control, gave (name of physician) the report and he concurred with the decision to terminate efforts." The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting conducted on 10/3/19 at 7:30 p.m. Complaint deficiency.	F 684	F688 1. Resident #57's left knee orthosis is being applied per physician order and per the plan of care. 2. Residents with orders for orthotic devices have the potential to be affected. 3. A. Rehab therapy will maintain a current listing of residents with orthotic devices (per physician order) and will audit 25% weekly for the next 12 weeks to ensure devices are applied properly and per physician order. B. Nursing staff educated on the facility's policy/procedure regarding splints and orthotics. C. Care plans for residents with orders for orthotic devices will be audited monthly for the next three months. 4. Rehab therapy and Care Plan Coordinator will present audit results at monthly QAPI committee meeting for the next three months. 5. Completion date: 11/15/2019	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 688	Continued From page 25 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure 1 of 42 residents in the survey sample received the appropriate treatment and services to prevent further decrease in range of motion, Resident #57. The facility staff failed to consistently apply the left comfy knee orthosis as ordered. The findings included: Resident #57 was admitted to the facility on 6/6/17 with diagnoses to include but not limited to, contracture of the left leg and functional quadriplegia (paralysis of all four extremities). The current MDS (Minimum Data Set) an annual assessment with an assessment reference date of 8/26/19 coded the resident as scoring a 2 out of a possible 15 on the brief interview for mental status (BIMS), indicating the resident had severely impaired cognition. The resident was dependent on staff for all activities of daily living (ADL) to include personal hygiene/grooming such as nail care and dressing. The resident had functional limitation of range of motion to both upper and lower extremities and was bed bound. The resident was dependent on a tube feeding for all nutrition. A physician order dated 9/26/19 was for the resident to wear a left comfy knee orthosis at all times except hygiene. Skin checks to be performed every 8 hours to check for signs of irritation/redness. Minor redness is acceptable. Remove brace/orthosis if blister formation is noted, redness is significant or if patient	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 688	Continued From page 26	F 688		

complains of pain. Contact Rehab Department with any questions.

Review of the comprehensive person-centered care plan for Resident #57 evidenced a care plan that identified the potential for impairment of skin integrity related to mobility issues, diabetes and contractures. The goal was that the resident would be free of skin related injuries through the next review date of 12/5/19. One of the interventions listed was that the resident is to wear left comfy knee orthotic at all times except during hygiene.

On 10/1/19 during the initial tour at 12:00 p.m., on 10/2/19 at 1:00 p.m. and on 10/3/19 at 10:30 a.m., the resident was observed in bed and awake. The resident did not have the left knee orthotic in place. Posted on the wall near the foot of the bed were instructions to the staff to apply the left comfy knee orthotic at all times except during hygiene care.

On 10/3/19 at approximately 3:30 p.m., the Licensed Practical Nurse (LPN) Nansemond unit manager and the Registered Nurse (RN#2) who was orienting the LPN unit manager escorted this inspector into Resident # 57's room, the blue comfy left knee orthotic was observed at the foot of the bed.

On 10/3/19 at approximately 4:00 p.m., the Rehab Director was asked to escort this inspector to the resident's room to assess for the use of the orthotic device. Upon entering the room the left comfy knee orthotic device was in use. The Rehab Director was asked about the posted sign on the wall near the foot of the bed, she stated it was there to remind the staff to apply the device.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 688	Continued From page 27 The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting on 10/3/19 at 7:30 p.m. No further information was provided by the facility staff.	F 688	F755 1. A. Facility medication administration times have been adjusted to ensure that Resident #3 receives his medications timely, per physician order. Resident encountered no negative effects. B. Resident #25 received one administration of medications in error. Resident's attending physician and legal representative notified. Resident condition monitored, with no negative effects observed. 2. All residents have the potential to be affected. 3. A. Facility medication administration times have been adjusted to ensure timely administration to residents, per physician order. B. Pharmacy Consultant will audit at least ten resident medication administration records (MAR) per month for the next three months. C. Nurses were educated on the facility's policy/procedure regarding medication administration. →	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 755	Continued From page 28 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, and clinical record review the facility staff failed to administer medications as ordered by the physician for 2 of 42 residents in the survey sample, Resident #3 and #25. The findings included: 1. The facility staff failed to administer medications at the correct time for Resident #3. Resident #3 was admitted to the facility on 9/1/18 with diagnoses to include, but not limited to, chronic obstructive pulmonary disease (COPD), restless leg syndrome, heart failure and high blood pressure. The current MDS (Minimum Data Set) an annual with an assessment reference date of 8/5/19, coded the resident as scoring a 15 out of a possible 15, indicating the resident's cognition was intact. On 10/1/19 during the initial tour of the facility, the resident was observed in bed and reading a letter. The resident was interviewed on the care and serviced provided by the facility . The resident stated that the staff often administer his medications late. He stated this occurred often. Review of the clinical record physician orders evidenced a drug regimen consisting of multiple medications to include the following: 1. Albuterol Sulfate Nebulization Solution (2.5 milligram/3 milliliters) inhale 3 ml inhale orally via nebulizer every 4 hours for shortness of breath. Hold if resident is asleep for COPD. Scheduled to	F 755	4. Pharmacy Consultant to share audit results with Director of Nursing and to be reported and reviewed at monthly QAPI committee meeting for the next three months. 5. Completion date: 11/15/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 755	Continued From page 29 be administered at 12 midnight, 4 a.m., 8 a.m., 12 p.m., 4 p.m., and 8 p.m. 2. Guaifenesin 600 milligram extended release tablet give one tablet every 12 hours for congestion. Scheduled at 9 a.m., and 9 p.m. 3. Mirapex tablet 0.25 milligram, give 0.5 mg by mouth every 12 hours for restless leg syndrome, scheduled at 9 a.m., and 9 p.m. 4. Neurontin 100 mg by mouth every 8 hours, scheduled at 6 a.m., 2 p.m., and 10 p.m. Review of the Medication Administration Record's for August and September 2019 evidenced the following medications were not administered at the correct times. They were administered at least one hour after the scheduled times: 1. Albuterol Sulfate Nebulization Solution-eighteen occurrences-8/1/19-4 p.m. given at 5:36 p.m., 8/6-8 a.m. given at 11:04 a.m., 12 p.m. given at 2:11 p.m. and 4 p.m. given at 6:25 p.m., 8/14- 12 p.m. given at 2:33 p.m., 8/20-8 a.m. given at 10:51 a.m., 8/29-8 a.m. given at 10:25 a.m., 8/30- 8 a.m. given at 10:55 a.m., and 4 p.m. given at 6:22 p.m., 8/31-8 a.m. given at 9:23 a.m., 9/3-4 p.m. given at 5:36 p.m., 9/4- 8 a.m. given at 11:41 a.m., 9/10- 4 p.m. given at 6:30 p.m., 9/11-4 p.m. given at 6:19 p.m., 9/12-12 p.m. given at 2:05 p.m., 9/15- 12 p.m. given at 3:10 p.m., 9/17- 12 p.m. given at 3:30 p.m., and 9/29- 8 a.m. given at 10:16 a.m. 2. Guaifenesin-three occurrences-8/20- 9 a.m. given at 10:51 a.m., 8/29- 9 a.m. given at 10:26 a.m., 9/1- 9 a.m. given at 10:48 a.m. 3. Mirapex-three occurrences-8/20- 9 a.m. given 10:15 a.m., 9/1-9 a.m. given at 10:48 a.m., and 9/1-9 a.m. given at 10:49 a.m.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 755	Continued From page 30 4. Neurontin-on 9/9 the 2 p.m. dose was administered at 4:41 p.m. The above findings was shared with the Director of Nursing 10/2/19 and again during the pre-exit survey conducted with the Administrator and Director of Nursing on 10/19 at 7:30 p.m. No additional information was provided to the survey team for this finding prior to exit. The facility policy titled Medication-Administration of Medications dated March 2019 read, in part as follows: Policy-Medications will be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 2. The facility staff failed to ensure Resident #25 received the correct medication while under direct supervision of the pharmacist during a medication pass observation with Registered Nurse (RN) #1. Resident #25 was admitted to the facility on 11/21/18 with diagnoses to include Type II Diabetes and Depressive Disorder. The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 07/29/19, coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. During the Resident Council Meeting held on	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 755	Continued From page 31 10/02/19 at approximately 10:00 a.m., Resident #25 reported she was given her roommate's medication. An interview was conducted with the Director of Nursing (DON) on 10/03/19 at approximately 10:05 a.m. The DON said she completed a Medication Error Report on Resident #25; the nurse Registered Nurse (RN) #1 gave Resident #25 her roommate medication while being observed by the pharmacist. The surveyor requested the Medication Error Report that was completed on Resident #25. On the same day, the DON presented the following documents dated 08/21/19: 1. Review of the Medication Error Report completed by the DON included the following documentation: Medication Error report: When passing medication identification of a resident should be by two forms of identity, picture/name band. This nurse failed to double check that she was giving medications to the correct resident. (RN #1) will remain on orientation to continue proper medication administration and will be checked off by the pharmacist before passing medications independently. The RN will be placed back into orientation for 2 more weeks but this could change based on her success to pass. 2. Medication Pass Observation completed by the pharmacist on 08/21/19 included the following documentation: (Meds prepared for patient in A-Bed; given in hallway to patient in B-Bed (Resident #25): -Ensure Plus (used as a nutritional supplement) -Aspirin 81 mg 1 tab (for antithrombotic & anti-inflammatory) -Colace 100 mg 1 tab (for treatment of	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 755	Continued From page 32 constipation) -Iron 325 mg 1 tab (used as a supplement) -Tylenol 325 mg 2 tabs (for pain/fever) -Isosorbide 20 mg 1 tab (for treatment of high blood pressure) An interview was conducted with the Director of Nursing (DON) on 10/03/19 at approximately 3:30 p.m. The DON said RN #1 should have rechecked Resident #25's picture in the computer and her ID bracelet before giving administering medications to Resident #25. The surveyor asked, "What is the purpose for rechecking the residents arm bands along with reviewing their picture prior to administering medication to a resident?" She said to make sure the right resident is receiving the right medication. On 10/03/19 at approximately 3:50 p.m., a phone interview was conducted with Registered Nurse (RN) #1. The RN said "I made a medication error on Resident #25 but not sure of the actual date." The RN said she gave Resident #25 her roommate's medications and stated "I mixed up the two residents." The RN said I had mistaken Resident #25 (B-Bed) for resident in A-Bed. She said when Resident #25 was being rolled out of the room by therapy, I thought it was the resident in A-bed but it was the resident in B-bed (Resident #25). The surveyor asked, "When did you realized the medication you administered to Resident #25 (Bed-B) was prepared for her roommate (Bed-A)?" She replied, "When the resident stated, "I don't drink Ensure my roommate does." The RN said she should have rechecked the resident's ID bracelet and her picture to make sure the right resident received the right medication especially because the resident was removed from the room. The RN	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 755	Continued From page 33 said she had just started working at the facility, and stated "I did not know the residents so a double check prior to giving the resident could have prevented (Resident #25) from receiving the wrong medication." The RN said "The pharmacist was with me when I made the medication error" and "She said I was placed back on orientation but could not pass medications independently until the pharmacist signed me off." An interview was conducted with the Pharmacist on 10/03/19 at approximately 3:00 p.m. She said RN #1 went into Resident #25's room who resided in B-Bed. The pharmacist said the RN spoke with the resident in A-Bed. She said the RN and myself returned to the medication cart, the RN pulled the medications for the resident in A-Bed. She (pharmacist) said the therapist was rolling Resident #25 out of the room; the nurse thought it was the resident in A-Bed. The pharmacist said the RN administered the pulled medications to Resident #25 but the medications were pulled for the resident residing in A-Bed. The surveyor asked the pharmacist, "When did you and the RN realize the medications pulled for A-Bed was given to the wrong resident (Resident #25)?" She said when the nurse offered Resident #25 the nutritional supplement and the resident stated, "I don't drink Ensure, my roommate does." The pharmacist said she "Did not know the residents so I was not able to identify them." The pharmacist said if you do not know the resident then the resident's armband should have been checked prior to administering the medication especially if they are being removed from their room. An interview was conducted with Resident #25 on 10/03/19 at approximately 4:10 p.m., who said	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 755	Continued From page 34 therapy was rolling me out of my room when the nurse stopped me at the door to give me my morning medication. She said the nurse gave me my medication then offered me some Ensure. The resident said she told the nurse, I do not drink Ensure, my roommate does. The resident said, my daughter called soon after I took my medication and asked if I had taken the wrong medication this morning. The resident said she told her daughter, "I did not take the wrong medications, if anything I was given the wrong medication." The resident said she told her daughter the nurse offered me Ensure to drink and I told her my roommate drinks Ensure; not me, so I guess the nurse then realized she had given me my roommate medications. The Administrator and Director of Nursing was informed of the finding during a briefing on 10/03/19 at approximately 7:35 p.m. The facility did not present any further information about the findings.	F 755	F757 1. Resident #25 received one administration of medications in error. Resident's attending physician and legal representative notified. Resident condition was monitored, with no negative effects observed. 2. Residents that receive medications administered by facility nurses could have the potential of being affected. 3. A. The Pharmacy Consultant's "medication pass inspection report" has been revised to include verification of proper identification of residents by both the nurse AND pharmacist. B. Pharmacy Consultant to perform two medication pass observations per month and report findings to the Director of Nursing. C. Nurses educated on the facility's policy/procedure on medication administration. D. Pharmacy Consultant educated on facility's policy/procedure regarding medication administration and the importance of her role to intervene to avoid medication errors during med pass observations.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 757	Continued From page 35 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure 1 out of 42 residents, Resident #25 was free from the use of unnecessary medications. Resident #25 was administered another resident's medications in error. The findings included: Resident #25 was admitted to the facility on 11/21/18 with diagnoses to include Type II Diabetes and Depressive Disorder. The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 07/29/19, 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. During Resident Council Meeting held on 10/02/19 at approximately 10:00 a.m., Resident #25 reported she was given her roommates medication. An interview was conducted with the Director of Nursing (DON) on 10/03/19 at approximately 10:05 a.m. The DON said she completed a	F 757	4. Pharmacy Consultant to share results of medication pass audits with Director of Nursing and to be reported and reviewed at monthly QAPI committee meeting for the next three months. 5. Completion date: 11/15/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 757	Continued From page 36 Medication Error Report on Resident #25; the nurse Registered Nurse (RN) #1 gave Resident #25 her roommate medication while being observed by the pharmacist. The surveyor requested the Medication Error Report that was completed on Resident #25. On the same day, the DON presented the following documents dated 08/21/19: 1. Review of the Medication Error Report completed by the DON included the following documentation: Medication Error report: When passing medication identification of a resident should be by two forms of identity, picture/name band. This nurse failed to double check that she was giving medications to the correct resident. RN #1 will remain on orientation to continue proper medication administration and will be checked off by the pharmacist before passing medications independently. The RN will be placed back into orientation for 2 more weeks but this could change based on her success to pass. 2. Medication Pass Observation completed by the pharmacist on 08/21/19 included the following documentation: (Meds prepared for patient in A-Bed; given in hallway to patient in B-Bed (Resident #25), -Ensure Plus (used as a nutritional supplement) -Aspirin 81 mg 1 tab (for antithrombotic & anti-inflammatory) -Colace 100 mg 1 tab (for treatment of constipation) -Iron 325 mg 1 tab (used as a supplement) -Tylenol 325 mg 2 tabs (for pain/fever) -Isosorbide 20 mg 1 tab (for treatment of high blood pressure). An interview was conducted with the Director of	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 757	Continued From page 37 Nursing (DON) on 10/03/19 at approximately 3:30 p.m. The DON said RN #1 should have rechecked Resident #25's picture that is in the computer and her ID bracelet before giving Resident #25 her medication. On the same day at approximately 3:45 p.m., the surveyor asked the DON, "Was education provided to the other nursing staff on how identify resident prior to administering their medication to ensure the residents are not receiving the wrong medication." The DON reviewed her paperwork but was unable to provide evidence that education was provided to the other nursing staff to include Staffing Resources. The DON said the staff should be checking the resident's armband along with reviewing the picture to make sure the nurses are administering the medication to the right patient. On 10/03/19 at approximately 3:50 p.m., a phone interview was conducted with Registered Nurse (RN) #1. The RN said "I made a medication error on (Resident #25) but not sure of the actual date." RN #1 said she gave Resident #25 her roommate's medications and stated "I mixed up the two residents." The RN said I had mistaken Resident #25 (B-Bed) for the resident in A-Bed. She said when Resident #25 was being rolled out of the room by therapy, "I thought it was the resident in A-bed but it was the resident in B-bed (Resident #25)." The surveyor asked, "When did you realized the medication you administered to Resident #25 (Bed-B) was prepared for her roommate (Bed-A) she replied, "When the resident stated, I don't drink Ensure my roommate does." The RN said she should have rechecked the resident's ID bracelet and her picture to make sure the right resident received the right medication especially because the	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 757	Continued From page 38 resident was removed from the room. The RN said she had just started working at the facility, I did not know the residents so a double check prior to giving the resident could have prevented Resident #25 from receiving the wrong medication. The RN said "The pharmacist was with me when I made the medication error." She said I was placed back on orientation but could not pass medications independently until the pharmacist signed me off. An interview was conducted with Resident #25 on 10/03/19 at approximately 4:10 p.m., who said therapy was rolling me out of my room when the nurse stopped me at the door to give me my morning medication. She said the nurse gave me my medication then offered me some Ensure. The resident said she told the nurse, I do not drink Ensure, my roommate does. The resident said, my daughter called soon after I took my medication and asked if I had taken the wrong medication this morning. The resident said she told her daughter, "I did not take the wrong medications, if anything I was given the wrong medication." The resident said she told her daughter the nurse offered me Ensure to drink and I told her my roommate drinks Ensure; not me, so I guess the nurse then realized she had given me my roommate medications. The Administrator and Director of Nursing were informed of the finding during a briefing on 10/03/19 at approximately 7:35 p.m. The facility did not present any further information about the findings. The facility's policy titled Medication-Administration of Medications (Review date: April 2019).	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 757	Continued From page 39 -Policy: Medications shall be administered in a safe and timely manner, and as prescribed. -Scope- Applies to all staff authorized to administer medications to residents. Procedure to include but not limited to: -22. Medications ordered for a particular resident may not be administered to another resident.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761	F761 1. No residents were directly affected by this practice. 2. All residents have the potential of being affected. 3. A. Nurses were educated on the facility's policy/procedure regarding storage of medications. B. Pharmacy Consultant to inspect medication carts weekly for the next three months to ensure compliance with proper storage of medications. 4. Results of medication cart inspections to be presented by Director of Nursing (or designee) reviewed monthly during the QAPI committee meetings for the next three months. 5. Completion date: 11/15/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 761	Continued From page 40 Based on general observations of the nursing facility, the facility failed to ensure medications were labeled in accordance with currently accepted professional principles in 1 out of 5 medication carts. The findings included: The facility staff failed to ensure medication that was taken out of its original package was identified in a medication cup inside the medication cart. On 10/02/19 at 2:45 p.m., an inspection of the medication cart was made on the Nansemond Unit. The surveyor inspected the cart with Licensed Practical Nurse (LPN) #1. The LPN opened the medication cart and located inside the medication cart was a white plastic medication cup containing 6 pink pills. The LPN had written Aspirin 81 mg on the outside of the medication cup. The LPN stated, "No one else is getting (Aspirin) on this shift." The LPN stated, "I did not have any Aspirin on this cart so I borrowed from another cart and placed them in the medication cart." When asked if the Aspirin should be in its original container, LPN #1 replied, "Yes, the aspirin should be in its original container when stored inside the medication cart." An interview was conducted with the Director of Nursing (DON) on 10/03/19 who said aspirin is a house stock item and there are plenty in the medication room. She said the LPN should have never pulled from another medication cart, she should have gotten a new bottle of Aspirin from the medication storage room." The Administrator and Director of Nursing was	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 761	Continued From page 41 informed of the finding during a briefing on 10/03/19 at approximately 7:25 p.m. The facility did not present any further information about the findings. The facility's policy titled Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles (Revision: 07/23/19.) Procedure: -Facility should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally received. Facility should ensure that no transfers between containers are performed by non-Pharmacy personnel.	F 761	F947 1. No residents were directly affected by this practice. 2. All residents and certified nursing assistants (CNA) have the potential to be affected. 3. A. Education records for active CNAs have been reviewed to validate compliance with annual dementia training requirement. B. Training sessions for CNAs on caring for residents with dementia to be held during orientation for new hires and monthly for current CNAs. C. Education Coordinator (or designee) will maintain accurate records of CNA education and report any non-compliance issues to the Director of Nursing. 4. Education Coordinator (or designee) will provide a report to the Quality Assurance & Performance Improvement (QAPI) committee monthly that reflects education compliance status and development, if applicable, of an action plan to ensure ongoing compliance. 5. Completion date: 11/15/2019	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 947	Continued From page 42 address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and documentation review the facility staff failed to ensure 2 out of 6 Certified Nursing Assistants (CNA) received their required annual dementia training. The findings included: On 10/03/19 at approximately 10:15 a.m., the surveyor requested evidence that Certified Nursing Assistant (CNA) #4 and CNA #5 received their annual mandatory training on dementia. On the same day at approximately 5:25 p.m., the Director of Nursing (DON) said the Staff Development Coordinator (SDC) had the facility's annual Skills Fair on July 15-16 2019. The DON said she reviewed the Program/Course Title from the Skills Fair but it did not include education on dementia. The DON stated, "I'm not able to provide evidence that CNA #4 and CNA #5 received their yearly mandatory dementia training." The DON stated the Skills Fair should have consisted of all the mandatory training required by the CNA's. The DON presented a list of the training from the Skills Fair presented on 07/15-07/16/19, which consisted of the following training: -Point Click Care Documentation -Transfers -Activities of Daily Living (ADL's) -Skin (Pressure ulcer prevention) -IV (Working around IV lines) -Blood Glucose (S/S of Hypoglycemia) -Abuse (Preventing and Reporting) -Resident Rights -Code Blue/drill (Who to call, who does what)	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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 947	Continued From page 43 -Respiratory (Oxygen use, storage, cleaning, maintenance) -Dining -Speech -Falls (Purposeful Rounding) -Grievances (Process and Procedures) The Administrator and Director of Nursing was informed of the finding during a briefing on 10/03/19 at approximately 7:35 p.m. The facility did not present any further information about the findings.	F 947	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.	