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

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	495206	A. BUILDING _____ B. WING _____	C 10/03/2019

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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

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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	

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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		

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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	

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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		

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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		

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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		

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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. →	