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 11/05/2019

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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 11/1/19 and 11/4/19 through 11/5/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. 2 complaints were investigated during the survey. The census in this 120 certified bed facility was 95 at the time of the survey. The survey sample consisted of 2 current Resident reviews and 2 closed record reviews.	F 000		
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 review of facility documents, the facility staff failed to ensure physician orders for physical therapy were conveyed to the physical therapist for 1 of 4 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 9/1/18 and the resident has never been discharged from the facility. The current diagnoses included, spondylosis of cervical region without myelopathy or radiculopathy. The annual Minimum Data Set (MDS)	F 658	1. Therapy spoke with Resident #1 regarding his therapy needs and the current physicians order. Therapist explained to resident that therapy would begin as ordered. Resident was initiated on therapy caseload immediately as of 11/ 4 /19. 2. Those residents with therapy needs could be affected by this practice. 3. A. Education was provided to the nursing staff and therapy staff related to the process and communication of a new order/eval for therapy services. The process review included a therapy communication form that will be utilized. B. An audit process has been initiated to review new therapy orders at a minimum of 3 times a week. This will be completed by the Unit manager in collaboration with the Therapy Manager to assure communication has occurred. All new therapy orders will be validated to assure the completion of a therapy communication form	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Exec. Admin | (X6) DATE 11/26/2019

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.

(Revised)

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 11/05/2019

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 1 assessment with an assessment reference date (ARD) of 8/5/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making are intact. In section "G" (Physical functioning) the resident was coded as requiring total care with bathing, extensive assistance of two people with bed mobility, extensive assistance of one person with transfers, locomotion, dressing, toileting, and personal hygiene and supervision of one person after set-up with eating. During the initial tour on 11/1/19 at approximately 12:30 p.m., Resident #1 stated he had a special cushion in his wheel chair which "flung" him from the wheel chair approximately one and a half months ago. The resident stated the staff picked him up and put him in bed but didn't notify the physician or obtain any x-rays until four days later after he constantly complained of neck pain and was making more request for pain medication. Review of the clinical record revealed nurse's notes dated 9/16/19, which included: the resident was found on the floor in his room on his back, bedside his bed with the wheel chair bedside him. He sustained a skin tear to his right hand and elbow and the resident stated he hit his head on the floor. Treatment to both skin tears were applied. No other injuries were noted, the resident was able to move all extremities with no complaints of discomfort. The resident was placed back in bed and is now resting comfortably. Neuro-checks completed and within normal limits. The supervisor, physician and responsible party were notified and teaching was provided on use of the assistive devices.	F 658	4. Audit findings will be provided by the Unit Managers to the DON weekly to assure compliance. The DON will report monthly to Quality Assurance (QAPI) for three months the findings of the audits to assure and maintain compliance. 5. Date of Compliance: 12/6/2019	

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 11/05/2019

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 2 On 9/17/19, the special wheel chair cushion was reassessed by the physical therapist and foundto be inappropriate for Resident #1 because the cushion was for a person weighing greater than 200 pounds and the resident was no longer greater than 200 pounds therefore; the "easy up seat assist" was removed from his wheel chair and a more appropriate cushion was applied. The clinical record also revealed on 9/19/19, an x-ray of the spine was obtained at the nursing facility and the results were reviewed by the physician 9/20/19. No new orders were given. Resident #1 stated during an interview on 11/4/19 at approximately 3:00 p.m., that he had an appointment with his orthopaedic physician for his knee on 10/22/19, and he told the physician about being flung from the wheelchair and the neck pain he had experienced since the fall. The resident stated the orthopaedic physician stated he was ordering physical therapy but he hadn't received any therapy since the appointment. Review of clinical record revealed the orthopaedic physician obtained x-rays of Resident #1's cervical region, and the following orders were sent to the nursing facility: increase the frequency of the Oxycodone-Acetaminophen 5-325 milligrams from every twelve hours to every six hours as needed for pain and physical therapy cervical; to include gentle range of motion, stretching all modalities and heat/ice. The orders also included a follow-up visit in one week, an appointment with ear, nose and throat for cerumen impaction of the left ear. The change in the Oxycodone-Acetaminophen	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 11/05/2019

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 3 5-325 milligrams order was observed on the medication administration record, the follow-up appointment in 1 week was kept, the ear, nose and throat appointment was scheduled but the physical therapy order wasn't carried out. An interview was conducted with the physical therapist on 11/5/19 at approximately 10:30 a.m., the therapist stated he didn't receive the 10/22/19, order for therapy services and he hasn't given resident #1 any recent therapy. The physical therapist further stated at the time he was notified of the resident's fall from the wheel chair, he removed the "easy up seat assist" which had been ordered to aid the resident in more independent during transfers. On 11/5/19 at approximately 1:45 p.m., the above findings were shared with the Administrator and Director of Nursing. The Administrator stated they had no further information to provide.	F 658		
F 755 SS=D	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.	F 755	1. Resident #3 and Resident #4 did receive their medications upon arrival. Resident #3 is no longer a resident at the facility. Resident #4 is receiving medication for sleep as ordered. 2. Those residents with orders for medications that may need a hard script or a prior authorization could be at risk for this practice. 3. A. Education with nursing staff was completed regarding appropriate medication delivery time frame. A back up plan was reviewed that includes a call to the house supervisor/ Designee if meds are not able to be delivered same day via next tote or stat.	

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 11/05/2019

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 4 §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 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 interview, staff interviews, clinical record review, and facility document review, the facility staff failed to obtain ordered medications timely for 2 of 4 residents (Resident #4 and #3), in the survey sample. The findings included: 1. Resident #4 was originally admitted to the facility 1/27/17 and readmitted 3/21/19 after an acute care hospital stay. The current diagnoses include heart failure and insomnia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/7/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #4's cognitive abilities for daily decision making were intact. In section "G" (Physical		B. Education was provided to nursing staff on the prior authorization process. The process/timeframe of the prior authorization forms were reviewed with pharmacy for time frame of returns and process validation. C. A log will be completed by the DON /designee for "exceptions" of pain med issues that may occur outside of same day delivery or prior authorization issues that need same day problem solving. 4. The DON will report to QAPI monthly for three months any issues identified and reported to her on an ongoing basis that were identified and corrected to assure and maintain compliance. 5. Date of Compliance: 12/6/2019	

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 11/05/2019

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 5 functioning) the resident was coded as requiring total care of one with bathing, extensive assistance of two people,with bed mobility transfers, and toileting, extensive assistance of one person with personal hygiene and dressing, and set-up only for eating. During the initial tour on 11/1/19 at approximately 1:50 p.m., Resident #4 stated he wasn't sleeping well because his sleeping pill had not been administered to him in over two weeks and no one was explaining to him why he wasn't receiving it. Resident #4 further stated each night I ask for the pill around midnight and they never return with it. The resident stated he doesn't like to go to sleep until after midnight therefore, he doesn't want the sleeping pill prior to midnight. Review of Resident #4's Physician Order Summary revealed an order dated 9/12/19, for Zolpidem Tartrate 10 milligrams - Give one tablet by mouth every 24 hours as needed for insomnia at hour of sleep. Zolpidem is a medication used for the treatment of insomnia. Review of the active care plan also revealed a problem dated 2/5/17 and revised on 9/13/19, which read: I use psychotropic medication because I have trouble sleeping. The goal read: I will be free of drug related complications including movement disorders, discomfort, hypotension, gait disturbances, constipation/impaction or cognitive/behavioral impairment through the review date 1/6/2020. The interventions included Administer medications as ordered. Monitor for side effects and effectiveness. Review of the Medication Administration Record revealed Resident #4 received the medication	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 11/05/2019

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 6 Zolpidem 10 milligrams October 2019 for the following dates; 1, 5, 7, 9, 10, 12, 13, 15, 16, 17, and 18. There was no documentation of administration of Zolpidem for November 2019 Review of the Controlled Medication Utilization Record revealed on 9/14/19, thirty Zolpidem 10 milligram tablets were delivered to the facility for Resident #4 and the supply exhausted 10/18/19. Review of the pharmacy delivery invoice also revealed on 9/14/19, Zolpidem 10 milligram tablets thirty tablets was delivered to the facility and a request for a refill was received by the pharmacy 10/22/19 and again 10/28/19, but the medication was not delivered to the facility. An interview was conducted on 11/4/19, at approximately 3:45 p.m., with Licensed Practical Nurse (LPN) #3. LPN #3 stated the resident addressed the concern about not receiving his sleeping pill with her 11/2/19, the physician was notified and gave an order to start Trazodone 50 milligrams for sleep until the Zolpidem authorization is resolved. LPN #3 stated the physician stated the Trazodone must be discontinued once the Zolpidem is available for administration. Review of the pharmacy invoice of delivery revealed the Trazodone was delivered to the facility 11/3/19 and the resident stated he received the Trazodone 11/3/19. An interview with the Pharmacist was conducted on 11/4/19 and revealed there was a problem obtaining authorization for payment of the medication Zolpidem. The Pharmacist further stated the pharmacy staff sent the authorization form to the facility and the facility's staff was	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 11/05/2019

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 7	F 755		

responsible for informing the physician and obtaining a signature for authorization indicating continued use of the medication was necessary prior to the resident's insurance approving payment.

The pharmacy provided the following written statement regarding the Zolpidem 10 milligrams on 11/5/19 at approximately 10:15 a.m.. "The drug was payable and dispensed every month from February 2019 through July 2019. The drug coverage was denied August 5, 2019 and the pharmacy sent a small supply (per non-covered rules). The facility's staff pulled doses from the (Name medication dispensing machine) August 18th and 20th 2019. We shipped thirty tablets September 2014 and billed the facility. We shipped another thirty tablets 11/3/19. The pharmacy had been attempting to get prior authorizations completed, signed and approved. Until then the facility would need to be responsible for all orders. The plan pays for Trazodone and requires authorization for Zolpidem. (most likely because the resident is also on an opioid)."

On 11/5/19, the pharmacist office also provided a statement of intent regarding expedition of medication rejections due to prior authorization requirements. "This is to inform you that (nameof the pharmacy) is in the process of implementing Collaborative Practice Agreement with Prescribers in Virginia in order to enhance our current pharmacy practice. (name of the pharmacist) will use Collaborative Practice Agreements to allow Clinical Intervention Center pharmacist to complete and submit coverage determinations, including prior authorization forms within the parameters of the agreement, to

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 11/05/2019

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 8	F 755		

decrease repetitive outreach to facilities and prescribers. This agreement will help expedite any rejections due to required prior authorizations".

On 11/5/19 at approximately 1:45 p.m., the above findings were shared with the Administrator and Director of Nursing. The Administrator stated they had no further information to provide.

2. For Resident #3, facility staff failed to ensure that her pain medication was available to be administered on 10/23/19 and 10/24/19.

Resident #3 was admitted to the facility on 09/25/19 and readmitted on 10/23/19 with diagnoses that included but were not limited cognitive communication deficit and Encephalopathy.

Resident #3's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 09/30/19.

Resident #3 was coded as being severely cognitively intact in the ability to make daily decisions scoring 2 out of 15 on the BIMS (Brief Interview for Mental Status) exam. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with personal hygiene, dressing, toileting, locomotion on the unit, transferring and bed mobility. Requiring set up assistance with eating.

Review of the Medication Administration Record revealed Resident #3 received pain assessment every 4 hours for pain management on 10/01/19-10/23/19.

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 11/05/2019

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 9 Review of the Pain assessment tool dated on 10/23/19 at approximately, 1720 (5:20 PM) revealed the following behaviors: restlessness, verbal expressions of distress/crying, loss of interest and withdrawal. When asked does resident deny pain symptoms, box was checked as "Yes." Review of Resident #3's Physician Order Summary (POS) revealed the following orders: Acetaminophen Suppository 650 MG insert 1 suppository rectally every 6 hours as needed for pain, elevated temperature. Dated 10/23/19. Morphine Sulfate Solution 20 MG/ML give 0.25 ml sublingually every 2 hours as needed for pain or shortness of breath. Dated 10/23/19. Morphine Sulfate Solution 20 MG/ML give 0.5 ml sublingually every 2 hours as needed for pain or shortness of breath. Dated 10/23/19. Morphine Sulfate Solution 20 MG/ML give 0.5 ml sublingually every 6 hours as needed for pain or shortness of breath. Dated 10/24/19. (Hard script faxed on 10/24/19 at approximately, 8:50 PM.) There was no record of morphine being administered until 10/24/19 at 2303 (11:03 PM). On 11/04/19 at approximately 2:50 PM, an interview was conducted with the Pharmacist concerning Resident #3's delay in getting her morphine. She stated that if the morphine wasn't available they would have had the medication as stat from a local pharmacy if there had been a delay coming from the hospice nurse. On 11/04/19 at approximately, 4:07 PM an interview was conducted with the Registered	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 11/05/2019

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 10	F 755		

Nurse, Clinical Supervisor (RN #1) concerning the above resident. She was asked if she remembered Resident #3. She stated, "She was sick on admission." She had two hospital visits, She would yell out a lot but when asked if she was hurting or if something is wrong she would say "No or I don't know." "She was placed under hospice care."

On 11/04/19 at approximately 4:48 PM a telephone interview was conducted with Hospice Nurse (Other Staff #4) concerning Resident #3 getting a morphine hard script faxed to facility. She stated, the doctor at Hospice faxed the hard copy to Maryview on 10/24/19. "The nurse saw Resident #3 on 10/23/19. A discharge order for morphine was ordered on 10/23/19. Resident was sent with hard script on 10/23/19. The Hospice nurse (Other staff #4) was asked to fax a copy of hospice admission papers to the facility. She stated that she will fax forms to the facility after she speaks to the Administrator or DON (Director of Nursing).

A telephone interview was conducted with LPN (Licensed Practical Nurse) #2 on 11/04/19 at approximately, 5:15 PM concerning Resident #3's pain issues. She stated that she was helping another nurse caring for Resident #3. She stated "There was an order for morphine and Ativan for resident #3 but Hospice Care didn't send the hard script." "I spoke to the on call nurse." "They still hadn't called when I left work at seven." "I gave the resident Tylenol suppositories." "Normally, hospice will have it ready." "The family called hospice also."

On 11/05/19 at approximately, 9:30 AM an interview was conducted with the DON (Director

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 11/05/2019

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 11	F 755		

of Nursing) concerning Resident #3's Hospice admission paperwork. She stated, "I can't find them." Those documents are usually uploaded."

On 11/05/19 Received faxed Hospice papers from DON.

An interview with the Nurse Practitioner (Other Staff #6) on 11/05/19 at approximately 11:15 AM., concerning the above resident not receiving her ordered morphine 0.5 ml to control her pain on 10/24/19. She was asked if she remembered Resident #3, she stated, "Yes," "She was very confused from day one." "She would answer questions appropriately, and have periods of confusion." She was then asked if she was aware that Resident #3 did not received her ordered Morphine on 10/24/19. The Nurse Practitioner looked through the computer and saw the order was sent via fax at 8:50 PM to the pharmacy but resident didn't receive her morphine until 2303 (11:03 PM). She stated that on 10/23/19 Resident #3 "Returned to the facility as a readmission from under hospice care orders." "Usually when resident's return from the hospital under hospice care the hospital provides the prescription." "The script is usually sent with the patient when they are returning." She reviewed the nursing note dated 10/24/19 from staff nurse reading that she had attempted several times to reach (Pharmacy) for code to pull out the morphine. "Usually we would have provided staff with script if they don't have one." "The wait was a long time." "The staff is stating in the note that I was aware of the issue, but I was not on-call." "They could have done one of three things to obtain the medication order. One-they could have called the hospital to ask them to send the hard script for the Morphine or to see if

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 11/05/2019

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 12	F 755		

they had already sent it with the patient, two-the on call provider needed to have known and we could have provided the script, three- Hospice could have been notified." "They were not able to pull the medication due to not having the pharmacy code."

On 11/05/19 at approximately, 11:00 AM an interview was conducted with the social worker, (Other staff #7). She was asked if there were any grievances filed by the Resident or her family. She stated, "I haven't seen any grievances." "I didn't hear of any concerns."

A review of progress notes dated on 10/24/19 at approximately, 19:08 (7:08 PM) read: Resident has not been eating or drinking. Hospice and Nurse Practitioner is aware. Resident is noted to be moaning. PRN (as needed) Tylenol given. This nurse attempted to pull Morphine from the (Pharmacy/medication machine) but no hard script is on hand. Home Health has been contacted twice and made aware. Nurse on call said that she will speak to MD and have him fax over orders and hard script. Family is at bedside and concerned and has been updated.

A review of progress notes dated on 10/24/19 at 2025 (8:25 PM) read: Currently, we are awaiting a script for pain medication. Hospice was called today on day shift and spoke with me at approximately, 8 PM. I am still waiting for the script for pain medication. The pharmacy called at 8:25 PM and noted that they had also not received anything. At 20:39 (8:39 PM) hard script for pain medication received. Pharmacy being faxed for access to (medication dispensing machine), family notified. At 20:48 (8:48 PM) progress note read: Request for removal of

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 11/05/2019

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 13 controlled substance medication from contingency supply faxed to (Name) Pharmacy and night shift nurse notified. Resident's husband was notified while visiting resident about new orders of morphine (different dosage/frequency). Husband thanked this writer for faxing the request to the pharmacy to open the (dispensing machine). Note read at 2237 (10:37 PM): Called and spoke to someone at (Name) Pharmacy about Morphine which she gave the code for (dispensing machine) to pull out the medication. Note reads at 2355 (11:55 PM): In to see patient sleepy, open eyes and says yes when name is called. Alert and oriented x 1. No grimace or yelling during assessment. The above allegations was addressed with the Administrator, Director of Nursing on 11/05/2019 at approximately 12:00 PM. They were asked if they did what they should have done to keep her pain under control? The Administrator stated: "The family never complained to me about anything." The Director of Nursing stated: "They did document facial grimace, no groaning. She would not take her medications. They should have given a substitute for her pain. " Complaint Deficiency.	F 755	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 above plan of correction. The plan of correction constitutes the centers allegations of compliance.	