WESTERN TIDEWATER COMMUNITY SERVICES BOARD

Serving the cities of Franklin and Suffolk and the counties of Isle of Wight and Southampton

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December 10, 2015

Ms. Elizabeth Hudnall, LTC Supervisor
Division of Long Term Care Services
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

RE: The Wilkins
Suffolk, VA
ICF/ID 49-G038

Dear Ms. Hudnall:

Enclosed please find Western Tidewater Community Services Board's corrected Plan of Correction addressing the deficiencies cited as a result of the unannounced Medicaid survey at The Wilkins ICF/ID ending November 20, 2015.

If you have questions or comments, please contact me at 757-255-7122; by fax at 757-255-7141; or drawls@wtcsb.org.

Sincerely,

Darlene W. Rawls, M.Ed., Director,
Community Integration and Rehabilitation Services
Western Tidewater Community Services Board

Enclosure(s)

DWR:rm

cc: Demetrios Peratsakis. Executive Director, WTCSB
Cheryl Collier, QA Director, WTCSB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G038	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINS, THE	437 JACKSON STREET SUFFOLK, VA 23434

(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
W 000	INITIAL COMMENTS	W 000		

An unannounced annual 55 Fundamental Medicaid Certification survey was conducted 11/18/15 through 11/20/15. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). The Life Safety Code survey report will follow.

The census in this 4 bed facility was 4 at the time of the survey. The survey sample consisted of 2 current Individual Reviews (Consumer #1 and #2).

W 369 483.460(k)(2) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by:
Based on observations and staff interviews the facility staff failed to administer medications without error.

The findings included

The Medication Pour and Pass observation was performed on 11/20/15 at approximately 6:05 a.m., with DSP (direct service provider) A. The DSP was observed checking Consumer #1's MAR (medication administration record) and opened a bottle of Glycolax, a generic version of Miralax, a medication that is in a class of medications called osmotic laxatives. It works by causing water to be retained with the stool. This increases the number of bowel movements and softens the stool so it is easier to pass.

W 369	1) The facility nurse will request a clarification order from the physician to include manufacturer's directions for amount of liquid or as ordered by PCP.	01/04/16
	2) An Incident Report was completed to report the medication error.	11/20/15
	DSP A is restricted from passing medications until successful completion of an 8-hour med refresher course to be taken by 1/4/16. In addition DSP A will not be allowed to pass medications until she is observed for 2 successful passes by nursing staff.	01/04/16
	DSP A is required to receive in-service training by the nursing staff on Proper Administration/ Measurement of Medications to include: Ensure the label on medication and the order on the MAR match; Read the full order as written on the MAR when administering medications; If medication is to be mixed in fluids and the amount of fluids/water to use is not included in the order on the MAR, read the medication label on the bottle/container or follow manufacturer's recommendations of how much to use; Demonstration of how to use a 1 oz. plastic medicine cup to measure liquids/water to ensure an adequate amount of liquids/water is used; When in doubt in administering medications, call the nurse.	12/03/15

continued on page 2

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Director | (X6) DATE: 12/10/15

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	49G038	A. BUILDING _____ B. WING _____	11/20/2015

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W 369	Continued From page 1	W 369	Continued from page 1	

"https://www.nlm.nih.gov/medlineplus/druginfo/meds/a603032.html". The DSP poured out the ordered 17 grams and then mixed it with water in a small paper cup. The DSP was asked how many ounces of water the cup contained and she stated: "Six." The DSP then proceeded and gave Consumer #1 the mixture which he then drank completely.
After the Consumer left the medication room the DSP was then asked to measure water into a clean paper cup the same size as that had been used. The DSP used a one ounce clear plastic souffle cup and proceeded to measure water into the paper cup. When the DSP had poured three ounces of water into the cup she noted that the water level was at the brim of the paper cup. She stated: "I thought these cups held six ounces. It doesn't." The DSP was then asked how much water should have been used to properly mix the Glycolax and she stated: "The order just says to mix it in liquid." The bottle of Glycolax was then inspected. On the back of the bottle the manufacturer's directions noted: "4. Stir the powder in a cup (4-8 oz.) {ounces} of water, juice, soda, coffee, or tea until completely dissolved." When it was brought to the DSP's attention she stated: "I didn't use enough water."
Upon reconciliation of the medication administration, the validated physician order noted: "04/04/13 Glycolax 17 GM (grams)/1 dose Power -Give 17 grams in liquid by mouth every day for constipation."

An interview was conducted on 11/20/15 at approximately 8:22 a.m., with Administration B-Residential Manager. The observations of the medication pour and pass was discussed regarding DSP A not using the manufacturer's directions to mix the ordered powered medication

DSP A will receive appropriate disciplinary action. 01/04/16
All DSP certified to administer medications will receive an in-service training by nursing staff by 1/4/16 on Proper Administration/ Measurement of Medications to include: Ensure the label on medication and the order on the MAR match; Read the full order as written on the MAR when administering medications; If medication is to be mixed in fluids and the amount of fluids/water to use is not included in the order on the MAR, read the medication label on the bottle/container or follow manufacturer's recommendations of how much to use; Demonstration of how to use a 1 oz. plastic medicine cup to measure liquids/water to ensure an adequate amount of liquids/water is used; When in doubt in administering medications, call the nurse.

The Residential Nursing Coordinator will facilitate another in-service training at the facility during a mandatory staff meeting. 12/18/15

All four residents' physician's orders have been reviewed for orders that may require following manufacturer's directions. No other resident's physician's orders require facility staff to mix a powder into a liquid. 12/01/15

3) Facility Policy and Procedure #898 Supervision of Medication, to include the system for drug administration, was also reviewed and it was determined that the policy continues to meet both federal and state requirements for medication administration. All DSP are required to take a 32-hour medication training at hire and an 8-hour refresher course annually thereafter. 12/1/15

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W 369	Continued From page 2	W 369		

in 4-8 oz. of water. The Residential Manager stated: "The DSP's have to be checked off by an RN (registered nurse) before they can give medications." He went on further, "The DSP's are trained to follow the physician orders. The order did not specify the amount of water to be used but the DSP should have followed the manufacturer's directions. The medication was not given correctly."

Administration consisting of the Community Support Services Director, the Clinical Services Administrator, the Residential Manager and the Nursing Services Coordinator RN were informed of the findings at a briefing on 11/20/15 at approximately 12:00 p.m. Administrations did not have any questions about the findings and did not submit any additional information for review.