

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2017
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NAME OF PROVIDER OR SUPPLIER COLBY WAY RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 6316 COLBY WAY VIRGINIA BEACH, VA 23464
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION
W 000	INITIAL COMMENTS The unannounced annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted on 1/31/17 through 2/02/17. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities. (ICF/ID) Federal Regulations. The Life Safety Code report will follow. The census in this 5 bed facility at the time of the survey was 4. The survey sample consisted of 2 current Individual records (Individual #1 through #2).	W 000		
W 348	483.460(e)(1) DENTAL SERVICES The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to make dental arrangements for one individual (Individual #2) in the survey sample of 2 individuals. The findings included: Individual #2 was admitted on 2/17/09 with diagnoses of organic mood disorder, Angleman's Syndrome, seizures, and Severe Intellectual Disability. The facility staff failed to make arrangements for dental services for Individual #2.	W 348	ICF staff are reaching out to all local dental providers in order to meet the needs of the individual regarding dental wellness.	3/10/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES' SIGNATURE 	TITLE DS Director	(X6) DATE 2/15/17
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See Instructions.) Except for nursing homes the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited an approved plan of correction is requisite to continued program participation.

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W 348	Continued From page 1 Individual #2 had a physician's order for Annual dental care under sedation. The order was signed and dated 1/19/16. A review of the clinical records indicated: "A Dental Health Consultation dated 10/28/15 identified Individual #2 needed general anesthesia for dental services. Recommendations and Prognosis: Annual recall schedule." During an interview on 2/1/17 at 10:04 A.M. with the Registered Nurse (RN) , she stated, " Individual #2 has not been seen by a dentist since 2015. We are in the process of finding him a dentist. His former dentist is no longer taking patients requiring sedation." A letter dated April 21, 2016 from the former dental services indicated: The dental contract for services has ended. New services and a new contract to be awarded. The FY17 (Fiscal Year) dental contract will include enhanced standards of practice and will open the opportunity for community dentistry. A Nursing Physical Assessment dated 1/12/17 indicated: Dental summary - Date: Continuing to look for Dental services. The facility staff failed to make dental services arrangements	W 348	ICF staff will collaborate and seek out assistance from all available community resources regarding dental health and hygiene in order to meet the needs of the individuals. At the time of the Nursing Quarterly Assessment, nursing will communicate with the individual's current provider to confirm continued eligibility to be treated by said provider. During each communication nursing staff will attempt to obtain an appointment per the individualized schedule of treatment. The ICF staff will document in the individual's record if a provider defers, refuses or otherwise abstains from treating the individuals.	3/10/17 3/10/17 3/10/17 3/10/17

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