STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G063	A. BUILDING _____ B. WING _____	04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS PLACE WEST	1825 ROKEBY AVENUE CHESAPEAKE, VA 23320

(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 An unannounced Fundamental Medicaid survey was conducted 04/27/2016 through 04/29/2016. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 5 certified bed facility was 5 at the time of the survey. The survey sample consisted of 4 Individual reviews (Individuals #1 through #4).	W 000	RECEIVED MAY 25 2016 VDH/OLC	
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observations, staff interview, facility documentation review and clinical record review the facility staff failed to ensure the clinical record was accurate and complete for one Individual (Individual #3) of four individuals in the survey sample. Individual #3's current annual physical dated 10/27/2015, was not in her clinical record. The findings included: Individual #3 was originally admitted to the facility on 09/09/14. Diagnoses included but were not limited to Severe Mental Retardation, Spastic	W 111	Annual physical for Individual #3 was completed on 10/27/2015 as scheduled; however, a hard copy was not located in medical book. Clinician III, RN, contacted physician a hard copy was faxed to Highlands Place and placed in Individual #3 record. There is a potential for other Individuals records to be affected. Individual #1, Individual #2, Individual #4 and Individual #5 medical binder and EHR was checked by RN for potential missing documentation appropriate documentation of annual physical present in each record. In order to minimize the discrepancies from this time forward, nursing staff will obtain a copy of physical upon completion of office visit prior to leaving and place hard copy in Individual record. RN will conduct monthly QA audits of medical binder and EHR to ensure appropriate documentation located in record and document on Audit Review sheet. Nursing staff and direct care staff will be educated on new procedures by RN. AOC Date - 06/01/2016	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea C. Lone — TITLE: Program Supervisor — (X6) DATE: 5/24/2016

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W 111	Continued From page 1	W 111		

Cerebral Palsy, Dysphagia, Scoliosis and perimenopausal.

A review of Individual #3's clinical review was performed by reviewing the individual's annual review for 10/11/15. During the review the individual's annual medical was not found.

An interview was conducted on 04/27/16 at approximately 10:15 am., with Clinical III-QIDP (Qualified Intellectual Disabilities Professional). When Clinical III QIDP was asked about the location of the individual's annual medical physical she stated: "We are changing over to a computer generated program and it may be in the individual's e-record (electronic record). I have asked our IT (information technology) Department to supply you with access to the e-record. I can try right now to locate it for you and print it out."

An interview was conducted on 04/27/16 at approximately 12:25 p.m., with Clinical III-QIDP. She stated: "I accessed the e-record for Individual #3 (name) and could not locate it. I then contacted the doctor that had done the annual physical, they faxed a copy of the results and have scanned it into the e-record." A copy of the Annual Physical was obtained and reviewed. The date of the annual physical for Individual #3 was 10/27/2015. Clinical III-QIDP was then asked why a copy was not already in either the Medical Binder or scanned into the e-record. She replied: "It should have been in both places. I don't know why it was missing.

Administration consisting of the ID Program Director, Program Supervisor, Clinical III-QIDP, a newly hired Clinical III-QIDP who was being

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W 111	Continued From page 2 oriented and the RN (registered nurse) supervisor were informed of the findings at a briefing on 04/29/16 at approximately 1:30 p.m. No new information was submitted for review.	W 111		
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 was performed on 04/28/16 at approximately 7:20 a.m., with LPN (licensed practical nurse) A. The LPN administered the following medications for Individual #4: 1. Carbamazepine 200 mg (milligrams)- PO (by mouth) one tablet three times a day 2. Cranberry Concentrate 500 mg- PO one tablet every day 3. Depakote DR (delayed release) 500 mg- PO one tablet three times a day 4. Clomipramine 75 mg- PO one tablet twice a day 5. Depakote 250 mg- PO one tablet three times a day 6. MVI (multivitamin)- PO every morning 7. Oyster Shell Calcium 500/D 200- PO twice a day 8. Polyethylene Glycol 17 grams in 8 ounces of	W 369	Individual #4 Primary Care Physician was contacted and clarification of order received on 4/28/16, MAR (medication administration record) was updated and new order faxed to pharmacy. Individual #4 was monitored an no adverse side effects were noted. There is a potential for other Individuals to be affected. POS and MARs for Individual #1,Individual #2, Individual #3 and Individual #5 were reviewed for accuracy by RN. No discrepancies were noted. In order to minimize discrepancies, PO (physician order form was updated to reflect RN Supervisor review to ensure accuracy of PO form with original orders and MAR prior to submission for physician signature. RN will notify physician of any discrepancies for clarification and new orders will be faxed to pharmacy. RN will conduct monthly audits of POS, MARs and medications to ensure accuracy and document on monthly QA audit sheet. AOC Date - 06/01/2016	

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W 369	Continued From page 3	W 369		

water- PO once a day
9. Propranolol 60 mg- PO one tablet twice a day
10. Vitamin D3 1000 units- PO 1 tablet every morning at 8 a.m.

The amount of tablets in the souffle cup was stated by LPN A as being 9 tablets prior to administering the ordered medications to Individual #4.

During the reconciliation of the administered medications with the individuals most recent POS (physician order sheet) signed by the physician on 02/16/16, the following was noted for Vitamin D3-2000 units by mouth daily. No additional orders for the supplement Vitamin D3 could be located in the Medical binder or in the electronic record. An order was found which was dated 12/28/15 which noted: "Vitamin D3 Capsule 1000 units-take 1 tablet po q (every) a.m. for supplement."

An interview was conducted on 04/28/16 at approximately 9:22 a.m., with LPN A. When asked about the Vitamin D3 1000 units, 1 tablet administered to Individual #4 she stated: "I gave what was written on the MAR (medication administration record." Review of the April 2016 MAR was noted that the order was for Vitamin D3 1000 units-PO 1 tablet every morning.

An interview was conducted on 04/28/16 at approximately 9:30 a.m., with RN (registered nurse) Supervisor. When informed of what had been administered by LPN A during the Medication Pour and Pass, the most recent signed POS she stated: "Oh." She proceeded to review the individual's clinical medical record which noted the most recent signed POS of

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W 369	Continued From page 4 02/28/16 where the dose was ordered as Vitamin D3 2000 to be administered every day her response was: "There is a problem with the the most current order of 2000. I'll get a clarification with the doctor." An interview was conducted on 04/28/16 at approximately 3:22 p.m., with RN Supervisor. She submitted a faxed clarification order which had been received from the prescribing doctor at 3:17 p.m., which noted: "Vitamin D3 2000 IU (International Units) daily, take two tabs daily for supplement." When asked if the medication dose had been given in error of only 1 tablet equaling 1000 u she stated: "Yes. The most recent order signed by the doctor on 02/28/16, noted the dose was to total 2000 units " Administration consisting of the ID Program Director, Program Supervisor, Clinical III-QIDP, a newly hired Clinical III-QIDP who was being oriented and the RN (registered nurse) supervisor were informed of the findings at a briefing on 04/29/16 at approximately 1:30 p.m. No new information was submitted for review.	W 369		