STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G013	A. BUILDING _____ B. WING _____	07/20/2017

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W 000	INITIAL COMMENTS The unannounced standard Medicaid Recertification survey was conducted on 07/18/17 through 07/20/17. Corrections are required for compliance with 42 CFR Part 483 ICF/ID Federal Regulations. The Life Safety Code report will follow. The census in this 28 bed facility at the time of the survey was 27. The survey sample consisted of 8 Individual records: 7 current individual reviews (Individuals #1 through #7) and 1 closed record review (Individual #8).	W 000		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to have the Special Constituted Committee (SCC) to review, approve and monitor the use of a gastrostomy tube protective belt for one client (client #2) in the survey sample of eight clients. The findings included: Client #2 was admitted to the facility on 9/1/2004 with diagnoses which included Intellectual disability, profound developmentally delayed	W 262	Point 1: Address how corrective action will be accomplished to address the issue(s), for those individuals found to have been affected by the deficient practice. The Facility QIDP will present Individual #2's use of a gastrostomy tube protective belt for the Special Constituted Committee (SCC) to review, approve and monitor at an Emergency SCC meeting scheduled on July 31, 2017. The SCC will review the amended Behavior Support Plan, which will include playing with, pulling and/or dislodging the gastrostomy tube and the procedures that the Nursing Department will follow with using the gastrostomy tube protective belt for Individual #2. Completion Date: July 31, 2017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
4a QIDP	Chief Adminsitrative Officer	July 28, 2017

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.

JUL 31 2017
VDH/OLC

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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W 262	Continued From page 1 verbally and a seizure disorder. Client #2 required use of a gastrostomy tube for medication administration because the facility staff experienced extreme difficulty with her accepting the medications orally. A pediatric surgery progress note dated 10/21/2011 read "I will fax the orders for her to get a G-tube protector belt so they do not have to keep using the binder around her abdomen". A physician's order dated 10/10/16 read: "G-Tube Protector belt to be used as needed". A gastrostomy tube protective belt provides coverage and protection from snagging, pulling, or removing the gastrostomy feeding tube button. Review of the clinical records revealed a nursing plan of care dated 8/31/16 through 8/31/2017 which addressed the gastrostomy tube but it did not address Client #2's G-Tube Protector belt with guidance indicating when to wear the protective belt, periods of removal or when to apply it. Neither did review of the Behavioral plan list a targeted/exhibited behavior of Client #2 as playing with, pulling or dislodging the gastrostomy tube. The documented behaviors were: inappropriate touching, property destruction, hair pulling, pinching, grabbing and throwing items on the floor.	W 262	Point #2: Address how the facility will identify other individuals having the potential to be affected by the same deficient practice. The Facility QIDP will ensure that any apparatus restricting an Individual to remove themselves without assistance (gastrostomy tube protective belt, orthotics, items with straps, etc.) is listed on the Restrictive Authorization Forms and presented to the Specially Constituted Committee for review and approval. Completion Date: August 24, 2017 Point #3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Chief Administrative Officer has reviewed the Specially Constituted Committee Policy regarding the review, approval and monitoring the use of any apparatus restricting an Individual to remove themselves without assistance (gastrostomy tube protective belt, orthotics, items with straps, etc.). The Chief Administrative Officer reviewed the Specially Constituted Committee Policy with the Facility QIDP's to ensure that the Facility QIDP's are educated in the Specially Constituted Committee policies and procedures. Completion Date: July 24, 2017	

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W 262	Continued From page 2 An interview was conducted with the Qualified Intellectual Development Professional (QIDP) on 7/20/17 at approximately 3:30 p.m. The QIDP stated the use of the G-Tube Protector belt had not been reviewed, approved or monitored by the SCC. During the pre-exit interview with the Administrator, Director of Nursing and the Licensed Practical Nurse (LPN) on 7/20/17 at approximately 5:15 p.m., the Administrator stated they were so elated they no longer had to use physical interventions for medication administration they didn't realize the protective belt was a restraint. The LPN stated the client had a history of pulling at the gastrostomy tube. The facility's policy titled "Special Constituted Committee" dated 1/30/12 read at Procedure #5; Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the Special Constituted Committee prior to implementation. This includes but is not limited to; restraints, drugs to manage behavior, restrictions on community access, contingent denial of any right; or restrictions of materials or locations in the home.	W 262	Point #4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing and the Facility QIDP will meet quarterly to discuss the individual's use of any apparatus restricting an Individual to remove themselves without assistance (gastrostomy tube protective belt, orthotics, items with straps, etc.). At this meeting, the Director of Nursing and the Facility QIDP will review any changes or additions to individuals who uses any apparatus restricting an Individual to remove themselves without assistance (gastrostomy tube protective belt, orthotics, items with straps, etc.). The Facility QIDP will review the Individual's Restrictive Authorization Forms to ensure that the use of any apparatus restricting an Individual to remove themselves without assistance (gastrostomy tube protective belt, orthotics, items with straps, etc.) are listed on the Restrictive Authorization Forms. The Facility QIDP will present these Restrictive Authorizations to the Specially Constituted Committee at the scheduled quarterly meetings for review, approval and monitoring. Completion Date: August 24, 2017	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by:	W 368		

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W 368	Continued From page 3 Based on record review and staff interview, the facility staff failed to ensure all medications were administered in compliance with the physician's order for one client (client #2) in the survey sample of eight clients. The facility staff failed to administer Diastat AcuDial to Client #2 as ordered by the physician. The findings included: Client #2 was admitted to the facility on 9/1/2004 with diagnoses which included Intellectual disability, profound developmentally delayed verbally and a seizure disorder. The clinical record revealed a seizure activity record which revealed Client #2 had a seizure on 7/15/17 at approximately 9:18 p.m., lasting until 9:20 p.m. The client was observed salivating, with head, shoulder and arm jerks followed by sleeping. Again on 7/15/17 at approximately 10:01 p.m., until 10:02 p.m., Client #2 was observed with seizure activity, the fist were clinched and there was mouth movement, followed by reaction to verbal stimulation. The Nursing plan of care dated 8/31/16 through 8/31/2017 contained a Seizure plan of care. Some of the interventions read; record all seizure activity, administer anticonvulsant medications as ordered The July 2017 physician order summary revealed	W 368	Point 1: Address how corrective action will be accomplished to address the issue(s), for those individuals found to have been affected by the deficient practice. The Director of Nursing will meet with the nursing staff to review the current survey results for the department. At that time the staff will be educated on the Nursing Management of Seizure, Individual #2's Physician Orders for Diastat AcuDial and the plan of action to communicate seizure activities on the 24 hour communication report sheet, nursing progress notes and to give a verbal report to include but not limited to seizure activity length, frequency and if any medications were given to the oncoming shift. The nurses will acknowledge understanding by signing off on the training roster. Completion Date: August 24, 2017 Point 2 Address how the facility will identify other individuals having the potential to be affected by the same deficient practice The Director will meet with the nursing staff to review all Individuals who have a seizure disorder. At that time the staff will be educated on the Nursing Management of Seizure, all Individual's Physician Orders regarding their seizure medications and the plan of action to communicate seizure activities on the 24 hour communication report sheet, nursing progress notes and to give a verbal report to include but not limited to seizure activity length, frequency and if any medications were given to the oncoming shift. The nurses will acknowledge understanding by signing off on the training roster. Completion Date: August 24, 2017	

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W 368	Continued From page 4 an order dated 1/2/17, which read; Diazepam 2 System 20 milligram Kit for Diastat AcuDial 20 milligram delivery system. One rectally 12.5 milligrams as needed for seizures longer than two minutes or two seizures within an hour. Diastat AcuDial gel is used for treating episodes of increased seizure activity (cluster seizures) in certain patients with epilepsy who already take other seizure medicines. Diastat AcuDial gel is a benzodiazepine. It works in the brain to decrease seizures. (https://www.drugs.com/cdi/diastat-acudial-gel.html) Review of the Medication administration record revealed the nurse did not administer the Diastat AcuDial as ordered for two seizures within an hour. During the pre-exit interview with the Administrator, Director of Nursing and the Licensed Practical Nurse (LPN) on 7/20/17 at approximately 5:15 p.m. The LPN stated the nurse should have administered the as needed Diastat AcuDial as ordered. No additional information was provided.	W 368	Point #3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.The Director of Nursing will amend the Nursing Management of Seizure to include the plan of action to communicate seizure activities on the 24 hour communication report sheet, nursing progress notes and to give a verbal report to include but not limited to seizure activity length, frequency and if any medications were given to the oncoming shift. Completion Date: August 24, 2017 Point #4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing or Change will ensure nurses will have quarterly medication testing to demonstrate knowledge base practice and proficiency of medication administering in compliance with physicians orders. Testing will be required within 30 days of hiring and quarterly thereafter. The Director of Nursing will bring a monthly Seizure Surveillance Report to the Risk Management Committee for review. The Seizure Surveillance Report will include the individuals whom had seizures throughout the month and with a statement that ensures that medications were given as the physician ordered. Completion Date: August 24, 2017	
W 420	483.470(b)(4)(iv) CLIENT BEDROOMS The facility must provide each client with functional furniture, appropriate to the clients needs.	W 420		

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W 420	Continued From page 5 This STANDARD is not met as evidenced by: Based on general observations of the facility, staff interviews and facility policy review, the furnishings on 2 of 3 living areas were in disrepair. On both the Right and Left Wing living rooms, the couch cushions were sunken in appearance. The findings include: On 7/18/17 at 3:00 p.m., during rounds on two individual living room areas, the sofa cushions the individuals sitting were sitting on were sunken. Upon a closer look on 7/20/17 at 9:45 along with the Maintenance Director and the Environmental Director, the cushions were unlocked and the covers removed which revealed broken rusted springs and stained worn shredded foam. The Environmental Director and assistant Environmental Director stated the cushion covers were removed for laundering and replaced by the Maintenance Director and they never put the cushion covers on or off, thus they did not know the springs were broken or the foam stained and worn. The Maintenance Director stated he made rounds weekly to identify necessary repairs and that he could repair the springs and replace the foam in the sofa cushions. On 7/20/17 at 5:00 p.m., the Chief Executive Officer (CEO) and the Director of Nursing (DON) were informed of the condition of the sofa cushions. The CEO stated the facility may purchase new sofas for both wings. The policy and procedure titled "Maintenance Services" (undated) indicated the primary purpose of the maintenance policies and procedures is to provide a uniform set of	W 420	Point#1: Address how corrective action will be accomplished to address the issue(s), for those individuals found to have been affected by the deficient practice. The Environmental Services supervisor will purchase new furniture for the Right and Left wings Completion Date: August 24, 2017 Point #2: Address how the facility will identify other individuals having the potential to be affected by the same deficient practice. The Maintenance Supervisor will implement weekly checks for all furniture fixtures in the Right and Left wings to ensure all furniture is in good working condition. If repairs are needed, the Maintenance Department will repair in a timely manner. If the furniture cannot be repaired, the Environmental Services Supervisor will purchase a replacement. Completion Date: August 24, 2017 Point #3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Maintenance Supervisor will complete a weekly walk through to check all furniture conditions to ensure that all furniture is in good condition. The Maintenance Supervisor will document on the weekly preventative maintenance inspection schedule regarding the furniture condition. Completion Date: August 24, 2017	

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W 420	Continued From page 6 guidelines for all personnel to follow in assuring that the facility is maintained in a safe and sanitary manner, maintain the facility and it's equipment in a safe and operative manner. The Weekly Preventative Maintenance Inspection Schedule dated 2/4/14 indicated the Right and Left Wing were last inspected on 7/14/17 with no problems identified to include furniture as one of the line items, specifically "sofas".	W 420	Point #4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Maintenance Supervisor will present the weekly preventive maintenance inspection schedule monthly to the Risk Management meeting for review to ensure checks and inspections are completed. Completion Date: August 24, 2017	
W 447	483.470(i)(2)(iii) EVACUATION DRILLS The facility must file a report and evaluation on each evacuation drill. This STANDARD is not met as evidenced by: Based on observations, staff interviews and facility documentation, the facility staff failed to provide a written report and evaluation on each evacuation drill. The findings include: On 7/20/17 at approximately 11:00 a.m., when asked to review the yearly evacuation drill with details and evaluation of the drill, the facility was unable to provide a report. The Chief Executive Officer (CEO) provided evidence that the evacuation of the entire facility to an offsite location took place 7/5/17 and stated he did not have a detailed written report and evaluation of the yearly drill, but should have had one. The facility's policy and procedures titled "Evacuation and Disaster Plan" dated 1/2016 indicated the Alpha and Beta Team composed of different departments and their responsibilities in	W 447	Point 1: Address how corrective action will be accomplished to address the issue(s), for those The Director of Recreation services created an evacuation drill form. The Director of recreation completed the evacuation drill form regarding facility evacuation drill that was held on July 5, 2017. Completion Date: July 31, 2017 Point #2: Address how the facility will identify other individuals having the potential to be affected by the same deficient practice. All evacuation drills will be documented on the evacuation drill form. Completion Date: August 24, 2017 Point #3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Recreation services created the evacuation drill form. The Director of Recreation will review and train her designee regarding the completion of the evacuation drill form. The Maintenance Supervisor will review and train his designee regarding completion of the evacuation drills form evidenced by signature on the training roster. Completion Date: August 24, 2017	

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W 447	Continued From page 7 relationship to the evacuation procedure. The CEO would call each team member on the teams if evacuation is needed. After the evacuation drill a report would be completed and turned into the Human Resources Manager. The report would be reviewed by the Quality Improvement Committee.	W 447	Point #4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Annual evacuation drill form will be reviewed by the risk management committee annually. The CAO has emphasized and reviewed with all staff the evacuation and disaster plan evidenced by signature on a training roster.	
W 454	483.470(I)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on general observations of the facility, staff interviews and facility documentation, the furnishings on 2 of 3 living areas (Right and Left Wings) exhibited food and debris between the sofa cushions. The findings include: On 7/18/17 at 3:00 p.m., during rounds on two individual living room areas, the sofas cushions the individuals sitting were sitting were inspected to reveal food and debris between all cushions. Upon a closer look on 7/20/17 at 9:45 along with the Maintenance Director and the Environmental Director, the cushions were unlocked and the food and debris fell onto the floor. The Environmental Director and Assistant Environmental Director stated they needed a vacuum cleaner with special attachments to enable cleaning access between the cushions. On 7/20/17 at 5:00 p.m., the Chief Executive Officer (CEO) and the Director of Nursing (DON) were informed of the food and debris in between the sofa cushions. The CEO stated the facility	W 454	Point #1 Address how corrective action will be accomplished to address the issue (s), for those individuals found to have been affected by the deficient practice. The couches, chairs and sofa cushions in all living areas (left wing, right wing and recreation areas) were thoroughly cleaned on July 21, 2017 removing any and all food and debris. The furniture was cleaned and sanitized under the direct supervision of the Environmental Services Supervisor and the Environmental Services Assistant. Completion Date: July 21, 2017 Point #2 Address how the facility will identify other individuals having the potential to be affected by the same deficient practice. The Environmental Services Supervisor and the Environmental Services Assistant has purchased two hand held vacuum cleaners on July 26, 2017. The hand held vacuum are equipped with attachments that allows staff to maneuver in small places and crevices for cleaning; removing small food particles, crumbs and debris from all furniture, sofa, chair and cushions . All Environmental Technicians have been trained on the use of the hand held vacuums by the Environmental Services Supervisor. Evidenced by a signed training roster. Completion Date: July 27, 2017	

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W 454	Continued From page 8 may have to purchase vacuum cleaners with wand attachments to effectively reach between parts of furniture to include sofa cushions. The facility's policy and procedures titled "Housekeeping Services" (undated) indicated daily cleaning schedules are developed and implemented to assure that each area of the facility is maintained in a safe, clean, sanitary and comfortable manner.	W 454	Point # 3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Environmental Services Supervisor has created a deep cleaning weekly schedule in addition to the daily routine cleaning schedule that the Environmental Technicians will use when cleaning. The technician cleaning the areas will check the item cleaned and sanitized, sign and date indicating that the area(s) or item(s) listed on the deep cleaning weekly schedule checklist has been thoroughly cleaned. The Environmental Services Supervisor and Maintenance Supervisor will coordinate the unlocking of all sofa cushions for vacuuming, deep cleaning while noting any need of sofa or cushion repair. Completion Date: July 26, 2017 Point # 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Environmental Services Supervisor or the Environmental Services Assistant checks, signs and dates ensuring that all areas as indicated on the deep cleaning weekly schedule checklist by the assigned Environmental Technician has been thoroughly cleaned. Ensuring that all furniture, sofa, chair and cushions have been thoroughly cleaned, sanitized and is in good repair. In addition the deep cleaning weekly schedule will be presented monthly to the Risk Management Committee for their review. Completion Date: August 4, 2017	