PRINTED: 02/03/2017 FORM APPROVED OMB NO. 0938-0391

CENIE	RS FOR MEDICARE	& MEDICAID SERVICES				OIVID IVO.	0000-000
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 .	TIPLE CONSTRU			E SURVEY PLETEO
		49G051	B. WING		o oo o	02/	01/2017
NAME OF	PROVIDER OR SUPPLIER			STREET AOO	RESS, CITY, STATE, ZIP COOE		
HOPE H	OUSE				OTTE AVENUE		
					E, VA 23950		
IX41 ID PREFIX TAG	FEACH OFFICIENCY	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREFI) TAG	( FEA	PROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOU SEREFERENCEO TO THE APPRO OEFICIENCY)	JLO BE	IX51 COMPLETION DATE
W 000	survey was conduct 02/01/2017. The fawith 42 CFR Part 4 Intermediate Care Intellectual Disabilit survey report will foinvestigated.	nnual Medicaid Certification ted 01/31/2017 through cility was not in compliance 33 Requirements for Facilities for Individuals with ies. The Life Safety Code llow. No complaints were	W 0	00 1.	The door to the laundr remain locked and closs times. Locks will be pla cabinets of the laundry contain laundry deterge and fabric softener she unlock the laundry door kept on a person or in a location at all times. No	ed at all ced on the room that ent, bleach, ets. Keys to r will be a secured	
W 104	lime of the survey.	eight bed facility was six at the The survey sample consisted idual reviews, (Individuals #1 ~ ERNING BODY	W 1	04 2.		e in reach o ne facility. I reminded	f
		must exercise general policy, ng direction over the facility.			to keep the laundry roo closed at all times along keeping the cabinets in room locked. The facilit purchase commercial cle	; with the laundry y does not	
	Based on observati	not met as evidenced by: on and staff interview, the ensure a safe environment in		3.	products and will not puthem in the future.  All staff will receive train 2/9/17 on where the key	archase	
	was observed pushed object placed in from open. The key to the lock. A gallon jug of of the washing machallway was also obwide open. There we strength surface distunopened hand soa	dry room was not shut and ed all the way open and an it of the door to hold/prop it e lock was observed in the laundry detergent was on top nine. A bathroom door in the served with the door pushed ere two cans of commercial infectant, a bottle of p, an opened bottle of hand opened hand sanitizer setting			kept in the facility, keep laundry room door close keeping surface disinfect secured away from resid times. All staff will receimonthly reminders during	ing the ed, and tant lents at all ve	•

LABORATORY OIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE IX6) DATE

1X6) DATE

1X6) DATE

1X6) DATE

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.

on a table inside the bathroom door.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<del>,</del>			(	DMB NO. 0938-0391
STATEMENT OF DELICIENCIES AND PLAN OF CORRECTION		IXTE PROVIDER SUPPLIES CLIA IDENTIFICATION NUMBER	1		ONSTRUC		(XII) OATE SURVEY COMPLETED
		49G051	II WING			,	02/01/2017
HOPE HOPE HOPE HOPE HOPE HOPE HOPE HOPE	SUMMARY STA	STEMENT OF OEFICIENCIES Y MUS I BE PRECEDED BY FULL SC IDENTIFYING INFORMATION [	IO PREFI TAG	154 ( <b>LA</b> (	CHARLO CROSSE PR	TESS CITY STATE ZIP COOE TTE AVENUE  VA 23950  ROVIOER'S PLAN OF CORRECTIVE H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROVOEFICIENCY)	OBE COMPLETION
W 104	door to the laundry was posted on the times. Employees back against the warectangular plastic hold/prop it open as ctosing. Observed set of keys with a lours of the laundry sitting on top of one was full, but had be place.  Across the hall from bathroom. The door back against the way Observed sitting instead two cans of comme disinfectant, a bottle opened bottle of had opened hand sanitic. One of the resident in the dining area. bathroom in the hall wants to use it." Stresiding at the facilit bathroom. She sta	pproximately 7:15 a.m., the room was observed. A sign door, "Keep Door Locked at All Only". The door was pushed all as far as it would go. A btue tub was in front of the door to not preventing the door from in the lock of the door was a ong lanyard hanging down. It is you was a proper of the machines. The jug sen opened. The lid was in the laundry room was a per to the bathroom was pushed all leaving the room open. Side the door on a table were recial strength surface to funopened hand soap, an and soap and a bottle of zer.  I tal techs (Other staff #2) was She was asked who used the tway. She stated, "Whoever he was asked if the individuals the in the hallway or in eyesight to the hallway or in eyesight."	W 1	104		meetings and every monthereafter. New staff wittrained upon hire and methereafter as well.  The facility administrator designee will make unantivists to the facility at lea monthly on each shift to policy is being followed a pertains to the laundry rolocked and all surface disspray is properly secured All staff will receive traininaforementioned policy or The locks will be placed of laundry room cabinets by All surface disinfectant speen secured as of 2/2/11	If be onthly rand/or nounced st twice ensure is it foom being infectant ing on the n 2/9/17. On the 1/2/15/17. Oray has

Facility ID VAICEMR45

At approximately 7:40 a.m., a residential tech (Other staff #1) entered the laundry room. She

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·	OND NO. 0930-0391		
STATEMENT	OF DEFICIENCIES F CURRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G051	B. WING		02/01/2017		
HOPE HO	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP ( 154 CHARLOTTE AVENUE LA CROSSE, VA 23950	CODE		
(X4) IEI PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		NISHOULD BE COMPLITION		
W 104	was asked about the open. She stated, while they (individual eating breakfast an upwe are coming need to be washed removed the items shut it completely, the lock.  At approximately 8: practical nurse) #1	we door being propped and left "We do that in the morning als residing in the facility) are down are getting everybody in and out bringing linens that." As she left the room she propping the door open and The key to the door was left in 30 a.m. LPN (licensed was shown the keys in the	<b>W</b> 1	04			
	and stated, "They so At approximately 10 was told of the above items in the bathrook know those doors are room is to be locked execute the proced those doors are to be No further informatic exit conference on the state of the	on was obtained prior to the 02/01/2017.		50			
W 153	The facility must en mistreatment, negle injuries of unknown immediately to the	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other ace with State law through ures.	W 1	<ol> <li>The findings of the from incident repo</li> </ol>	L/ LU/ L/		
	Based on clinical re	s not met as evidenced by: ecord review, staff interview nt review, facility staff failed to					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFIC AND PLAN OF CORRE		OVIDER/SUPPLIER/DEIA NTIFICATION NUMBER.		HML CONSTRUCTION	:X3; DATE SURVEY . COMPLETED
		49G051	B WING		02/01/2017
NAME OF PROVIDER HOPE HOUSE	OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE 154 CHARLOTTE AVENUE LA CROSSE, VA 23950	
(X4) ID PREFIX (E/ TAG REG	SUMMARY STATEMENT ( ACH OEFICIENCY MUST BE BULATORY OR LSC IOENTI	PRECEOED BY FULL	ID PREFI IAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE LOMPETION

#### W 153 Continued From page 3

implement policies and procedures for investigating an injury of unknown source for one of four individuals in the survey sample, Individual #4.

Facility staff did not implement policies and procedures for investigating a facial cut that occurred 03/02/2016 for Individual #4.

#### Findings included:

Individual #4 was admitted to the facility on 03/24/2006 with diagnoses including, but not limited to: Profound MR (mental retardation), Autism Spectrum Disorder, esophageal reflux, hypothyroidism and intellectual disability.

During the review of incident/accident reports on 01/31/2017 at approximately 3:00 p.m., it was identified that on 03/02/2016 during his morning self-care with a RT (resident tech), Individual #4 was noted to have a facial "...cut about 1 1/2 inches long on the right side of his hairline. The cut was not bleeding but appeared deep enough to require stitches...I called 911 at 8:20 a.m. and took (Name) Individual #4's vital signs while waiting for EMS (emergency medical services) to arrive...EMS arrived at 8:33 a.m. (Name) LPN (licensed practical nurse) also arrived at 8:33 a.m. and was briefed of the situation. (Name) Individual #4 was transported by ambulance to (Name) Emergency Room. (Name), LPN followed the ambulance in the agency van." Also included in the incident report, "Was an internal investigation initiated by supervisor?: N (no)...Was the situation resolved?: Yes (how was it resolved?) (Name) Individual #4 was transported by ambulance to the ER..."

W 153

involving Individual #4 will be recorded on Exhibit 2005f2. Prevention measures for reoccurrence of the incident was recorded in Individual #4's chart on Exhibit 5004a dated 3/10/16 (see attached), which included adding a video monitor in Individual#4's room to be used overnight while sleeping to ensure Individual#4 does not get out of bed unassisted. There have been no injuries since this prevention has been in place. The completed investigation report will be forwarded to the residential manager by 2/10/17.

 All injuries of unknown origin will be investigated by the facility administrator. Findings will be presented to the residential manager regardless of the outcome of the initial investigation for further review. Any findings of abuse or neglect will be forwarded to the local Human Rights advocate and escalated as policy dictates.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OC EOD MEDICARE	& MEDICAID SERVICES				0	MB NO. 0938-0391
STATE MENT	ENTERS FOR MEDICARE & MEDICAID SERVICES  ATEMENT OF DETICIENCIES   IX1) PROVIDER SHIPPLICATION NUMBER.   IX21 MULTIPLE CONSTRUCTION   A BIJLI DING					(X3) OATE SURVEY COMPLETED	
		49G051	B. WING	;			02/01/2017
NAME OF F	PROVIDER OR SUPPLIER			15	TREET ADDRE 54 CHARLOT A CROSSE,		
(X4) ID PREFIX FAG	FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG	•	IEACH	OVIOER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCEO TO THE APPROP OEFICIENCY)	DBE COMPLETION
W 153	Residents" was rev approximately 3:30 following: "1. (Faci appropriately and d and behavioral incident that occurs	ge 4 Reporting Incidents Involving iewed on 01/31/2017 at p.m. The policy included the ility Name) shall respond ocument significant medical dents involving residents. a. A incident is defined as an involving the resident which pentation of first aid training by	W	153	3.	The residential manager review all incident report injury of unknown originaresidential manager will and sign off on the invest report of each incident or origin, regardless of the infindings by the facility	ts for an . The review tigation f unknown

staff, the immediate care of a medical professional, or has the potential to cause medical care in the near future and requires monitoring by staff...2. When a significant medical incident occurs, the primary responsibility of staff is to provide immediate care to the resident to assure their health and safety. a. Examples of significant medical incidents include but are not limited to: falls, cuts, burns, bruising, etc...3. Once the immediate medical needs of the resident are mel by staff or medical professionals, staff will assure appropriate documentation of the incident. a. Staff will complete incident reporting form...b. This form includes but is not limited to the inclusion of the following: ...supervision at the time of incident, a diagram depicting the injury, witnesses, how the incident occurred, what factors could contribute to the incident...recommendations to prevent future

The Administrator was interviewed on 01/31/2017 at approximately 4:00 p.m. regarding the above incident. She stated, "[Individual #4] has had injury to this same area before and has a scar there that contributes to the same area opening back up whenever [Individual #4] rubs or bangs his head in this same area. [Individual #4] gets out of bed on his own sometimes without

incidents, and supervisor's review and

- administrator. The investigation report will be edited to add a place for the residential manager's comments and signature.
- The facility administrator will review all incident reports as they are written and again on a monthly basis to ensure policies are followed. All findings of abuse or neglect will be forwarded to the local human rights advocate and escalated as policy dictates.
- The investigation report from incident 3/2/16 Individual#4 will be completed by 2/10/17 and forwarded to the residential manager. The investigation report will be updated by 2/10/17.

Facility IO: VAICFMR45

recommendations."

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/03/2017 FORM APPROVED OMB NO: 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				T 140. 0530-0351
STATEMENT	OF BEFICIENCIES F CORRECTION	(XI) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		49G051	B. WING			02/01/2017
NAME OF I	PROVIDER OR SUPPLIER				RESS CITY STATE ZIP CCIDE	
норе но	DUSE	_			DITE AVENUE E, VA 23950	
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W 153	residents are on Q1 throughout the night in between checks, bathroom on that dreceived stitches the stitches, I believe the wouldn't leave stitch used." When aske information was do stated, "Corporate I information on the reshould be a puthat documents the care from the emer	is to the bathroom. All 15 [every 15] minute checks it, but he will sometimes get up. The tech found hin in the ay." When asked if he e Administrator stated, "No ney used Dermabond. He nes alone, so skin glue was	W 1	53		
W 154	AM" that included a written by the LPN. by the RT regarding the injury, witnesses to the incident, or proceed in the clinical No further informati team prior to the ex 483.420(d)(3) STAF	"3/2/2016 11:30 AM to 11:45 synopsis of his ER visit No progress note was written the incident. No diagram of s, what could have contributed revention measures were all record.  on was received by the survey it conference on 02/01/2017. F TREATMENT OF CLIENTS we evidence that all alleged	W 1	54	The findings of the investi	
	Based on clinical re	s not met as evidenced by: ecord review and staff off failed to thoroughly			from incident report 3/2/1	16

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIFICATION NUMBER			ONSTRUCTION	(X3) OATE SURVEY COMPLETED
		49G051	B WING			02/01/2017
NAME OF	PROVIDER OR SUPPLIER		<u>'                                    </u>	STREE	ET ADDRESS, CITY, STATE, ZIP COOE	
			Ì	Į.	CHARLOTTE AVENUE	
HOPE HO	OUSE			LA C	ROSSE, VA 23950	
(X4† II) PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION!	IO PREFII TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	IFO BE COMPATITION
W 154	Continued From pa	age 6	W 1	154	involving Individua! #4 v	vill be
	investigate an injury	y of unknown source for one of			recorded on Exhibit 200	
	four individuals in the	he survey sample, Individual			Prevention measures fo	
	#4.				reoccurrence of the inc	
	Facility staff did not	t thoroughly investigate a facial			recorded on Exhibit 500	
	cut that occurred 03			3/10/16 which included	<del></del>	
				video monitor in Individ	-	
	Findings included:			room to be used overnig		
	Individual #4 was a	dmitted to the facility on			sleeping to ensure Indivi	
	03/24/2006 with dia	agnoses including, but not			does not get out of bed	
	limited to: Profound	d MR (mental retardation),			There have been no inju	
	Autism Spectrum of hypothyroidism and	Disorder, esophageal reflux, d intellectual disability.			this prevention has been	
					All injuries of unknown of the control of the	•
	During the review o	of incident/accident reports on			be investigated by the fa	=
	01/31/2017 at appro	oximately 3:00 p.m., it was 3/02/2016 during his morning			administrator. Findings	
	self-care with a RT	(resident tech), Individual #4			presented to the residen	
	was noted to have a	a facial "cut about 1 1/2			manager regardless of th	
	inches long on the r	right side of his hairline. The			outcome of the initial inv	
	cut was not bleeding	ng but appeared deep enough l called 911 at 8:20 a.m. and			for further review.	/estigation
	took (Name) Individ	dual #4's vital signs while			The residential manager	savitt
	waiting for EMS (en	mergency medical services) to			review all incident report	
	arrive EMS arrived	d at 8:33 a.m. (Name) LPN			·	
	(licensed practical r	nurse) also arrived at 8:33 ed of the situation. (Name)			injury of unknown origin residentiat manager will	
	Individual #4 was tr	ransported by ambulance to				
	(Name) Emergency	y Room. (Name), LPN			and sign off on the invest	- ' <del>-</del> '
	followed the ambula	ance in the agency van." Also			report of each incident o	
	included in the incid	dent report, "Was an internal ed by supervisor?: N			origin, regardless of the i	nitiai
1	(no). Was the situa	etion resolved?: Yes (how was			findings by the facility	-8 44
	it resolved?) (Name	e) Individual #4 was oulance to the ER"			administrator. The inves	tigation

Facility policy for "Reporting Incidents Involving Residents" was reviewed on 01/31/2017 at

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES SEASTED COD MEDICADE & MEDICAID SEDVICES

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UENIEK	2 LOK MEDIOVVE	& MEDICAID OF LANCED			
	DI DEFICIENCIES CORRECTION	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MIJLTIPLE CO			CI) DATE SURVEY COMPLETED
		49G051	B. WING		02/01/2017
NAME OF PE	ROVIDER OR SUPPLIER		]	STREET ADDRESS, CITY, STATE, ZIP CODE	
HOPE HO				154 CHARLOTTE AVENUE LA CROSSE, VA 23950	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	(X5) E COMPLETION ATE DATE

#### W 154 Continued From page 7

approximately 3:30 p.m. The policy included the following: "1. (Facility Name) shall respond appropriately and document significant medical and behavioral incidents involving residents. a. A significant medical incident is defined as an incident that occurs involving the resident which requires the implementation of first aid training by staff, the immediate care of a medical professional, or has the potential to cause medical care in the near future and requires monitoring by staff .. 2. When a significant medical incident occurs, the primary responsibility of staff is to provide immediate care to the resident to assure their health and safety. a. Examples of significant medical incidents include but are not limited to: falls, cuts, burns, bruising, etc...3. Once the immediate medical needs of the resident are met by staff or medical professionals, staff will assure appropriate documentation of the incident. a. Staff will complete incident reporting form...b. This form includes but is not limited to the inclusion of the following: ...supervision at the time of incident, a diagram depicting the injury, witnesses, how the incident occurred, what factors could contribute to the incident...recommendations to prevent future incidents, and supervisor's review and recommendations."

The Administrator was interviewed on 01/31/2017 at approximately 4:00 p.m. regarding the above incident. She stated, "[Individual #4] has had injury to this same area before and has a scar there that contributes to the same area opening back up whenever [Individual #4] rubs or bangs his head in this same area. [Individual #4] gets out of bed on his own sometimes without assistance and goes to the bathroom. All residents are on Q15 [every 15] minute checks

W 154

- report will be edited to add a place for the residential manager's comments and signature.
- The facility administrator will review all incident reports on a monthly basis to ensure policy is followed.

DEFICIENCY)

The investigation report from incident 3/2/16 Individual#4 will be completed by 2/10/17. The investigation report will be updated by 2/10/17.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	, ·		CONSTRUCTION	IXID DATE SURVI Y COMPLETED
		49G051	B WING	٠,		02/01/2017
NAME OF	PROVIDER OR SUPPLIER		T	ST	REET ANDRESS, CITY, STATE, ZIP CODE	
	ouer.			15	CHARLOTTE AVENUE	
HOPE H	UUSE			LA	CROSSE, VA 23950	
JX4) ID PREFIX TAG	IEACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEOED BY FULL  SC IDENTIFYING INFORMATION	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	DBE COMPLETION
W 154	Continued From pa	ge 8	W 1:	54		
		t, but he will sometimes get up				
	in between checks.	The tech found him in the				
		ay." When asked if he				
		e Administrator stated, "No ney used Dermabond. He				
		nes alone, so skin glue was	•			i
	used." When aske	d where any of this				
	information was do	cumented the Administrator				
		nas told us not to include				
		eport that is speculation. progress note in his record				
	that documents the	incident and any follow-up				
	care from the emer-	gency room visit. I will look				
		inything in his record and get				
	that for you."					
	AM" that included a written by the LPN. by the RT regarding the injury, witnesses	"3/2/2016 11:30 AM to 11:45 synopsis of his ER visit No progress note was written the incident. No diagram of s, what could have contributed revention measures were				
W 382	No further information team prior to the ex 483.460(I)(2) DRUGRECORDKEEPING		W 3	82		
	The facility must kee locked except when administration.	ep all drugs and biologicals being prepared for			The door to the medication     will remain locked and clo	
	Based on observati	not met as evidenced by: ion and staff interview, the ensure all medications and				

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CENTERS FOR MEDICANE	& MILDIONID OLIVIOLO			
STATEMENT OF DUFFICIENCIES AND PLAN OF CURRECTION	(XT) PROVIDER/SUPPLILE/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	X31 OATE SURVEY COMPLETED	
	49G051	8 WING		02/01/2017
NAME OF PROVIDER OR SUPPLIER		STI	REET ADDRESS CITY STATE, ZIP CODE	
MANUE (II. INCOMINE IN ON ONE IN-		154	4 CHARLOTTE AVENUE	
HOPE HOUSE		i	CROSSE, VA 23950	
DEELY TEACH DEFICIENCY	TIEMENT OF OUFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION!	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ITEACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCYL	BE COMPLETION

#### W 382 Continued From page 9

biologicals were locked when not being prepared for administration.

The door to the medication room was observed pushed all the way open. No staff members were in the room. After medication administration, Other Staff #2 left the room with one of the individuals and left all of that resident's medication cards lying on the counter unattended and out of her eyesight.

#### Findings were:

On 02/01/2017 at approximately 7:15 a.m., the door to medication room was observed to be open and pushed back against the wall as far as it would go. The lights were out in the room. A fan was sitting on the far side of the room and was on. There was a large whirlpool tub in the room (no water was in the tub), a large bottle of hand sanitizer was on a prep table in the room. No staff members were in the room or within eyesight of the room.

At approximately 7:40 a.m., a residential tech (Other staff #2) went to the medication room to administer medications. This surveyor accompanied her and observed the medication pass and pour. After the medications were prepared and administered, the residential tech accompanied the individual out of the medication room. She left the medication cards and a bottle for the medications administered on the counter in the medication room (Risperidone, Colace, Celexa, Zantac, Divalproex and a bottle of Lactulose). She left the room and assisted the individual to another area. She then assisted another individual to the medication room.

W 382

times. Keys to unlock the medication room along with the cabinets containing medications and biologicals will be kept on the person assigned to administer medications during the shift or in a secured location at all times.

- All staff will be trained and reminded to keep the medication room door closed at all times along with keeping the cabinets in the medication room locked and the key to these areas in a secure place at all times.
- 3. All staff will receive training on 2/9/17 on where the medication room keys are to be kept at all times while in the facility and keeping the medication room door closed, All staff will receive monthly reminders during staff meetings every month thereafter. New staff will be trained upon hire and monthly thereafter as well.
- The facility administrator and/or designee will make unannounced visits to the facility at least twice monthly on each shift to ensure

Facility IO VAICEMR45

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	MENT UF DEFICIENCIES AN OF CORRECTION   IX11 PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   A. BUILDING			TE SURVEY MPLETED		
		49G051	B. WING		02	/01/2017
NAME OF PR	OVIDER OR SUPPLIE	R	15	REET ADDRESS. CITY, STATE. ZIP CODE 4 CHARLOTTE AVENUE A CROSSE, VA. 23950	E	
(X4) II) SUMMARY STATEMENT OF DEFICIENCIES PREFIX IEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION;		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	

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FORM CMS-2567(02-99) Previous Versions Obsolete

Other staff #2 was interviewed at approximately 8:00 a.m. about the medication room door being left open and leaving the medications on the counter. She stated that she did not have a key to the medication room on her key chain and that the key was located in the desk at the nurse's station. She stated it was easier to just leave the door open. She also stated that she normally stays in the medication room in the mornings but had gone out to help with breakfast that morning (02/01/2017). She was asked about the medications being left on the counter post administration. She stated, "I know, I saw them when I went back in there...I should have put them away."

The administrator was notified of the above information on 02/01/2017 at approximately 10:50 a.m. She stated the medication room door should have been locked. She also stated, "They failed to execute the procedures we have in place. All those doors are to be shut and locked."

No further information was obtained prior to the exit conference on 02/01/2017.

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- policy is being followed as it pertains to the medications and biologicals being locked.
- All staff will receive training on the aforementioned policy on 2/9/17. The medication room door and medication cabinets have been locked since 2/2/17.

Facility ID: VAICEMR45