DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G030	A. BUILDING ______ B. WING ______	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY'S PLACE	1406 BLYTHEWWOOD LANE 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 An unannounced Annual Medicaid survey for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) was conducted 10/3/17 through 10/4/17. Corrections are required for compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. 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 3 individual reviews: 3 current Individuals's #1, #2 and #3.	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation review, the facility staff neglected to provide the necessary supervision to safeguard 1 of 3 Individuals (I #3) from ingesting foreign objects. Individual #3's behavioral management plan (BMP) required constant in line of sight supervision due to severe PICA* behaviors (ingesting inedible objects that might require surgical removal) which was not fully implemented resulting in the ingestion of 2 latex gloves. The findings include:	W 149	1) Environmental sweeps of the facility, as well as Pathways Day Support program and of vehicles were conducted immediately after the incident. No gloves of any color were found. The Residential Clinical Services Administrator advised all facility staff via email of the incident and reminded all of the critical nature of Individual #3's pica diagnosis. The email emphasized that line of sight supervision and conducting environmental sweeps is required. Further, all were reminded to be diligent in monitoring Individual #3 in all areas, whether at home, day support, in a vehicle or in the community. A second email specifically outlined instruction for environmental sweeps every 15 minutes; no office supplies left unattended; staff	06/29/17 06/30/17

RECEIVED
OCT 23 2017
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE [signature] (X6) DATE 10/10/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G030	A. BUILDING ______ B. WING ______	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY'S PLACE	1406 BLYTHEWWOOD LANE 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 149 Continued From page 1

Individual #3 was admitted to the facility on 8/1/2003 with diagnoses that included intermittent explosive behavior, profound ID level and PICA.

Individual #3's BMP in affect at the time of the incident was dated 8/20/15. The BMP indicated he had PICA behaviors and required "line of sight supervision" at all times in order to prevent him from putting objects into his mouth, at his residence or at the day program site.

The record of the incident indicated on 6/29/17 at 7:02 a.m., Individual #3 was at the residence when, after breakfast, two Direct Support Professionals (DSP) assisted the individual when he started making coughing and gagging sounds. It was documented that one of the DSP's noticed something black coming out of his mouth and was able to pull it from his mouth, identifying it as a black glove. The individual vomited a second glove that was bluish green in color. The On-call nurse was called and the individual was transferred to a local urgent care facility. Once the individual was stabilized and no other foreign objects were identified in the individual's stomach or esophagus, he was transferred back to his residence.

On 10/4/17 at 3:00 p.m., the Licensed Practical Nurse (LPN) that received the call on 6/29/17 was interviewed. She stated she was called one time on 6/29/17 which led her to believe the individual vomited both gloves at the same time. She said she ordered the staff to send the individual to the urgent care to have him evaluated. She stated, it was reported to her that the resident did not have any airway or breathing problems at anytime during the vomiting episode. She stated it was

W 149

office area locked at all times. Line of sight supervision was defined as keeping the individual within sight. Staff were instructed not to leave Individual #3 unattended while awake, to sweep the bedroom closely before the individual gets in bed, and to not ever leave the individual in the restroom unattended. The importance of documentation was also emphasized.

2) The number of unannounced environmental sweeps conducted by the House Manager was increased to more than once a week at the facility and day support program. — 06/29/17

A "Daily Trash Can Log" was instituted in the facility to ensure trash is taken outside to the city trash can three times a day. The trash container designated for gloves and adult disposable undergarments is now kept on the outside porch, instead of in the house. The only trash container allowed in the house, may be in the kitchen with the lid secured. The log sheet includes instruction that gloves, wipes, trash bags or small items should be stored behind lock and key and at no time left lying around the house. — 06/30/17

The Residential Clinical Services Administrator confirmed with the Pathways Day Support Supervisor that all trash cans in areas Individual #3 has access to are now kept behind locked doors and not readily accessible. — 06/29/17

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	49G030	A. BUILDING ______ B. WING ______	10/04/2017

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY'S PLACE	1406 BLYTHEWWOOD LANE 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	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE

W 149 Continued From page 1

Individual #3 was admitted to the facility on 8/1/2003 with diagnoses that included intermittent explosive behavior, profound ID level and PICA.

Individual #3's BMP in affect at the time of the incident was dated 8/20/15. The BMP indicated he had PICA behaviors and required "line of sight supervision" at all times in order to prevent him from putting objects into his mouth, at his residence or at the day program site.

The record of the incident indicated on 6/29/17 at 7:02 a.m., Individual #3 was at the residence when, after breakfast, two Direct Support Professionals (DSP) assisted the individual when he started making coughing and gagging sounds. It was documented that one of the DSP's noticed something black coming out of his mouth and was able to pull it from his mouth, identifying it as a black glove. The individual vomited a second glove that was bluish green in color. The On-call nurse was called and the individual was transferred to a local urgent care facility. Once the individual was stabilized and no other foreign objects were identified in the individual's stomach or esophagus, he was transferred back to his residence.

On 10/4/17 at 3:00 p.m., the Licensed Practical Nurse (LPN) that received the call on 6/29/17 was interviewed. She stated she was called one time on 6/29/17 which led her to believe the individual vomited both gloves at the same time. She said she ordered the staff to send the individual to the urgent care to have him evaluated. She stated, it was reported to her that the resident did not have any airway or breathing problems at anytime during the vomiting episode. She stated it was

W 149

office area locked at all times. Line of sight supervision was defined as keeping the individual within sight. Staff were instructed not to leave Individual #3 unattended while awake, to sweep the bedroom closely before the individual gets in bed, and to not ever leave the individual in the restroom unattended. The importance of documentation was also emphasized.

2) The number of unannounced environmental sweeps conducted by the House Manager was increased to more than once a week at the facility and day support program. — 06/29/17

A "Daily Trash Can Log" was instituted in the facility to ensure trash is taken outside to the city trash can three times a day. The trash container designated for gloves and adult disposable undergarments is now kept on the outside porch, instead of in the house. The only trash container allowed in the house, may be in the kitchen with the lid secured. The log sheet includes instruction that gloves, wipes, trash bags or small items should be stored behind lock and key and at no time left lying around the house. — 06/30/17

The Residential Clinical Services Administrator confirmed with the Pathways Day Support Supervisor that all trash cans in areas Individual #3 has access to are now kept behind locked doors and not readily accessible. — 06/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G030	A. BUILDING ______ B. WING ______	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY'S PLACE	1406 BLYTHEWWOOD LANE 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 149 Continued From page 2

fortunate that the gloves the individual ingested did not obstruct his airway during the swallowing or vomiting of the gloves.

On 10/4/17 at 3:10 p.m., an interview was conducted with the Residential Manager. He stated he was told by the Residential Clinical Services Administrator that the staff either at the residence or at the day support failed to properly supervise Individual #3 which resulted in his acquiring the 2 latex gloves and managing to swallow them without detection. He stated they could not determine where the individual got the gloves because they were black and neither the residence or day support used black latex gloves. The Residential Manager stated the individual loved latex gloves and they had to make sure they kept them away from him at all times.

On 10/4/17 at 3:45 p.m., during an interview with the Residential Counselor, he stated a detailed investigation was conducted and it was concluded no one could figure out where Individual #3 located the gloves, and then have an opportunity to swallow them undetected. He stated the resident had PICA behaviors and it was imperative nothing was left around for him to ingest.

The Residential Clinical Services Administrator was not available for interview, but the investigation report at the conclusion of the investigation dated 7/7/17, documented the Administrator reminded all staff of the critical nature of Individual #3's PICA diagnosis. She emphasized that providing "line of sight" supervision and conducting environmental sweeps were required in whatever area he was in, whether at home, day support, in a vehicle or

W 149

Jay's Place instituted staff assignment sheets to ensure designated responsibility for client supervision. — 07/03/17

Dr. Rex Walker, psychologist consultant conducted an environmental observation of Pathways Rehab I area where Individual #3 receives day support. Dr. Walker reviewed Individual #3's Behavioral Support Plan for appropriateness and updated as of 7/5/17 to include specific procedures regarding pica. — 07/05/17

Dr. Walker, psychologist consultant provided Pica Behavior training to all staff who work with Individual #3, including Van Drivers. The training reviewed the Pica disorder and Individual #3's Behavioral Support Plan. It emphasized the importance of "line of sight" supervision at all times, including during outings. Residential Clinical Services Administrator supplemented the training with practical guidance for providing line of sight supervision at all times, including during outings. — 07/07/17

Person-centered plans were reviewed for all other individuals residing in the facility. it was determined no other individual has needs for line of sight supervision. — 06/29/17

3) Facility Policy #943 Facility Staffing and Supervision was revised to state: Individuals requiring line of sight supervision will have specific procedures requiring this requirement outlined in their — 10/17

RECEIVED
OCT 23 2017
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G030	A. BUILDING ____ B. WING ____	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY'S PLACE	1406 BLYTHEWWOOD LANE 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 149	Continued From page 3 in the community. PICA training was conducted for all staff by the psychologist on 7/7/17. The facility's revised policy and procedure titled "Facility Staffing and Supervision" dated 8/2017 indicated there will be sufficient direct care staff to manage and supervise individuals in accordance with the individual's plan. The facility's policy and procedures titled "Abuse/Neglect" dated 11/2012 indicated the facility prohibited any form of neglect and it was defined as any omission inconsistent with prescribed treatment and care which resulted in physical or emotional pain or distress to individuals. *Pica: A craving for something that is not normally regarded as nutritive, such as dirt, clay, paper, or chalk. medcinenet.com	W 149	support plan. Line of sight supervision is defined as keeping an individual within a staff person's sight during awake hours unless otherwise defined by an order or plan of care specified by licensed staff or providers. Facility Polices #805 Abuse/Neglect of Individuals, #816 Reporting Requirements and #809 Restraints have all been updated to include the new DBHDS Human Rights regulations and HCBS DMAS regulations. Policy #805 was revised to include Serious incidents, defined as any incident or injury resulting in a body damage or loss requiring medical attention by a licensed physician, doctor or osteopathic medicine, physician assistant, nurse practitioner while the individual is supervised or involved in services such as attempted suicide, medication overdoses or reactions from medication administered or prescribed by the service. Medication errors resulting in adverse outcomes are also considered serious incidences. Policy #809 wording was revised to define restraint per the new DBHDS Human Rights regulations "any mechanical physical restraints and pharmacological agents intended to confine or otherwise restrict the movement or activity of an individual." Policy #816 includes reporting requirements under DBHDS CHRIS system.	10/17 10/17 10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G030	A. BUILDING ______ B. WING ______	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY'S PLACE	1406 BLYTHEWWOOD LANE 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 149	Continued From page 3 in the community. PICA training was conducted for all staff by the psychologist on 7/7/17. The facility's revised policy and procedure titled "Facility Staffing and Supervision" dated 8/2017 indicated there will be sufficient direct care staff to manage and supervise individuals in accordance with the individual's plan. The facility's policy and procedures titled "Abuse/Neglect" dated 11/2012 indicated the facility prohibited any form of neglect and it was defined as any omission inconsistent with prescribed treatment and care which resulted in physical or emotional pain or distress to individuals. *Pica: A craving for something that is not normally regarded as nutritive, such as dirt, clay, paper, or chalk. medcinenet.com	W 149	support plan. Line of sight supervision is defined as keeping an individual within a staff person's sight during awake hours unless otherwise defined by an order or plan of care specified by licensed staff or providers. Facility Polices #805 Abuse/Neglect of Individuals, #816 Reporting Requirements and #809 Restraints have all been updated to include the new DBHDS Human Rights regulations and HCBS DMAS regulations. Policy #805 was revised to include Serious incidents, defined as any incident or injury resulting in a body damage or loss requiring medical attention by a licensed physician, doctor or osteopathic medicine, physician assistant, nurse practitioner while the individual is supervised or involved in services such as attempted suicide, medication overdoses or reactions from medication administered or prescribed by the service. Medication errors resulting in adverse outcomes are also considered serious incidences. Policy #809 wording was revised to define restraint per the new DBHDS Human Rights regulations "any mechanical physical restraints and pharmacological agents intended to confine or otherwise restrict the movement or activity of an individual." Policy #816 includes reporting requirements under DBHDS CHRIS system.	10/17 10/17 10/17