DDINTED: 10/10/2017

DEPAR	TMENT OF HEALTH	AND HÜWAN SERVICES		<b>\</b> .		M APPROVEI
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		49G030	B. WING		1	0/04/2017
NAME OF	PRDVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JAY'S PI	ACE			1406 BLYTHEWWOOD LANE		
5,11 5 1 1				SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	IX5I COMPLETION OATE
W 000	INITIAL COMMENT	rs	W 0			
	Intermediate Care Intellectual Disabilit 10/3/17 through 10/ for compliance with	ntermediate Care Facilities for		,		
	The Life Safety Coo	de survey report will follow.				
	of the survey. The s	the bed facility was 4 at the time survey sample consisted of 3 current Individuals's #1, #2				
W 149	483.420(d)(1) STAF	F TREATMENT OF CLIENTS	W 14	19		
	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.			<ol> <li>Environmental sweeps of the fa- well as Pathways Day Support pro and of vehicles were conducted immediately after the incident. No of any color were found.</li> </ol>	ogram	06/29/17
	Based on observati staff interviews and the facility staff negl necessary supervisi Individuals (I #3) fro Individual #3's beha (BMP) required consupervision due to s	on to safeguard 1 of 3 m ingesting foreign objects. vioral management plan		The Residential Clinical Services Administrator advised all facility semail of the incident and reminde the critical nature of Individual #3' diagnosis. The email emphasized of sight supervision and conducting environmental sweeps is required Further, all were reminded to be comonitoring Individual #3 in all area whether at home, day support, in	d all of s pica that line ng l. diligent in as,	06/30/17 UCT 23 20

The findings include:

gloves.

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

implemented resulting in the ingestion of 2 latex

surgical removal) which was not fully

or in the community. A second email

environmental sweeps every 15 minutes;

no office supplies left unattended; staff

specifically outlined instruction for

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.

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

Event ID: 80JR11

Facility ID: VAICFMR10

(Xf) DATE

PRINTED: 10/10/2017

DEFAR	MENT OF HEALTH	AND IT JAN SERVICES			FORM APPROVE
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		ON.	<u>MB NO. 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		49G030	B. WING _		10/04/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-
JAY'S PL	ACE			1406 BLYTHEWWOOD LANE SUFFOLK, VA 23434	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
W 149	8/1/2003 with diagn explosive behavior, Individual #3's BMP incident was dated he had PICA behav supervision" at all ti	dmitted to the facility on oses that included intermittent profound ID level and PICA.  In affect at the time of the 8/20/15. The BMP indicated iors and required "line of sight mes in order to prevent him	W 14	office area locked at all times. Line of sight supervision was defined as kee the individual within sight. Staff were instructed not to leave Individual #3 unattended while awake, to sweep the bedroom closely before the individual in bed, and to not ever leave the individual in the restroom unattended. The importance of documentation was alsemphasized.	eping e ne nl gets vidual
	The record of the in 7:02 a.m., Individua when, after breakfa: Professionals (DSP	cident indicated on 6/29/17 at I #3 was at the residence st, two Direct Support ) assisted the individual when		2) The number of unannounced environmental sweeps conducted by House Manager was increased to me than once a week at the facility and coupport program.	ore
	It was documented something black columns was able to pull it from a black glove. The inglove that was bluis nurse was called an transferred to a locative individual was stobjects were identification.	coughing and gagging sounds. that one of the DSP's noticed ming out of his mouth and om his mouth, identifying it as ndividual vomited a second h green in color. The On-call d the individual was all urgent care facility. Once tabilized and no other foreign ed in the individual's stomach as transferred back to his		A "Daily Trash Can Log" was institute the facility to ensure trash is taken out to the city trash can three times a day. The trash container designated for gland adult disposable undergarments now kept on the outside porch, instead in the house. The only trash container allowed in the house, may be in the kitchen with the lid secured. The log includes instruction that gloves, wiper trash bags or small items should be setted.	utside y, oves is ad of er sheet s,

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

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

readily accessible.

behind lock and key and at no time left

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

The Residential Clinical Services

lying around the house.

06/29/17

# DEPARTMENT OF HEALTH AND HU......N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETEO	
		49G030	B. WING		10/04/2	2017
NAME OF PROVIOER OR SUPPLIER  JAY'S PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE		
				SUFFOLK, VA 23434		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING (NFORMATION)		ID PREFI TAG	PROVIOER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) MPLETION 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.

06/30/17

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.

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

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/10/2017

OENTER		A MEDICALD SERVICES			FORM APPROVE	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1	OM	<u>IB NO. 0938-039</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	IPLE CONSTRUCTION (	(X3) DATE SURVEY COMPLETED	
		49G030	B, WING_		10/0 <b>4/20</b> 17	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAVIC DI	ACE			1406 BLYTHEWWOOD LANE		
JAY'S PL	AGE			SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT DF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
W 149	Continued From pa	ne ?	W 14	0	<u> </u>	
** 1.0			VV 14	Jay's Place instituted staff assignment	t 07/03/17	
	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			sheets to ensure designated responsi for client supervision.		
				Dr. Rex Walker, psychologist consultate conducted an environmental observation of Pathways Rehab I area where Individual #3 receives day support. Description of Walker reviewed Individual #3's Behavioral Support Plan for appropriateness and updated as of 7/s to include specific procedures regarding pica.  Dr. Walker, psychologist consultant	5/17	
	The Residential Mai loved latex gloves a they kept them away.  On 10/4/17 at 3:45 pthe Residential Country investigation was cono one could figure located the gloves, at to swallow them uncresident had PICA by	pport used black latex gloves. hager stated the individual hd they had to make sure y from him at all times.  o.m., during an interview with hiselor, he stated a detailed hiducted and it was concluded out where Individual #3 and then have an opportunity letected. He stated the ehaviors and it was vas left around for him to		provided Pica Behavior training to all s who work with Individual #3, including Drivers. The training reviewed the Pic disorder and Individual #3's Behaviora Support Plan. It emphasized the importance of "line of sight" supervisionall times, including during outings. Residential Clinical Services Administration supplemented the training with practic guidance for providing line of sight supervision at all times, including during outings.	staff Van ca al on at rator cal	
	was not available for investigation report a investigation dated 7	ical Services Administrator interview, but the at the conclusion of the 7/7/17, documented the ded all staff of the critical		Person-centered plans were reviewed all other individuals residing in the faci it was determined no other individual heads for line of sight supervision.  3) Facility Policy #943 Facility Staffing	ility. nas	
		#3's PICA diagnosis. She		Supervision was revised to state: Individuals requiring line of sight	und 10/17	

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

supervision and conducting environmental

sweeps were required in whatever area he was

in, whether at home, day support, in a vehicle or

Event ID: 80JR11

Facility ID: VAICEMR10

supervision will have specific procedures

requiring this requirement outlined in their

If continuation sheet Page 3 of 4



PRINTED: 10/10/2017

CENTERS FOR MEDICARE & MEDICAID SERVICES				<b>'</b> \.		MAPPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·		OMB INC	). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G030	B. WING		10	/04/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COC	Œ		
JAY'S PL	_ACE			1406 BLYTHEWWOOD LANE SUFFOLK, VA 23434			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(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.		W 149 support plan. Line of sight supervision is defined as keeping an individual within a staff person's sight during awake hours		al within a ke hours		
		d policy and procedure titled d Supervision" dated 8/2017		unless otherwise defined by an plan of care specified by license providers.			

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

indicated there will be sufficient direct care staff to manage and supervise individuals in accordance

individuals. \*Pica: A craving for something that is not normally regarded as nutritive, such as dirt, clay, paper, or

physical or emotional pain or distress to

chalk, medcinenet.com

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 10/17 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

# DEPARTMENT OF HEALTH AND HU. A SERVICES

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

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C		0938-039
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IX1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO	
		49G030	B. WING _		10/	<b>04/2</b> 017
NAME OF F	PROVIOER OR SUPPLIER		T	STREET AOORESS, CITY, STATE, ZIP COOE		
JAY'S PL	.ACE			1406 BLYTHEWWOOD LANE SUFFOLK, VA 23434		
(X4) IO PREFIX TAG	(EACH OEF(CIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	D BE	(X5) COMPLET(ON OATE
W 149	for all staff by the per The facility's revised "Facility Staffing and indicated there will I manage and superwith the individual's The facility's policy a "Abuse/Neglect" daracility prohibited and defined as any omis prescribed treatment physical or emotional individuals.  *Pica: A craving for	PICA training was conducted sychologist on 7/7/17.  d policy and procedure titled d Supervision" dated 8/2017 be sufficient direct care staff to vise individuals in accordance plan.  and procedures titled ted 11/2012 indicated the my form of neglect and it was ssion inconsistent with and care which resulted in al pain or distress to  something that is not normally e, such as dirt, clay, paper, or	W 14	support plan. Line of sight supervis defined as keeping an individual wit staff person's sight during awake ho unless otherwise defined by an order plan of care specified by licensed st providers.  Facility Polices #805 Abuse/Neglect Individuals, #816 Reporting Require and #809 Restraints have all been used to include the new DBHDS Human Fregulations and HCBS DMAS regulate Policy #805 was revised to include Sincidents, defined as any incident or resulting in a body damage or loss requiring medical attention by a licer physician, doctor or osteopathic medication, doctor or osteopathic medication assistant, nurse practitions the individual is supervised or involving services such as attempted suicide, medication overdoses or reactions from the service. Medication errors result adverse outcomes are also consider serious incidences. Policy #809 wor was revised to define restraint per the DBHDS Human Rights regulations mechanical physical restraints and pharmacological agents intended to confine or otherwise restrict the movor activity of an individual." Policy #includes reporting requirements und DBHDS CHRIS system.	hin a burs ar or aff or	10/17 10/17