PRINTED: 0210712017
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 Kentucky Avenue VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION
W 000	INITIAL COMMENTS The unannounced annual 55 Fundamental Medicaid Certification was conducted on 1/24/17 through 1/26/17. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities. (ICF/ID) Federal Regulations. The Life Safety Code report will follow. The census in this 8 bed facility at the time of the survey was 6. The survey sample consisted of 2 current Individual records (Individual #1 through #2) and one closed record (Individual #3). 483.410(a)(1) GOVERNING BODY	W 000		
W 104	The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to ensure necessary staffing was available to ensure Resident's health and safety. The findings include: Individual #1 was admitted to the facility on 3/5/12 with diagnoses which included a history of cardiovascular accident with left sided hemiparesis (weakness), dementia, hypertension, hypothyroidism, and history of urinary tract infection. Individual #1 had a change in condition with a delay in medical intervention. A review of the facilities daily Staffing report indicated that on May 1, 2016, the facility did not	W104	Personnel action occurred on 6/6/16 for the On-Call RN that failed to respond to the individual's change of condition. Retraining of expectations and required response while On-Call occurred on 5/4/16 for the On-Call RN that failed to respond to the individual's change of condition.	

LABORATORY DIRECTOR 8 OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE | TITLE | (X6) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XVN11 Facility ID: VAICFMR11 If continuation sheet Page 1 of 38

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W 104	Continued From page 1 have a licensed Nurse on duty. The RN (Registered Nurse) On Call failed to report to duty when contacted A review of the Staff schedule for 5/1/2016 indicated that the morning shift Licensed Practical Nurse (LPN) did not report for duty. The overnight LPN staff was asked to remain over. Individual #1 was increasingly presenting with signs and symptoms of distress due to breathing issues. The RN On Call staff failed to report for duty after being contacted regarding Individual #1's, declining health. House staff contacted RN On Call requesting her to come and assess the individual. RN On Call requested staff to call On Call Supervisor to ok her time to go to the facility. RN On Call did not arrive at the facility. An Incident Report dated 5/1/2016 indicated: "On 5/1/16 at 11:00 A.M. Individual #1 was experiencing coughing, wheezing and runny nose, was assessed by overnight Licence Practical Nurse #1, and assisted with receiving Mucinex D and Delsyum according to OTC (Over The Counter) physician's orders. About 1 1/2 hours later there was an increase in cough and wheezing and a decline in her level of alertness. Re-assessed by LPN #1. 02 Sat's (oxygen saturation in blood) were 81% (normal range 95 to 100%), administered Oxygen at 2 Liters per Minute (LPM) and 02 Sat's increased to 88%. Registered Nurse (RN) Supervisor notified. EMS (Emergency Medical System) called and upon arrival increased 02 to 4 LPM with only an increase to 89%. BP (Blood Pressure) 109/160 Transported to Hospital."	W 104	Monitoring for compliance of RN On-Call policies and procedures will occur through monthly supervision with the Nurse Manager, as well as weekly submission and review of On-Call logs to the site supervisor, ICF Administrator, and DS Nurse Manager. The ICF On-Call policy that covers all individuals residing in the City of Virginia Beach ICF's will be updated to include both the On-Call Supervisor and On-Call RN will communicate with the A.M. and P.M. shifts at each ICF at least once during the on call hours on weekends and holidays to monitor for staffing, and the safety and wellness of the residents. The ICF On-Call policy that covers all individuals residing in the City of Virginia Beach ICF's will be updated to include both the On-Call Supervisor and On-Call RN will be available to report to any of the ICF's in the event of staffing shortages until the shortage is rectified. Further updates to the On-Call policy will include the expectation that once an Individual is identified as having a change in health condition the On-Call RN will be alerted and the individual will be assessed by an ICF nurse. This will occur by either the LPN on site, as directed; an LPN from another ICF or by the On-Call RN. LPN's completing an assessment will be required to report their findings to the On-Call RN to collaborate on necessary interventions All On-Call Supervisors, On-Call RNs and LPNs will be trained on the updated practices.	3/10/17 3/10/17 3/10/17 3/10/17 3/10/17

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KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVE VIRGINIA BEACH, VA 23452

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W 104	Continued From page 2 A facility internal investigation dated 514116 indicated: "Adult Protective Services (APS) were contacted on 5/1/16. APS was notified that staff of the facility felt they were following the process to contact on-call nursing staff for consultation when it appeared that the individual was increasingly in distress due to breathing issues and prior medical history, but not getting prompt responses. Additionally, there was disagreement with the decision to wait and monitor the individual over the weekend rather than contact 911 earlier than they had. APS interviewed house staff on 5/2 and 5/3." A Time Line provided by the Nurse Manager gives the following: 4/29 (0830 (8:30am) RN #1 assesses Individual #1 for skin integrity-no notation of illness 4/30- LPN #2 who arrives at (06:30am) notes shortly after shift report that Individual #1 has a low grade Temperature (99.2), non-productive cough, lethargic and a runny nose. 4/30 (0800) LPN #2 medicates Individual #1 with PRN Tylenol at (0800). Per routine orders she also receives Claritin 10 mg (milligrams). 4/30- (1400) (2:00pm)- LPN #2 places a call to MD (medical doctor) to report symptoms' MD states "It sounds like viral symptoms; push fluids offer Tylenol every 8 hours for 72 hours and continue to monitor" LPN #2 calls both the On Call Supervisor and On Call RN to report Individual #1's change in health status- this is within minutes of the call to the MD and confirmed on both (facility telephone) logs from the On Call supervisors. 4/30- (1500) (3:00pm) -Individual #1 is monitored throughout the day with no change in status. (VS: 97.2, 153-93, 85, 20, 97%) prior to	W 104	All ICF staff will be trained on the updated On-Call practices. The On-Call Supervisor and the On-Call RN will be required to keep a running log for the duration of their rotation that captures all communication with ICF staff members. This log will be submitted to the Site Supervisor's, ICF Administrator and the DS Nurse Manager weekly for review.	3/10/17 3/10/17

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KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVE VIRGINIA BEACH, VA 23452

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W 104	Continued From page 3 LPN #2's departure she advises staff to monitor Individual temperature and reminds them to medicate Individual #1 with Tylenol at (1600) (4:00pm) Per MAR- (Medication Administration Record) 5/1 [Sometime before (0800)- time not indicated on facility phone log] facility staff (Direct Service Professional) DSP #1 notifies ON call RN that Individual #1 was not feeling well and they could not get her off the toilet, RN log notes, directs staff to put her to bed and let her rest, 5/1 (0842) ON call RN receives call from facility's House Manager that he is holding overnight LPN #1 over to perform an assessment on Individual #1, House Manager and RN #1 converse about available PRN's- OTC orders include Mucinex and Robitussin because they are on the OTC page and not on the MARs the medication need to be purchased, Per RN #1 log she doesn't indicate which medication to give because she's not sure of the ingredients. During the (investigation process) it noted that RN #1 told the House Manager to "Pick One" referring to one of the two cough medicines. 511 -(0800) Per MAR- and nursing notes LPN #1 indicates he medicated Individual #1 with both cough medicines. During the investigation it comes out that the medication does need to be purchased, it was purchased at (0830) on 5/1/16 and given immediately upon arrival. There was a previous business practice that medication on the OTC form were not kept in the house and were purchased when needed. This practice has changed, all medications that are on the OTC or Physician's order form are kept in house at all times and part of the Bulk	W 104		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23454

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W 104	Continued From page 4 inventory log. 5/1 (0955) RN #1 (RN On Call) a receives call from facility staff DSP #2 regarding Individual #1's wellness. Per RN log staffs Individual #1 is in bed with head of bed elevated and having difficulty breathing. Also per RN log she indicates to facility staff she "would be gladly to come assess her when the on call notifies her to do so, but no further calls were received." 5/1 (0955) per Supervisor Log- receives call from facility staff regarding Individual #1 and notifies her that the RN is on the way to perform an assessment. 5/1 (1019) Per RN log she ind'1cates House Manager calls RN to inform that they are calling 911 and Individual #1 was being transported to hospital. 5/1 between 10:20 am- 11:00 am- facility staff continue to struggle with Individual #1's presentation, the LPN #1 assessment and treatment provided. During investigation staff noted that the LPN #1 was aware of the oxygen saturation levels dropping below 90 but he had not placed her on Oxygen. Instead House Manager (NON- Clinical Nurse) places her on Oxygen. 5/1 -(11:17) per log On Call Supervisor places call to facility to inquire about Individual #1- speaks with LPN #1 who indicates the low oxygen. On Call Supervisor asks why 911 was not called, LPN #1 does not respond. On Call speaks with House Manager and they decide to call 911. 511- (11:05 am) 911 is called." An investigation interview involving Direct Care Staff (DSP #1) indicated: DSP #1 worked day	W 104		

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KENTUCKYAVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

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W 104	Continued From page 5 shift Saturday and Sunday at the facility. Because he worked both days he was very concerned about the individual when her condition worsened on Sunday May 1. He reports f that when he came to work on Sunday the individuals condition was worse than Saturday and resident still had not eaten. He reports that the nurse in the house, LPN #1, called RN on call (Call not made by LPN #1 but by the House Manager) sic. Staff was instructed to put the individual back into bed. The individual's condition appeared to decline after she was transferred back to the bed so DSP #1 called RN on Call . This call is recorded by RN On Call on her log at 0957. DSP #1 reports that the RN ON Call informed him that she would come to the facility to assess the individual but he (DSP#1) had to notify the ON Call Supervisor that ON Call RN needed to come to the building (sic). The ON Call Supervisor was informed of situation and asked The RN ON Call update her after she got to Facility. Approximately an hour passed, the House Manager and DSP #1 decided due to the decline in the condition of the Individual that they were calling 911. The ON Call RN had not been to building by this time. An investigation conducted with DSP#2 Indicated: "The situation with Individual #1 was Chaotic and that staff were looking for permission to call 911 to send someone out, ASAP. OSP#2 was concerned that RN On Call did not seem to comprehend the seriousness of the individual's health decline that day and that getting a hold of On Call staff is difficult as they are often times not Able to be reached." An Investigation conducted with DSP#3 Indicated: "In the past staff had been admonished	W 104		

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W 104	Continued From page 6 to (sic) call 911 "too much" because the individuals may not come back from the hospital but go to a nursing home and then that would close the facility and they would be out of their jobs." DSP#3 reports that the staff felt powerless in How to go about sending out the individual and that the LPN was not offering any direction. DSP# 3 reports the staff informed the RN that Individual#1 had dark foul smelling urine about 2-3 weeks ago and the RN informed the staff that. "Individual #1 has that sometimes, it doesn't mean it's UTI (urinary tract infection)." An investigation conducted with RN On Call Indicated: "RN On Call stated she was not informed that the individual was needing 02. She assumed that the nurse (LPN#1) was capable of assessing and decision making regarding care for the individual. RN On Call did not ask to speak at any time with LPN #1 and now agrees that she should have. RN On Call reports that she would've come to assess but no one told her that it was ok to do so because she "doesn't work weekends. During an interview on 1/25/17 at 1:30 P.M. with the Nurse Manager, she was asked why did the RN On Call need permission from the On Call Supervisor to come on site? The Nurse Manager stated, she was not aware that permission needed to be granted by anyone to come on site. The RN On Call "made that up on her own." A Staffing Policy indicated: "Purpose- To ensure the availability of sufficient numbers of competent, trained staff and consultants to	W 104		

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W 104	Continued From page 7 provide active treatment and to protect the health and safety of each client." Policy: It is the policy of the the agency to ensure the ICFs have a sufficient number of qualified trained staff and consultants to carry out the client's treatment plan and protect their health and safety In compliance with all regulatory agencies. This policy is applicable to the Facility Administrator and House Manager.			
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to implement written Policies and Procedures that prohibit neglect for one individual (Individual# 1) in the survey sample of three (3) individuals. Individual#1 presented with a change of Condition while experiencing coughing, wheezing, and decline in alertness. The findings included: Individual #1 was admitted to the facility on 3/5/12 with diagnosis which included a history of cardiovascular accident with left sided hemiparesis (weakness), dementia, hypertension, hypolhyroidism, and a history of urinary tract infections. Individual #1 had a change in condition with a delay in medical intervention.	W 149	Staff who failed to respond appropriately to the neglect of the client had personnel action and/or retraining as appropriate by 6/6/16.	

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W 149	Continued From page 8 An Incident Report dated 5/1/2016 indicated "On, 5/1/16 at 11:00 A.M. Individual #1 was experiencing coughing, wheezing and runny nose, was assessed by overnight License Practical Nurse #1, and assisted with receiving Mucinex 0 and Delsyum according to OTC (Over The Counter) physician's orders. About 1 1/2 Hours later there was an increase in cough and wheezing and a decline in her level of alertness. Re-assessed by LPN #1. 02 Sat's (oxygen saturation level in blood) were 81% (normal range 95-100%), administered Oxygen at 2 Liters per Minute (LPM) and 02 Sat's increased to 88%. Registered Nurse (RN) Supervisor notified. EMS (Emergency Medical System) called and upon arrival increased 02 to 4 LPM with only and increase to 89%, BP (Blood Pressure) 109/60. Transported to Hospital." The facility staff contacted RN On Call requesting her to come and assess the individual. RN On Call requested staff to call On Call Supervisor to Ok her time to go to the facility. RN On Call did not arrive at the facility. A facility internal investigation dated 5/4/16 Indicated: "Adult Protective Services (APS) were contacted on 5/1/16. APS was notified that staff of the facility felt they were following the process to contact on-cal. nursing staff for consultation when it appeared that the individual was increasingly in disiress due to breathing issues and prior medical history, but not getting prompt responses. Additionally, there was a disagreement with the decision to wait and monitor the individual over the weekend rather than contact 911 earlier than they had. APS interviewed house staff on 5/2 and 5/3."	W 149	All staff were retrained on 5/4/16 regarding the prevention, identification and interventions of abuse, neglect and mistreatment of clients. All staff were also retrained on calling 911 relative to the Acute and Chronic Health Conditions Policy. All staff are required to review, at least annually, and when any updates occur, the Client Abuse Policy. Staff will be required to attest via a signature that they have reviewed the Policy. Site supervisors will maintain this affirmation and documentation in the training records. The ICF has a training month when all required reviews and retraining occurs. Site supervisors will keep a record of reviews and retraining's, along with documentation of staff attendance and participation in the training records.	3/10/17 3/10/17

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W 149	Continued From page 9 A Time Line provioed by the Nurse Manager gives the following: "4129 (0830) (8:30am) RN #1 assesses Individual #1 for skin integrity-no notation of illness 4130- LPN #2 who arrives at (0630) (6:30 am)notes shortly after shift report that Individual #1 has a low grade Temperature (99.2), non-productive cough, lethargic and a runny nose. 4130 (0800) LPN #2 medicates Individual #1 with PRN Tylenol at (0800). Per routine orders she also receives Claritin 10 mg (milligrams). 4130- (1400) (2:00pm)- LPN #2 places a call to MD (medical doctor) to report symptoms- MD states "It sounds like viral symptoms; push fluids offer Tylenol every 8 hours for 72 hours and continue to monitor." LPN #2 calls both the On Call Supervisor and On Call RN to report Individual #1's change in health status- this is within minutes of the call to the MD and confirmed on both (facility telephone) logs from the On Call supervisors. 4130- (1500) (3:00pm) -Individual #1 is monitored throughout the day with no change in status, (VS: 97.2, 153-93, 85, 20, 97%) prior to LPN #2's departure she advises staff to monitor Individual temperature and reminds them to medicate Individual #1 with Tylenol at (1600) (4:00pm) Per MAR- (Medication Administration Record). 511 [Sometime before (0800) time not indicated on facility phone log] facility staff (Direct Service Professional) DSP #1 notifies ON call RN that Individual #1 was not feeling well and they could not get her off the toilet, RN log notes directs staff to put her to bed and let her rest. 511 (0842) RN On Call receives call from facility's House Manager that he is holding overnight LPN	W 149		

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KENTUCKY AVE RESIDENCE	145 KENTUCKY AVE VIRGINIA BEACH, VA 23452

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W 149	Continued From page 10 #1 over to perform an assessment on Individual #1. House Manager and RN (RN On Call) converse about available PRN's- OTC orders include Mucinex and Robitussin because they are on the OTC page and not on the MARs, the medication needed to be purchased. Per RN (RN On Call) log she doesn't indicate which medication to give because she's not sure of the ingredients. During the (investigation process) it noted that the RN (RN On Call) told the House Manager to "Pick One" referring to one of the two cough medicines 5/1 -(0800) Per MAR- and nursing notes LPN #1 indicates he medicated Individual #1 with both cough medicines. During the investigation it comes out that the medication does need to be purchased, it was purchased at (0830) on 5/1116. and given immediately upon arrival. There was a previous. business practice that medication on the OTC form were not kept in the house and were purchased when needed This practice has changed, all medications that are on the OTC or Physician's order form are kept in house at all times and part of the Bulk inventory log. 5/1 (0955) RN (RN On Call) receives call from facility staff DSP #2 regarding individual #1's wellness. Per RN (RN On Call) log staffs Individual #1 is in bed with head of bed elevated and having difficulty breathing. Also per RN (RN On Call) log she indicates to facility staff she "would be gladly to come assess her when the on call Supervisor notifies her to do so, but no further calls were received." 5/1 (0955) per Supervisor Log - receives call from facility staff regarding Individual #1 and notifies	W 149		

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	49G026	A BUILDING _____ B WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

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W 149	Continued From page 11 her that the RN is on the way to perform an assessment. 5/1 (1019) Per RN (RN On Call) log she indicates House Manager calls RN to inform that they are calling 911 and Individual #1 was being transported to hospital. 5/1 between 10:20 am - 11:00 am - facility staff continue to struggle with Individual #1's presentation, the LPN #1 assessment and treatment provided. During investigation staff noted that the LPN #1 was aware of the oxygen saturation levels dropping below 90 but he had not placed her on Oxygen. Instead House Manager (NON- Clinical Nurse) places her on Oxygen. 5/1 -(1117) per log On Call Supervisor places call to facility to inquire about Individual #1- speaks with LPN #1 who indicates the low oxygen. On Call Supervisor asks why 911 was not called, LPN #1 does not respond. On Call speaks with House Manager and they decide to call 911. 5/1- (11:05 am) 911 is called." A Hospital Summary dated 05/01/16 indicated: "Chief Complaint- Shortness of breath. Diagnoses Sepsis, due to unspecified organism (HCC), Acute cystitis without hematuria (blood in urine), acute on chronic congestive heart failure, unspecified, congestive heart failure type (HCC), Atrial-fibrillation,unspecified (HCC). ED (emergency room) arrival (5/1/2016, 11:44) call went out to EMT (5/1/2016, 11:05). PT (patient) placed on NC (nasal cannula) 6L (Liters). Hospital nursing notes: 05/01/16 -1200: PT has been having increasing difficulty breathing for the past 2 days. PT has developed wet cough	W149		

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W 149	Continued From page 12 crackles heard in lower lobes bilaterally. PT arrives on NC (nasal cannular) 6 Ls by EMS (emergency medical services)saturations 92%; pt placed on non-rebreather 10ls. History of stroke; left sided deficit." Hospital Discharge Summary: indicated: "Admit Date: 5/1/2016- Discharge Date: 511112016, 4:55 PM. According to staff RN 2 days prior to admission she has increased shortness of breath and breathing fast and labored, associated with wet cough there was no fever or chills. No significant swelling in the legs. In the ED (emergency department) labs revealed, WBC of 21.000, elevated and BNP 3591, creatinine 1.2 from baseline around 0.9, chest x-ray with possible right middle lobe and right lower lobe infiltrate. Hospital Course: 1. Sepsis (HCC): Multifactorial, secondary to health care acquired Pneumonia and UTI (urinary tract infection). Resolved, no fever, no leukocytosis. Blood culture is negative. 2. RML (right middle lobe)? RLL (right lower lobe) Health Care acquired pneumonia: Will continue Levaquin, Robitussin. Blood and sputum culture is negative. 3. Morganella UTI: Continue Levaquin for 3 more days. 4. Acute diastolic CHF (congestive heart failure): Improved. maintains good Oxygenation on RA (room air). Continue Metoprolol, Lisinopril, Lasix, PO (by mouth). 5. Atrial Fibrillation: will continue HR (heart rate) control with Toprol and not a good candidate for anticoagulation secondary to risk for fall. ECHO (echocardiogram) showed normal LVEF (left	W 149		

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W 149	Continued From page 13	W 149		

ventricular ejection fraction-amount of blood pumped out after each heartbeat) at 60%.
6. ARF (acute renal failure) on CKD (chronic kidney disease), stage 3: Resolved and creatinine is back to baseline. Monitor BUN/Creatinine.
Elevated liver enzymes: Monitor , sip (status post) cholecystectomy. Liver US (ultrasound) showed liver congestion VS (versus) inflammation. Will stop Pravachol and repeat liver function tests in a few weeks. Patient stable for discharge."

During an interview on 1/25/17 at 10:00 A.M. with the Nurse Manager, she was asked why the delay in services for Individual #1. The Nurse Manager stated the On- Call RN nurse failed to respond to facility staff repeated calls to come into the facility due to Individual #1's increasingly decline due to breathing issues.

An internal review of an investigation conducted on 5/4/16 by the (QIDP) (Qualified Intellectual Disability Professional) regarding the events of Individual #1 on 5/1/161ndicated: "LPN #1 was interviewed on 5/4/16. LPN #1 stated, he worked the over night shift on 4/30/16. He reported that the information he received in report when he came on duty was that Individual #1 was experiencing "viral" symptoms and that she had received an order for Tylenol to be given every 8 hours. He documented on the over nightshift report that the individual slept through the night. Because the individual was coughing and congested, the House Manger requested that he stay until the individual was seltled. He was asked by staffto assess Individual #1 around 0800 on 5/1/16.
Staff reported to him that the individual was "off' in her presentation. That morning she was a 2-3 person assist when usually she would assist

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W 149	Continued From page 14	W 149		

herself and leaning to one side while she was on the toilet. Staff requested that he assess her which he did. He reports that he asked staff if she had any PRNs (as needed medications) for congestion/cough. The individual had orders for Mucinex and cough syrup as needed but none were in house so staff had to go and purchase them. The OTC (over the counter) medication was purchased by direct care staff at 0829. It arrived in the facility shortly after and was administered by LPN #1 at approximately 0900. THE MEDICATION ADMINISTRATION RECORD (MAR) WAS SIGNED OFF THAT THE MEDICATION WAS GIVEN AT 0800. LPN #1 reports that the assessment he performed on Individual #1 revealed normal temp, 0 2 sat's and blood pressure but that she was congestion and coughing. LPN# reported that he went back to administering medications as staffing was short and staff were tending to other individuals for their morning routines.

LPN #1 reports that he was asked later to check Individual #1 (around 103/1100) sic and that her 02 sat's at that time were in the low to mid 80's on room air and shortly and again shortly afterward with 02 sat's still in the low to mid 80's. He did not recall the exact time but approximately around 1030 he suggests that someone could transport Individual #1 to the ER (emergency room) for evaluation which staff disagreed and called 911. He clocked out after the individual was picked up by EMT. At no time did he call or contact the On Call RN Supervisor for direction."

An investigation interview involving Direct Care Staff (DSP #1) indicated: "DSP #1 worked day shift Saturday and Sunday at the facility. Because he worked both days he was very

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W 149	Continued From page 15 concerned about the individual when her condition worsened on Sunday May 1. He reports that when he came to work on Sunday the individual's condition was worse than Saturday and still had not eaten. He reports that the nurse in the house LPN #1 called RN on call (Cal not made by LPN #1 but by the House Manager) sic. Staff was instructed to put the individual back into bed. The individual's condition appeared to decline after she was transferred back to the bed so DSP #1 called RN on Call. This call is recorded by RN On Call on her log at 0957. DSP #1 reports that the RN On Call informed him that she would come to the facility to assess the individual but he (DSP #1) had to notify the ON Call Supervisor that On Call RN needed to come to building (sic). The On Call Supervisor was informed of situation and asked the RN On Call update her after she got to facility. Approximately an hour passed, the House Manager and DSP #1 decided that due to the decline in the condition of the Individual that they were calling 911. The RN On Call had not been to building by this time." An investigation interview conducted with the House Manager indicated: "The House Manager I asked LPN #1 if he had given Individual #1 her scheduled Tylenol and he answered that he had. The House Manager reports that she reviewed The MAR's (medication administration record) for any additional PRNs for the symptoms that the individual was experiencing and she had cough syrup and Mucinex orders. The House Manager called the RN On Call to let her know that because the individual was doing poorly that she wanted to keep LPN #1 at the facility until the individual was assessed. The House Manager then called the RN On Call to discuss the OTC PRNs and the RN On Call informed the House	W 149		

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W 149	Continued From page 16 Manager to "pick one to use PRN" as RN On Call (delegated to non-licensed staff) did not know specific ingredients in either medication. House Manger then went to purchase the 2 OTC (over the counter) meds and returned. LPN #1 administered them both 0800 (but documented incorrect time -0900). When RN On Call instructed staff to put the individual back into bed, the House Manager was approached by DSP #1. He reported to House Manager that he did not like the way that Individual #1 was breathing House Manager asked DSP #1 to re-assess Individual #1. House Manager obtained 02 sat's and the reading was 81%. House Manager informed LPN #1 that the individual needed oxygen which the House Manager placed on Individual #1 The House Manager is a non-licensed staff- also- Individual #1 did not have a physician order for the use of oxygen). Individual# 1's 0 2 sat's increased to 88%. House Manager then listened to Individual #1's lungs and then informed LPN #1 that Individual #1 needed to go to the hospital. LPN #1 called RN On Call to tell her that she was needed at the facility ASAP and her response was, "Call the regular on call and have her call me so "I can get paid". On call Supervisor was contacted and informed that 911 was being called. LPN #1 told staff that he thought the individual could be transported by staff to ER but staff informed him 9i i was needed for the safety of the individuaL House Manager contacted RN On Call to inquire about her location and House Manager was informed that the RN On Call was still waiting for On Call Supervisor to tell her where she needed to be. RN On Call was notified that the individual was being transported to ER via 911. An Investigation conducted with DSP #2	W 149		

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W 149	Continued From page 17 Indicated: "The situation with Individual #1 was #1. chaotic and that staff were looking for permission to call911 to send someone out, ASAP. DSP #2 was concerned that the RN On Call did not seem to comprehend the seriousness of the individual's health decline that day and that getting a hold of On Call staff is difficult as they are often times not able to be reached." An Investigation conducted with DSP #3 indicated: "In the past staff had been admonished to (sic) call 911 "too much" because the individuals may not come back from the hospital but go to a nursing home and then that would close the facility and they would be out of their jobs." DSP #3 reports that the staff felt powerless in how to go about sending out the individual and that the LPN was not offering any direction. DSP #3 reports the staff informed the RN (Same as RN On Call-Staff) that Individual #1 had dark foul smelling urine about 2-3 weeks ago and the RN informed the staff that, "Individual #1 has that sometimes, it doesn't mean it's UTI". An Investigation conducted with RN On Call indicated: RN On Call stated that she was not Informed that the individual was needing O2. She Assumed that the nurse (LPN #1) was capable of assessing and decision making regarding care for The individual. RN On Call did not ask to speak at any time with LPN #1 and now agrees that she should have. RN On Call reports that she would've come to assess but no one told her that it was ok to do so because she "doesn't work weekends."	W 149		

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W 149	Continued From page 18 During an interview on 1/25/17 at 1:30 P.M. with the Nurse Manager, she was asked, why did the RN On Call need permission from the On Call Supervisor to come on site? The Nurse Manager stated, she was not aware that permission needed to be granted by anyone to come on site. The RN On Call "made that up on her own." During an interview on 1/25/17 at 11:33 AM with the RN On Call Nurse she stated, "In order for me to get paid, I had to have approval from the On Call Supervisor." When asked if On- Call not mean that you report where ever you are needed. The RN stated, "Yes". House staff contacted RN On Call requesting her to come and assess the individual. RN On Call requested staff to call On Call Supervisor to ok her time to go to the facility. RN On Call did not arrive at the facility. APS was called by staff because they felt there was a delay in individual #1 receiving the next level of care (i.e. going to hospital for further treatment/care for breathing difficulties). An Adult Protective Services (APS) Investigative Report dated 5/2/16 Indicated: "Client is a 79 year old female who resides at (Facility named). The client has a Guardian. The client has an Intellectual Disability. The caller reports the client was ill and lethargic, not eating and rattled breathing. Caller reports the worker noticed on Saturday that the client was not well and appeared to be getting worse. The worker asked for an assessment with the nurse and the other nurse on Saturday shift agreed that the client may	W 149		

	need to go to a physician. The caller reports they			

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W 149	Continued From page 19 consulted with "On Call" nurse and were told to put her back to bed. On Sunday the client appeared to be getting progressively worse. Caller reports she was not eating and appeared lethargic and her breath rattle was worse. The caller was uncomfortable with the situation and felt she needed direct care by physician and requested an assessment with "ON Call Nurse" to come in and visually see the client He was told the nurse would respond and she did not show. The caller reports it is not protocol for staff to call 911 without consulting with House Manager nurse but after contacting House Manager they called for 911. The Client was admitted to the hospital with Congestive heart Failure. The caller was upset that the nurse do not respond or complete assessments when requested. The caller also reports that at times they are without a nurse present at the home. The Caller is concerned for neglect" A Revised Abuse Policy dated 12/11/15 Indicated: "Purpose- To provide all staff and consultants who work with clients at the facility in any capacity, a system for ensuring that all persons recommended for hire receive a background check; and upon hire receive training to recognize and report all suspected incidents of abuse neglect, exploitation, crimes, or suspicious injuries from an unknown source relating to clients living at the facility." Policy Statement: It is the policy of this administration to protect the individuals we serve from abuse, neglect, exploitation, crime and injury. Incidents of suspected Abuse, neglect	W 149		

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W149	Continued From page 20 Exploitation, or suspicious injuries of unknown origin. additional reporting is required: If a staff witness action towards a client that appear to be abuse, staff is to immediately take action to protect the client from any further abuse. The facility staff failed to implement il's policies and procedures to prevent neglect.			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has forrTiulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review, and staff interviews, the facility staff failed to implement a Program Plan (provide medical treatment with a change of condition) to one individual (Individual #1) in the survey sample of three (3) individuals Individual #1 presented with a change of condition while experiencing coughing, wheezing, and a decline in alertness. The findings included: Individual #1 was admitted to the facility on 3/5/12 with diagnoses which included a history of cardiovascular accident with left sided	W 249	Personnel action occurred on 6/6/16 for the Licensed Nurses that failed to respond to the individual's change of condition.	

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W 249	Continued From page 21 hemiparesis (weakness), dementia, hypertension, hypothyroidism, and history of urinary tract infection. Individual #1 had a change in condition without medical intervention. Facility staff failed to implement in a timely manner Individual #1's Program Plan. An Individualized Program Plan (IPP) dated 211/16 indicated: "Objective Coordination of heath care related to acute or changes to baseline or onset of chronic conditions. Service Objective: Maintain appropriate communication between aiiiDT (Interdisciplinary Team) members in order to support Individual with her health care needs. Observations: Routine calls are made to PCP (primary care physician) family dietician, pharmacy consultant. Calls are also made to other health care providers that are authorized to assist Individual #1 with her health care needs Methods: Nurse will record pertinent contact information in nursing progress notes." Nursing Interventions: Tracking frequency of voids (void calendar). I & 0 (intake and output) Sheets. House RN staff was asked if there was a tracking calendar for Individual #1's voiding. and the RN stated. "No". When asked if there were I & O flow sheets the RN stated "No." An Incident Report dated 5/112017 indicated: "On 5/1/16 at 11:00 A.M.Individual #1 was experiencing coughing, wheezing and runny nose, was assessed by overnight Licence Practical Nurse #1, and assisted with receiving Mucinex D and Delsyum according to OTC (Over The Counter) physician's orders. About 1 1/2 hours later there was an increase in cough and wheezing and a decline in her level of alertness Re-assessed by LPN #1. 02 Sats (oxygen	W 249	Retraining occurred on 6/6/16 for the Licensed Nurses that failed to respond to the individual's change of condition. The Acute and Chronic Health Conditions Policy that covers all City of Virginia Beach ICF individuals will be updated to reflect the level of response by each profession as indicated by their scope of practice. All ICF staff are to be retrained on the Acute and Chronic Health Conditions Policy and the level of response indicated for their scope of practice. Monitoring for compliance of the Acute and Chronic Health Conditions policy for the RNs will occur during monthly supervision with the Nurse Manager. Monitoring for the LPNs will occur through monthly supervisions with the site RN.	3/10/17 3/10/17 3/10/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVE RESIDENCE	145 KENTUCKY AVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION
W 249	Continued From page 22 saturation in blood) were 81% (normal95-100%), administered Oxygen at 2 Liters per Minute (LPM) and 02 Sats increased to 88%. Registered Nurse (RN) Supervisor notifted. EMS (Emergency Medical System) called and upon arrival increased 02 to 4 LPM with only and increase to 89%, BP (Blood Pressure) 109/60. Transported to Hospital." During an interview on 1/25/17 at 10:00 AM. with the Nurse Manager, she was asked why the delay in services for Individual #1. The Nurse Manager stated the On- Call RN nurse failed to respond to facility staff repeated calls to come into the facility due to Individual #1's increasing decline due to breathing issues. An internal review of an investigation conducted on 5/4/16 by the (QIDP) regarding the events of Individual #1 on 5/1/16 indicated: "LPN #1 was interviewed on 5/4/16. LPN #1 stated, he worked the over night shift on 4/30/16. He reported that the information he received in report when he came on duty was that Individual #1 was experiencing "viral" symptoms and that she had received an order for Tylenol to be given every 8 hours. He documented on the over nightshift report that the individual slept through the night. Because the individual was coughing and congested, the House Manger requested that he stay until the individual was settled. He was asked by staff to assess Individual #1 around 0800 on 5/1/16. Staff reported to him that the individual was "off" in her presentation. That morning she was a 2-3 person assist when usually she would assist herself and leaning to one side while she was on the toilet. Staff requested that he assess her which he did. He reports that he asked staff if she	W 249		

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W 249	Continued From page 23	W 149		

had any PRN's for congestion/cough. The individual had orders for Mucinex and cough syrup as needed but none were in house so staff had to go and purchase them. The OTC (over the counter) medication was purchased by direct care staff at 0829. It arrived in the facility shortly after and was administered by LPN #1 at approximately 0900. THE MEDICATION ADMINISTRATION RECORD (MAR) WAS SIGNED OFF THAT THE MEDICATION WAS GIVEN AT 0800. LPN #1 reports that the assessment he performed on Individual #1 revealed normal temp, 02 sat's and blood pressure but that she was congested and coughing. LPN# reported that he went back to administering medications as staffing was short and staff were tending to other individuals for their morning routines.

LPN #1 reports that he was asked later to check Individual #1 (around 103/1100) sic and that her 02 sat's at that time were in the low to mid 80's i on room air and shortly and again shortly afterward with 0 2 sat's still in the low to mid 80's. He did nol recall the exact time but approximately around 1030 he suggests that someone could transport Individual #1 to the ER (emergency room) for evaluation which staff disagreed and called 911. He clocked out after the individual was picked up by EMT (emergency medical transport). At no time did he call or contact in way the On Call RN Supervisor for direction."

An Individual Program Plan Policy Indicated. "Purpose- To ensure that all clients have an individual program plan, based on initial, ongoing, and annual assessments: and that continuous active treatment is implemented to allow clients to function with as much independence and self

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W 249	Continued From page 24 -determination as possible and to prevent or minimize regression." A Health Care Services Policy updated 3/3/16 indicated: "Subject- Acute and Chronic Health Conditions Procedure: To ensure the provision of a comprehensive plan for preventative services and prompt treatment of acute and chronic health conditions of each individual Applicability- All staff and consultants who work with individuals at the facility in any capacity. Purpose: It is the responsibility of all staff at the facility to participate in the provision of a comprehensive prevention plan and provide prompt treatment for acute and chronic health conditions of each individual. the interdisciplinary team (IDT) process is used to assess the needs of each individual and develop a plan to address any identified chronic health conditions and develop preventative measures to maintain the individual's health status. 6. The following guidelines should be used by all staff in determining their response to a change in a resident's health status. Medical Emergency Guidelines: Level of response: 911- Difficulty Breathing: Sudden onset with 02 sat's <(less than) 85% noted wheezing. stridor and increased anxiety. Based on baseline 02 sat's of 98-100%. Level of response: Call PCP (Primary Care Physician) or Nursing Supervisor-Difficulty Breathing: 02 sat's 90-95%. Increased congestion, wheezing PRN HHH given and pulmovest with slight improvement or temporary improvement.	W 249		

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W 249	Continued From page 25 Level of response: Nursing Care Plan/Observation: Difficulty Breathing: 02 Sat's within baseline. Schedule PRN medications for routine assistance for 24 to 48 hours." The facility staff failed to implement Individual #1's IPP when a change in health status was presented.	W 249		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review, and staff interviews, the facility staff failed to provide medical treatment with a change of condition to one individual (individual #1) in the survey sample of three (3) individuals. Individual #1 presented with a change of condition while experiencing coughing, wheezing, and a decline in alertness The findings included: Individual #1 was admitted to the facility on 3/5/12 with diagnoses which included a history of cardiovascular accident with left sided hemiparesis (weakness), dementia, hypertension, hypothyroidism, and history of urinary tract infection. Individual #1 had a change in condition with a delay in medical intervention. An Incident Report dated 5/1/2017 indicated: "On 5/1/16 at 11:00 A.M. Individual #1 was	W 331	RECEIVED MAR 08 2017 VDH/OLC All licensed nurses who failed to respond to the individual's change in health condition received personnel action and retraining of their roles and the Policy on Acute and Chronic Health Conditions on 6/6/16. Acute and Chronic Health Conditions Policy will be updated to reflect the level of response by each profession as indicated by their scope of practice.	3/10/17

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W 331	Continued From page 26 experiencing coughing, wheezing and runny nose, was assessed by overnight Licence Practical Nurse #1. and assisted with receiving Mucinex D and Delsyum according to OTC (Over , The Counter) physician's orders. About 1 1/2 I hours later there was an increase in cough and wheezing and a decline in her level of alertness. Re-assessed by LPN #1. 02 Sat's (oxygen saturation in blood) were 81% (normal95-100%), administered Oxygen at 2 liters per Minute. (LPM) and 02 Sats increased to 88%. Registered Nurse (RN) Supervisor notified. EMS (Emergency Medical System) called and upon arrival increased 02 to 4 LPM with only and increase to 89%, BP (Blood Pressure) 109/60. Transported to HospitaL" A Multi-Service Progress Note dated 4/30/16 assessed Individual #1's Health needs. Goal: Individual #1 will maintain a baseline level of wellness to reside in a community based-residence and to participate in active treatment/day program. Health Need: Medication Management- Related to: High Blood Pressure, chronic constipation, hypothyroidism, pain management, skin conditions, general health conditions seasonal allergies, dry eye, dementia, minor and acute illness. Objective: Assist Individual #1 with safe and accurate medication administration without adverse effects. And to assist Individual #1 to minimize signs and symptoms of distress with minimal use of medication and explore alternative measures.	W 331	All licensed nurses are to be retrained on their required response for a change in health condition. At the first sign of a change in health condition, individuals will be assessed by a licensed nurse. The nurse performing the assessment will develop and implement an appropriate Nursing Care Plan (NCP) based on observations, Physician's Orders and the baseline of the individual. During non-emergencies the Nursing Care Plan will be reviewed by an RN prior to implementation to review predicted outcomes, evaluation of the interventions and next steps should identified interventions fail. During On-Call hours, LPNs will initiate a call to the RN to alert them to the change of condition and the development of the NCP. RN On-Call has two hours to respond to the communication and provide support to the LPN in identifying predicted outcomes, evaluation of interventions and any necessary next steps should the interventions identified fail. All NCPs will be reviewed during the Nursing Quarterly Assessment and any change in baseline will be incorporated into the individual's IPP.	3/10/17 3/10/17 3/10/17 3/10/17 3/10/17

	Observations: Individual #1 will express			

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W 331	Continued From page 27 discomfort verbally, she may cry or become restless. Her needs must be addressed as soon as possible to develop trust and decrease anxiety. Individual #1 experiences the most pain when she is tired or doesn't want to weightbear. She has seasonal allergies conjunctivitis that becomes bacterial due to her constantly rubbing her eyes. She has chronic crippy eyes from artificial lens (cataract surgery) and seasonal allergies. Current Medications: Aspirin to prevent blood clots, Levoxyl for hypothyroidism, Metoprolol and Zestril for high blood pressure, Pravachol and Lisinopril for High Cholesterol, Ditropean to maintain urinary continence, Seroquel to decrease agitation and to promote rest, Zoloft for depression, Depakote as a mood stabilizer, multivitamin and Calcium as nutritional supplements, Namenda for clarity of thought (dementia) Colace and Miralax to maintain bowel regularity, Refresh eye drops for dry eyes, Voltaren Gel for Osteoarthritis of the knees. Valium as needed for anxiety related to medical procedures. PRN (as needed) medications available: Mabie and Tylenol for osteoarthritis pain, Pepto Bismol for indigestion, Milk of Magnesia and Fleets enema for bowel protocol. Hemorrhoidal cream, Epsom salt soaks for relief of sore feet Mucines-D for cough/congestion, Refresh as needed for dry eyes/irritated eyes. Medication changes: Depakote was discontinued and restarted as Individual #1 needed to maintain her mood. Pain Assessment- chronic osteoarthritis pain.	W 331		

	Receiving daily Voltaren Gel to knees, Inoividual			

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W 331	Continued From page 28 #1 is now limited to weight bearing for toileting and transfers with use of mechanical lift. A Time Line provided by the Nurse Manager gives the following: "4129 (0830) (8:30am) RN #1 assesses Individual #1 for skin integrity-no notation of illness. 4/30- LPN #2 who arrives at (0630) (6:30 am)notes shortly after shift report that Individual #1 has a low grade Temperature (99.2), non-productive cough. lethargic and a runny nose. 4/30 (0800) (8:00am) LPN #2 medicates Individual #1 with PRN Tylenol at (0800). Per routine orders she also receives Claritin 10 mg (milligrams). 4/30- (1400) (2:00pm)- LPN #2 places a call to MD (medical doctor) to report symptoms- MD states "It sounds like viral symptoms; push fluids offer Tylenol every 8 hours for 72 hours and continue to monitor" LPN #2 calls both the On Call Supervisor and RN On Call to report Individual #1's change in health status- this is within minutes of the call to the MD and confirmed on both (facility telephone) Jogs from the On Call supervisors. 4/30- (1500) (3:00 pm)-Indivioual #1 is monitored throughout the day with no change in status, (VS: 97.2, 153-93, 85, 20, 97%) prior to LPN #2's departure she advises staff to monitor Individual temperature and reminds them to medicate Individual #1 with Tylenol at (1600) (4:00pm) Per MAR - (Medication Administration Record) 5/1 [Sometime before (0800) time not indicated on facility phone log] facility staff (Direct Service Professional) DSP #1 notifies RN On Call that Individual #1 was not feeling well and they could	W 331		

	not get her off the toilet, RN log notes directs staff			

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W 331	Continued From page 29 to put her to bed and let her rest. 5/1 (0842) RN On Call receives call from facility's House Manager that he is holding overnight LPN #1 over to perform an assessment on Individual #1. House Manager and RN #1 converse about available PRN's- OTC (over the counter) orders include Mucinex and Robitussin because they are on the OTC page and not on the MARs the medication need to be purchased. Per RN #1 (Same staff as RN On Call) log she doesn't indicate which medication to give because she's not sure of the ingredients. During the (investigation process) it came out the RN #1 told the House Manager to "Pick One" referring to one of the two cough medicines. 5/1 -(0800) Per MAR- and nursing notes LPN #1 indicates he medicated Individual #1 with both cough medicines. During the investigation it comes out that the medication does need to be purchased, it was purchased at (0830) on 5/1/16. and given immediately upon arrival. , There was a previous business practice that medication on the OTC form were not kept in the house and were purchased when needed. This practice has changed, all medications that are on the OTC or Physician's order form are kept in house at all times and part of the Bulk inventory log. 5/1 (0955) RN #1 receives call from facility staff DSP #2 regarding Individual #1's wellness. Per RN log, individual #1 is in bed with head of bed elevated and having difficulty breathing. Also per RN log, she indicates to facility staff she "would be gladly to come assess her when the on call Supervisor notifies her to do so, but no further calls were received." 5/1 (0955) per Supervisor Log - receives call from	W 331		

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W 331	Continued From page 30 facility staff regarding Individual #1 and notifies her that the RN is on the way to perform an assessment. 5/1 (1019) Per RN log she indicates House Manager calls RN to inform that they are calling 911 and individual #1 was being transported to hospital. 5/1 between 10:20 am - 11:00 am - facility staff continue to struggle with Individual #1's presentation, the LPN #1 assessment and treatment provided. During investigation staff noted that the LPN #1 was aware of the oxygen saturation levels dropping below 90 but he had not placed her on Oxygen. Instead House Manager (NON- Clinical Nurse) places her on Oxygen. 5/1 -(1117) per log On Call Supervisor places call to facility to inquire about Individual #1- speaks with LPN #1 who indicates the low oxygen. On Call Supervisor asks why 911 was not called, LPN #1 does not respond. On Call Supervisor speaks with House Manager and they decide to call 911. 5/1- (11:05 am) 911 is called." A Hospital Summary dated 05/01/16 indicated " Chief Complaint- Shortness of breath. Diagnoses Sepsis, due to unspecified organism (HCC). Acute cystitis without hematuria (blood in urine), acute on chronic congestive heart failure, unspecified, congestive heart failure type (HCC), Atrial-fibrillation,unspecified (HCC). ED (emergency department) arrival (5/1/2016, 11:44) callwentouttoEMT(5/1/2016, 11:05). PT (patient) placed on NC (nasal cannula) 6L (Liters)." Hospital nursing notes 5/1/06-1200; Pt has	W 331		

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W 331	Continued From page 31 been having increasing difficulty breathing for the past 2 days. PT has developed wet cough; crackles heard in lower lobes bilaterally. PT arrives on NC 6 Ls by EMS saturations 92%; pt placed on non-rebreather 10ls. History of stroke; left side deficit." Hospital Discharge Summary: indicated: "Admit Date: 5/1/2016- Discharge Date: 5/11/2016, 4:55 PM. According to (staff RN) 2 days prior to admission she has increased shortness of breath and breathing fast and labored, associated with wet cough there was no fever or chills. No significant swelling in the legs. In the ED labs revealed, WBC of 21,000, elevated and BNP 3591, creatinine 1.2 from baseline around 0.9, chest x-ray with possible right middle lobe and right lower lobe infiltrate Hospital Course 1. Sepsis (HCC): Multifactorial, secondary to health care acquired Pneumonia and UTI. Resolved, no fever, no leukocytosis. Blood culture is negative. 2. RML (right middle lobe)?RLL (right lower lobe) Health Care acquired pneumonia: Will continue Levaquin, Robitussin. Blood and sputum culture is negative. 3. Morganella UTI: Continue Levaquin for 3 more days. 4. Acute diastolic CHF (congestive heart failure): Improved, maintains good Oxygenation on RA (room air). Continue Metoprolol, Lisinopril, Lasix, PO (by mouth). 5. Atrial Fibrillation: will continue HR (heart rate) control with Toprol and not a good candidate for anticoagulation secondary to risk for fall. ECHO (echocardigram) showed normal LVEF (left	W 331		

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W 331	Continued From page 32	W 331		

ventricular ejection fracture) at 60%.
6. ARF (acute renal failure) on CKD (chronic kidney disease), stage 3: Resolved and creatinine is back to baseline. Monitor BUN/Creatine. Elevated liver enzymes: Monitor, sip (status post) cholecystectomy. Liver US (ultrasound) showed liver congestion VS (versus) inflammation. Will stop Pravachol and repeat liver function tests in a few weeks. Patient stable for discharge.

During an interview on 1/25/17 at 10:00 A.M. with the Nurse Manager, she was asked why the delay in services for Individual #1. The Nurse Manager stated the RN On Call nurse failed to respond to facility staff repeated calls to come into the facility due to Individual #1's increasingly decline due to breathing issues.

An internal review of an investigation conducted on 5/4/16 by the (QIDP) Qualified Intellectual Disability Professional regarding the events of Individual #1 on 5/1/16 Indicated: "LPN #1 was interviewed on 5/4/16. LPN #1 stated, he worked the over night shift on 4/30/16. He reported that the information he received in report when he came on duty was that Individual #1 was experiencing "viral" symptoms and that she had received an order for Tylenol to be given every 8 hours. He documented on the over nightshift report that the individual slept through the night. Because the individual was coughing and congested, the House Manger requested that he stay until the individual was settled. He was asked by staff to assess Individual #1 around 0800 on 5/1/16.
Staff reported to him that the individual was "off" in her presentation. That morning she was a 2-3 person assist when usually she would assist herself and leaning to one side while she was on

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W 331	Continued From page 33 the toilet Staff requested that he assess her which he did. He reports that he asked staff if she had any PRN's for congestion/cough. The individual had orders for Mucinex and cough syrup as needed but none were in house so staff had to go and purchase them. The OTC (over the counter) medication was purchased by direct care staff at 0829. It arrived in the facility shortly after and was administered by LPN #1 at approximately 0900. THE MEDICATION ADMINISTRATION RECORD (MAR) WAS SIGNED OFF THAT THE MEDICATION WAS GIVEN AT 0800. LPN #1 reports that the assessment he performed on Individual #1 revealed normal temp, 02 sat's and blood pressure but that she was congested and coughing. LPN #1 reported that he went back to administering medications as staffing was short and staff were tending to other individuals for their morning routines. LPN #1 reports that he was asked later to check Individual # around 10311100) sic and that her 02 sat's at that time were in the low to mid 80's on room air and shortly and again shortly afterward with 02 sat's still in the low to mid 80's. He did not recall the exact time but approximately around 1030 he suggests that someone could transport Individual #1 to the ER for evaluation which staff disagreed and called 911. He clocked out after the individual was picked up by EMT. AT no time did he call or contact in any way the On Call RN Supervisor for direction." A Health Care Services Policy updated 3/3/16 indicated: Subject- Acute and Chronic Health Conditions Procedure: To ensure the provision of a comprehensive plan for preventative services and	W 331		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A BUILDING _____ B WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVE RESIDENCE	145 KENTUCKY AVE VIRGINIA BEACH, VA 23452

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W 331	Continued From page 34 prompt treatment of acute and chronic health conditions of each individual. Applicability- All staff and consultants who work with individuals at the facility in any capacity. Purpose: It is the responsibility of all staff at the facility to participate in the provision of a comprehensive prevention plan and provide prompt treatment for acute and chronic health conditions of each individual. the interdisciplinary team (IDT) process is used to assess the needs of each individual and develop a plan to address any identified chronic health conditions and develop preventative measures to maintain the individual's health status. 6. The following guidelines should be used by all staff in determining their response to a change in a resfdent's health status. Medical Emergency Guidelines: Level of response: 911- Difficulty Breathing: Sudden onset with 02 sat's <(less than) 85% noted wheezing stridor and increased anxiety. Based on baseline 02 sat's of 98-100%. Level of response: Call PCP (primary care physician) or Nursing Supervisor-Difficulty Breathing: 02 sat's 90-95%. Increased congestion, wheezing PRN HHH given and pulmovest with slight improvement or temporary improvement. Level of response: Nursing Care Plan/Observation: Difficulty Breathing: 02 Sat's within baseline. Schedule PRN medications for routine assistance for 24 to 48 hours."	W 331		

	The facility staff failed to respond to a change in an Individual's health status			

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W 361	1483.460(i) PHARMACY SERVICES The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to ensure routine medications were available for one Individual (Individual #1) in the survey sample of three individuals The findings include: Individual #1 was admitted to the facility on 3/5/12 with diagnoses which included a history of cardiovascular accident with left sided hemiparesis (weakness), dementia, hypertension hypothyroidism, history of urinary tract infection and dry eyes. Facility staff failed to provide eye drops to Individual #1 for two days due to medications being unavailable. Individual #1 had a physician order for Refresh Liquigel1% one (1) drop in both eyes three times daily for dry eyes. Individual #1 had an order for Refresh eyes drops to be administered 3 times a day at 0300 (8:00am), 1400 (2:00pm), and 1900 (7:00pm). A Multi-Service Progress Note dated (04/30/16) indicated: "Visual Impairment- Related to History of cataracts with implanted lens-developed cloudy artificial lens.	W 361	All staff were retrained on 6/6/16 on to identifying and taking the appropriate actions when medication supply is depleting. Medication Inventory and Storage policy was updated on 8/24/16 to include weekly inventorying of all non-routine medication. All responsible staff were trained on the revisions to the Medication Inventory and Storage Policy. Contracted Pharmacy subcontracted by 12/01/16 with a private courier that operates 365 days a year, 24 hours per day, 7 days per week to ensure medications are always available to residents.	

	Service Objective: To assist Individuat #1 with management of vision needs			

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W 361	Continued From page 36 Observations: Individual #1's vision is Compromised her typicat vision pattern is Remained unchanged, Her lens implants have developed clouding which affects her vision and she has altered depth perception. She has to put things ciose to her face to see them. Individuat #1 has a history of allergic conjunctivitis, her eyes have shown some redness and clear drainage throughout the year and respond to the daily and PRN (As needed) dosing with Refresh eye drops." An incident report dated 6/7/16 indicated: "On 6/6/16 when the AM staff came in to give (0800) dose of medications there were no eye drops left It isn't known if the Nurse on Duty was notified of the lack of medication. There is no evidence that there was any request made recently or on that day for the medication. Individual #1 missed three does of her eye drops. When the Registered Nurse (RN arrived on 6/6/16 t0800) she was notified that there were no eye drops to assist and the RN went and obtained for 6/6/16 medication assist" A review of the Medication Inventory Sheet for April indicated there there were 2 bottles of eye drops received into the facitity on 4/20/16. One bottle should last 15 days. A review of an Abuse Allegation report dated 6/7/161ndicated: "On Saturday June 4, 2016 Individual #1 received all of her scheduled eye drops and the med certified Direct Care Staff (DSP) returned the bottle to the individual's medication drawer. On the morning of Sunday June 5 the day shift med certified DSP could not locate the bottle of eye drops in the medication drawer. The Licensed Practical Nurse (LPN	W 361	All staff will be updated on Pharmacy practices and use of the courier service. Since 12/01/16, weekly inventory forms have been reviewed by the Site Supervisors, ICF Administrator and DS Nurse Manager for completeness and accuracy.	3/10/17

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W 361	Continued From page 37 contacted the pharmacy to order a refill but they would not be deliverec until late Monday or Tuesday. The individual was sent out to the ER emergency room) later in the day and was unable to receive her scheduled eye drops at 1400 and 1900. The individual returned from the ER later that night with new medication orders. Because these orders were sent to the back-up pharmacy, the RN Supervisor picked up the new medications orders. The RN also purchased a new bottle of Refresh eye drops for the individual.The pharmacy ordered bottle of eye drops arrived on Tuesday June 7. During an interview on 1/24/17 at 1:28 P.M. with the Program Director she stated, "Not sure how many doses missing. During an interview with the RN she stated, "We had trouble getting medication in from the pharmacy in past. The meds were not available went to drug store picked up over the counter meds. I think someone threw the meds away not sure why. (There was no evidence or documentation to support this allegation). A Pharmacy Policy indicated: All medications will be delivered within a 24 hour period. The facility staff failed to ensure routine medications were available.	W 361		