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 _____	01/29/2016

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 DATE
W 000	INITIAL COMMENTS The unannounced annual 55 Fundamental Medicaid Certification survey was conducted on 1/27/16 through 1/29/16. 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 7. The survey sample consisted of 4 current individual records (Individual #1 through #4).	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to ensure the clinical record Was accurate for one individual (Individual #1) in the survey sample of 4 individuals. The findings included: Individual #1 was admitted on 4/1/02 with Diagnoses which included seizures, failure to thrive, scoliosis, cerebral palsy and profound intellectual disability. The facility staff failed to ensure the Medication Administration Record (MAR) accurately documented a medication error.	W 111	Facility staff failed to accurately document in the clinical records. All nursing and medication trained staff will be re-trained on the correct procedures for documenting on both the Controlled Count Record and the Medication Administration Record. All other individuals' Inventory, Medication Administration and Controlled Count records will be reviewed by the Registered Nurse to ensure accurate reconciliation and administration has occurred. Controlled Count Policy and associated recordkeeping form will be updated to include a specific documentation area for shift count	3/14/16 3/14/16 3/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPUER REPRESENTATIVES' SIGNATURE	TITLE	(X6) DATE
Tim Capaldo	DS Director	2/22/16

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W 111	Continued From page 1 A review of signed physician's orders for individual #1 indicated: "Vimpat 200 milligrams (mg) tab (tablet) crush and dissolve in (H2O) Water and give 1 tab via G-tube (gastrostomy tube-tube inserted into abdomen) twice daily for seizures (0800 am / 1900 pm)." A review of an Incident Report dated 10/20/15 indicated: "Upon look behind (medication check off) Licence Practical Nurse #1 (LPN) discovered that there was only one Vimpat (Medication used to treat seizures) missing from the bingo card for the 19th, when 2 should have been missing. It appeared that Individual #1had missed his 1900 dose, but it was unclear as both 0800 am and 1900 pm does on the MAR were signed as given. LPN#1 spoke to (LPN #2 an agency nurse) who had signed for the PM dose. LPN #2 stated that she thought Registered Nurse (RN Supervisor) had given the med at 3 pm which was the time noted on the narcotic count sheet: LPN #2 said she did want to double dose (Individual # 1) by giving the medication too close together so she did not give it. LPN 31 told LPN #2 there was only one pill missing from the card, which was the 8 am dose given by RN Supervisor. At 6 am on 10/20 LPN #1 called on call RN #2, to inform her that Individual #1 missed his 1900 dose on Vimpat. LPN #1 notified the physician and that Individual #1 had no adverse effect." A review of the MAR for the month of October Indicated a staff signature at the 19th date for the 1900 time slot. A review of the back of the MAR which included Nurses Medication notes and instructions for errors there were no notes indicating Individual #1 had missed a dose of	W 111	Continued: and an area for time of administration per shift. All nursing and medication trained staff will be re-trained on appropriate documentation on the Medication Administration Record for recording any deviation in treatments ordered by a prescriber. During weekly audits, nursing staff will include a verification of both the MAR for accurate documentation of any events that deviate from the intended plan of care as well as the Controlled Count Record to ensure medications and treatments are being administered per the prescriber's orders.	3/14/16 3/14/16

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W 111 Continued From page 2
Vimpat at the 1900 hour on 10/19/15.

During an interview on 1/28/16 at 10:30 am with the RN Supervisor she stated, "LPN #2 was an agency nurse and she reviewed the Narcotic count sheet." When asked why LPN #2 would sign off for a medication that was not given, the RN stated she did not know. When asked by staff would not document that a medication error had occurred on the Medication Administration Record, the RN stated all staff are trained to document on the MAR that an error occurred on the MAR.

The facility staff failed to accurately document in the clinical records.

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on record review and staff interviews, the facility staff failed to ensure continuing training for all staff.

The findings included:

Individual #1 was admitted on 4/1/02 with diagnosis which included seizures, failure to thrive, scoliosis, cerebral palsy and profound intellectual disability. The facility staff failed to provide ongoing training for all employees after identifying issues with medication administration and look-behind procedures.

W 189 Facility staff failed to ensure continuing training for all staff. Supervisor interviewed answered "yes" to the interviewer when asked if all staff are responsible to re-order medication; this is not accurate. City of Virginia Beach Developmental Services policy only allows Medication aides to request refills of pre-existing medications. New or revised medications orders or refills that do not meet all five rights of medication administration must be reviewed by a nurse before the medication can be administered. Bulk medications inventoried weekly will be marked with an anticipated re-order date and/or triggers for re-ordering i.e. when there are only ten pills remaining, when there is half a bottle remaining etc. These triggers

3/14/16

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W 189	Continued From page 3 A signed physician's order indicated: "Phenytoin (an anticonvulsant) 50 milligram (mg) take one tab (tablet) in the morning 0600 (6 am) and 2 tabs in the evening at 1900 (7 pm) on odd days and take 2 tabs 2 times daily at 0600 and 1900 on even days; crush and mix in H2O (water); for seizures give via G-tube (gastrostomy tube- tube into abdomen). A incident report dated 12/18/15 indicated: "Individual #1 received 1 pill of a 2 pill does of phenytoin on 12/18/15 during AM med administration. The bubble pack indicates on extra pill of phenytoin was removed on 12/13/15. Meds were not reordered in time to have enough of a supply for 12/18/15 administration." A review of a Plan of Correction dated 12/18/15 indicated: Two staff members will receive counseling statements identifying issues with medication administration and look-behind procedures, as well as communication. Medication reorder protocol to be made specific, specific time interval for ordering mediation will be noted on the packing, communication log." During an interview on 1/28/16 at 11:00 AM with the ICF Supervisor II she stated, "Initially since it was two staff members involved, we decided to counsel just the two." When asked if all staff are responsible for reordering medication, the Supervisor II stated, "Yes". The facility staff failed to train all employees on the process and procedures to reorder medications.	W 189	CONTINUED: will be set based on historical use of the medication and delivery method of the medication. Anticipated re-order dates or triggers will be clearly visible to all staff administering the medication and/or completing the inventory. For individuals that have medications that are ordered on an as needed basis all relevant medication orders will be reviewed and medication packages marked with an anticipated re-order date as noted above. All staff will be trained on the re-ordering dates and/or triggers. Medication Inventory policy will be updated to include identifying the anticipated re-order date and/or trigger for all bulk medications. All staff will be trained on the follow up procedure for ordering needed medications or supplies. Procedures to include that the item in question will be reported out each shift and will be addressed each shift by the Nurse on duty or by the shift leader and the Registered Nurse on call if necessary. If there will be a deviation from the plan of care, the ordering physician must be notified to amend or clarify the plan of care accordingly. In the event the ordering physician is not responsive, the ICF Medical Director will be contacted for clarification.	3/14/16 3/14/16

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	W 189 CONTINUED:			
	During the weekly nursing audits, nursing staff will review all anticipated re-order dates to ensure there is still a plentiful supply. Registered Nurse will review and verify the contents of the audits weekly to ensure documentation, follow up and supply are following the standards of care.			3/14/16

Tim CAPoldo — DS Director/Administrator — 2/19/16

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