STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G033	A. BUILDING _____ B. WING _____	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW RESIDENCE	1206 RED TOP ORCHARD ROAD WAYNESBORO, VA 22980

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/13/18 through 3/14/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 03/13/18 through 03/14/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 6 certified bed facility was 6 at the time of the survey. The survey sample consisted of 3 Individual reviews (Individuals one and two, and three).	W 000		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review the facility failed to ensure the Individual Program Plan (IPP) was reviewed and revised for one of 3 Individuals in the survey sample, Client #3.	W 255		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Loretta Myers ICF/IID Services Manager 3/20/18

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.

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W 255	Continued From page 1 The facility did not revise the IPP in regards Client #3 not using a wide handled spoon to eat. The findings include: Client #3 was admitted to the facility on 12/6/2004 with an intellectual development of profound and a medical diagnoses of cerebral palsy and epilepsy. On 3/13/17 at 2:30 p.m. a Client interview was conducted with a Direct Service Person (DSP #1). During the interview DSP #1 verbalized that Client #3 relied on the staff for feeding and other activities of daily living (ADL's). When asked how long has Client #3 relied on the staff for eating. DSP #1 verbalized that Client #1 has relied on staff to feed as long as she (DSP #1) has been employed. On 3/14/18 at 9:00 a.m. Client #1 was observed at the dining room table being fed by staff. Client #3 did not attempt to hold on to cups or any utensils and staff did not encourage Client to assist in feeding self. Review of Client #3's record (IPP, dated 2/26/18) documented that Client #3 used an "Adaptive spoon with wide handle." On 3/14/18 at 11:30 a.m. the service support manager (Administrative Staff #1, AS #1) was interviewed concerning the above finding. AS #1 was asked, how would an employee know how to care for a Client in regards to adaptive equipment used. AS #1 verbalized that adaptive equipment information is documented on the Client's Physical Management form (IPP) and this form gives employees a information on how to care for	W 255	W 255 The Occupational Therapist has completed an evaluation to determine if the wide spoon is needed to meet the individual's needs. The report has not been made available to the ICF/IID at this time. Once the determination is made as to the need for the spoon, the order will be rescinded or be enforced depending on the determination. At least annually, at the IPP meeting, all adaptive equipment will be reviewed to determine if the need continues to exist. In the event a change occurs prior to the IPP meeting, the equipment need will be reevaluated by the Occupation Therapist, Physical Therapist and/or Speech Therapist.	4/16/18

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W 255	Continued From page 2 a Client. This surveyor asked AS #1 to review Client #3's IPP in regards to the adaptive spoon. After reviewing the form, AS #1 verbalized that Client #3 has not used an adaptive spoon in years. AS #1 verbalized that she (AS #1) thought several years ago the staff had tried to use an adaptive spoon and also hand over hand technique with Client #3, but these attempts did not work. AS #1 verbalized that the IPP along with the physician's orders for an adaptive spoon, should have been removed a long time ago. On 3/14/18 at 1:45 p.m. the QIIDP (Qualified Individuals with Intellectual Disabilities Professional) was informed of the above finding. The QIIDP verbalized understanding. No other information was provided prior to exit conference on 3/14/18.	W 255		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to follow physician orders for one of 3 Individuals in the survey sample, Client #2. The facility did not collect a Hemoglobin A1C (a test used to monitor an average of glucose levels for a period of time) and CMP (a panel of labs	W 322		

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W 322	Continued From page 3 used to test the metabolic levels) every 3 months as ordered. The findings include: Client #2 was admitted to the facility on 6/28/2004 with an intellectual development of moderate and a medical diagnoses of diabetes and chronic kidney disease. Review of Client #2's medical record via Physician order Set (POS) dated 2/1/18 documented "Hemoglobin A1C, and CMP Every Three Months." This order did not have an origination date, so other POS's were reviewed for the past year (since 1/1/17) and also had the same order for the lab collection in question. Review of the labs collected evidenced that the A1C and the CMP were collected on 1/12/17, 5/10/17 (a 4 month period), 8/2/17 (a three month period), and 12/3/17 (a 4 month period). On 3/14/18 at 9:00 a.m. registered nurse (RN #1) was interviewed regarding lab collections that were not being done as ordered. RN #1 verbalized that she did not know when Client #2's lab orders originated, but verbalized they had been in place for a long time. RN #1 was asked to review the orders for the labs and reconcile them against the actual collection date. After reviewing the order and the collection dates, RN #1 verbalized that she did not know why the labs were not collected every three months as ordered. RN #1 did verbalize that Client #2 has several physician's and that it was hard to correlate what each physician was ordering as far as lab testing. RN #1 also	W 322	W322 A chart has been developed, tracking labs that have been ordered by all medical providers. Lab slips documenting the physician's orders will be submitted to the pharmacy, which the pharmacist will add to the quarterly Physician's Orders. The Medical Director will review these orders and determine if any changes are needed and write orders discontinuing the labs, if needed.	3/28/18

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W 322	Continued From page 4 verbalized that she (RN #1) kept a notebook so that she could monitor when lab tests were due. RN #1 verbalized that the past years notebook was not in her possession at the time of the survey and did not know if there was a reason for not doing the labs as ordered. On 3/14/18 at 1:45 p.m. the QIIDP (Qualified Individuals with Intellectual Disabilities Professional) was informed of the above finding. No other information was provided prior to exit conference on 3/14/18.	W 322		