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
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		

An unannounced Medicaid re-certification survey was conducted on 4/11/17 through 4/13/17. The facility was not in compliance with the following Federal ICF/ID regulations. The Life Safety Code will follow.

The census in this 223 certified bed facility was 75 individuals at the time of survey. The survey sample consisted of 11 current individual reviews (Individuals #1 through #11).

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 staff interview and client oriented record (COR), the facility staff failed to ensure 1 of 11 individuals (Individual #6) was accurate.

The findings included:

The client oriented record for Individual #6 had a physician order dated 10/28/13 for a t-shirt pad to right clavicle to protect from pressure from hand. The order of the wording of the physician order was not corrected from 10/28/13 through 4/12/17.

Individual #6 was admitted to the facility on 5/3/1976 with diagnoses of profound mental retardation, gastroesophageal reflux disease, Parkinson's disease, Vitamin D deficiency, disruptive behavior, and allergic conjunctivitis.

W 111 Client Records
1. Physician to discontinue order dated 10/28/13 for t-shirt pad to right clavicle of client #6 to protect from hand pressure; it is no longer needed due to lack of reported incidents. 5-26-17
2. Qualified Intelectual Disability Professional (QIDP) to review record of all individuals receiving treatment for medical problems and identify and notify nurse of clients a) receiving treatment that is no longer needed, and b) receiving treatment that is needed but not currently listed on treatment or plan implementation sheets. On receiving notification the nurse will remove items no longer needed from list, and establish treatment and implementation sheets for items needed. 5-26-17
3. RN to review medical summaries every 30 days to determine if current treatment for medical problems continues to be needed. The RN reviewer will request discontinuation or relist as indicated. MD/DNP to re-evaluate new orders within 2-6 weeks after entry, and document

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Facility Director, SWVTC — (X6) DATE: 5/5/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111 Continued From page 1

The clinical record of Individual #6 was reviewed 4/12/17 and 4/13/17. The signed physician order from 3/21/17 through 4/18/17 contained an order that read "10/28/13 T-Shirt pad to right clavicle to protect from pressure from hand."

The surveyor interviewed medication technician #1 and direct service provider #1 on 4/12/17 at 8:30 a.m. about the "T shift pad" for Individual #6. Both the medication technician #1 and DSP #1 checked Individual #6 for the pad and were unable to find the pad.

The surveyor interviewed the activity instructor on 4/12/17 at 11:08 a.m. about the t-shirt pad. The activity instructor wasn't sure what the t-shirt pad was either and stated she would check with the physical therapist.

The surveyor met the activity instructor during Individual #6's outing to a local park on 4/12/17 at 1:55 p.m. The activity instructor stated part of Individual #6's ISP (Individual Support Plan) for the period 9/12/2016 through 9/30/17 was the use of a Tee shirt to be worn to protect the right shoulder from the hand pressure. The activity instructor stated the wording on the physician order was out of sequence. The activity instructor provided the surveyor with a corrected physician order dated 4/12/17 that read to discontinue (D/C) order M16. T-shirt pad to right clavicle @ (at) this time 2° (secondary) no reported incidents. Clarification-Wedge to bend of right upper extremity (UE) to ? (decrease) tone pattern and right clavicle /AC (antecubital) against pressure."

The activity instructor stated the order should have been updated.

W 111 (cont.)

discontinuation or extension in progress notes. 5-26-17

4. The Quality Assurance/Risk Manager (QA/RM) will schedule audits to verify new orders are reviewed, discontinued, or extended with corresponding documentation in progress notes. The QIDP will check CORs to verify new orders have corresponding treatment and implementation sheets filed and consistently used to document treatment administration. The QIDP will note in the next quarterly QIDP summary the date the new order was entered, the treatment and implementation sheets were checked, in place, and treatment administration as required by the Physician was consistently documented. The Senior QIDP will check quarterly QIDP summaries to verify checks for new orders were completed and documented. 5-26-17

W159 QIDP

1. The QIDP will coordinate with the Interdisciplinary Team (IDT) to develop an active treatment program for client #11 that specifies the rationale, location, schedule, and methods for use of geri chair lap top table for activities. Physical Therapist to evaluate client #11 for ways to reduce and eliminate reliance on the lap top table such as obtaining shoes and developing an ambulation plan. 5-26-17

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W 159	Continued From page 2 483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility QIDP failed to develop an active treatment program for 2 of 11 Individuals in the survey sample (Individual #11 and #6). The findings include: 1. The QIDP failed to develop an active treatment program for Individual (Ind) #11 for the use of a geri chair lap top table for activities. Ind #11 was admitted to facility on 9/30/86 with diagnoses of spastic cerebral palsy, profound intellectual disability, epilepsy, autism, bipolar disease, and obsessive -compulsive disorder. Ind #11 was observed on 4/11/17 at 4:40 p.m. sitting in the dayroom of the cottage where he resides. Ind #11 was sitting in a geri chair with a locked table top attached to the geri chair. The direct care staff stated the table top was there because the Individual falls and the Ind. was to be kept in line of sight by staff. Ind #11 was walked to dining room for dinner by 2 staff and also walked to the bathroom by 2 staff with use of a gait belt. While in the geri chair , the staff sat near the Ind. and supplied him with "toys" consisting of balls, plastic toys and an Ipad so he could punch the buttons and listen to music. Ind #11 was observed on 4/12/17 at 7:15 a.m. sitting in the geri chair listening to music on his	W 159 W 159	(continued) 2. MD/DNP to review all individuals for acute changes in medical condition requiring protective measures and identify those who need an active treatment program. The QIDP will coordinate with the IDT to ensure a plan is developed and implemented as needed for the individuals identified.5-26-17 3. Each individual who experiences a change in medical status that requires a change in treatment will be assessed by the MD/DNP and IDT. The QIDP will coordinate the development and implementation of a plan to continue active treatment and facilitate recovery. 5-26-17 4. The QA/RM will monitor event reports to identify individuals experiencing a change in medical status, and follow up to assure the IDT has developed and implemented a plan. 5-26-17 Part A - Failed to ensure fleet enema for client #6 after 3 days of no BM 1) The Bowel Movement (BM) Chart for client #6 will be checked daily by DSPs to ensure BM status is recorded. If "no BM" is recorded for two consecutive days the DSP will notify the nurse and an ID note entered documenting notification. The nurse will ensure a fleet enema is provided before the end of the third day of no BM, and this	

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W 159 Continued From page 3

Ipad with staff near . The Ind asked to sit in his wheel chair and was ambulated by 1 staff member to sit in the wheel chair. The active treatment service staff member stated the table top was to be used for activities because the Ind. kept his Ipad in his lap and it would slide to the floor and he would lean over to pick it up and fall resulting in injury. The active treatment service staff member stated he was not to stay in the chair all the time and was to ambulate with assistance. The active treatment service staff member stated the Ind had been very sick in December and became weak and sitting in the geri chair helped him to not fall. The Ind was also seen by physical therapy weekly for strengthening.

The QIDP was ill and unavailable for interview at this time.

The Individual Support Plan for Ind #11 was reviewed. There was no active treatment plan for the use of the geri chair table top. The active treatment coordinator came in and reviewed the support plan and agreed there was no plan developed. The active treatment coordinator stated he knew the table top was discussed in discharge plan meetings, but failed to include it in the plan.

The physician was interviewed on 4/12/17 at 2:00 p.m. and stated he was aware of the table top use and a written order was obtained on 12/27 /16 for "Lap tray to geri chair for table top activities". The physician stated he expected and discussed with staff that the Ind. was to be ambulated often to regain his strength and was not to be just kept in the chair all the time. He stated this was temporary and planned to

W 159 (cont.)

action will be documented on the PRN medication record and in the ID notes. The results will be documented on the BM Chart and in the ID notes. If no BM results the MD/DNP will be contacted, instructions provided, and treatments administered and documented, until results are obtained and documented. 5-26-17

2) The BM Chart for each individual will be checked daily by Direct Support Professionals (DSP) to ensure BM status is recorded. If "no BM" is recorded for two consecutive days (or for one day if order specified "every other day") the DSP will notify the nurse and enter an ID note to document notification. The nurse will ensure constipation treatment is provided before the end of the third day (or second day if order specifies "every other day") of no BM, and this action will be documented on the PRN medication record and in the ID notes. If no constipation treatment is ordered before the end of the third day, the nurse will contact the MD/DNP for treatment recommendations. The results will be documented on the BM Chart and in the ID notes. If no BM results, the MD/DNP will be contacted, instructions provided, and treatment administered and documented, until results are obtained and documented. 5-26-17

3) Whenever nurse is notified of need for constipation treatment based on physician's orders, the nurse will administer the treatment and ensure the results of the treatment are written

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W 159 Continued From page 4

discontinue the use of the geri chair and table top as the Ind. regained his strength.
2. The QIDP (qualified intellectual delayed professional) failed to integrate and co-ordinate care for Individual #6 by failing to ensure a fleet enema was administered per the physician order when the individual did not have a bowel movement for 3 days. Individual #6 did not have a bowel movement for 4 days. He was not administered a scheduled fleet enema (for constipation) per physician orders. The QIDP also failed to ensure physician ordered laboratory tests had been obtained. The QIDP also failed to ensure the client oriented record was accurate for a current treatment for Individual #6.

Individual #6 was admitted to the facility on 5/3/1976 with diagnoses of profound mental retardation, gastroesophageal reflux disease, Parkinson's disease, Vitamin D deficiency, disruptive behavior, and allergic conjunctivitis.

(a) The clinical record was reviewed and contained a current physician order signed 3/21/17 to administer a phosphate enema (fleet enema) for no BM (bowel movement) x 3 days (order date 07/11/11).

The January 2017, February 2017, and March 2017 bowel movement chart was reviewed. The January 2017 bowel movement chart documented Individual #6 did not have a bowel movement on any shift on 1/2/17 through 1/5/17 and on the 1st shift on 1/6/17, 1/8/17 through 1/11/17 and on the first shift on 1/12/17, 1/20/17 through 1/23/17 and on the first shift on 1/24/17, and 3/5/17 through 3/8/17 and on the first shift on 3/9/17. For the days Individual #6 had no bowel movement, a "0" was documented for every shift

W 159 (cont.)
in the ID notes and on the PRN record. Nurses are to be reminded that it is not acceptable to leave blanks on enema entries on the PRN record. Health Services Instruction #84-Enemas will be revised to reflect under Key points #6. The nurse will always chart the results of any constipation treatment in the ID Notes and on the PRN record. SWVTC Instruction 414, General Care Guidelines, will be revised to clarify requirements for monitoring, notification, treatment, and documentation of BMs. All nurses and DSPs will be retrained in documenting, detecting, and responding to BM patterns and the rationale and need for prompt treatment as prescribed. 5-26-17
4) QA/RM will develop and implement an audit system to assure the protocol outlined in A1-A3 is followed. The audit process will consist of randomly sampling individuals, checking BM charts for actual BM frequency, and audits of ID notes and PRN medication records to verify the documentation of notifications, treatments, and results. 5-26-17
Part B.1 - Failed to obtain lab test (no results in COR for urinalysis order 10/17/16)
1) This order for client #6 was referred to the Physician on 4/14/2017 and the order was discontinued as it was no longer indicated.
2) By 5-26-17 Medical Summaries for all individuals will be reviewed by the

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W 159 Continued From page 5

indicating no bowel movement. According to the bowel record, Individual #6 did not have a bowel movement for 4 days. The physician order read to administer a fleet enema if no BM for 3 days. A review of the January 2017 prn (whenever needed) medication sheet had an entry that read "Phosphate enema (fleet enema) 07/11/11 Use as directed if needed for no BM x 3 days 8a.m." All boxes on the January 2017 prn medication form were blank in the entry about the enemas. There was no documentation on the March 2017 prn medication record that Individual #6 had received a fleet enema on 3/8/17.

The Individual Support Program (ISP) for 9/12/2016 -9/30/2017 was reviewed. The ISP noted under Health and Safety that the plan included fleet enema as directed if needed for no bowel movement every three days.

The surveyor interviewed the Service Coordinator #1 on 4/12/17 at 8:50 a.m. The Service coordinator stated the direct service providers were to notify the nurses when an individual had no bowel movements for three days. The nurses then document their findings in the interdisciplinary notes as well as in the nurses' data base. A review of the data base for 1/5/17, 1/11/17, 1/23/17 and 3/8/17 had no documentation that Individual #6 had received the physician ordered fleet enemas.

The service coordinator also stated the living unit had different staff the last several months that were not familiar with Individual #6 needs. The service coordinator stated "I take full responsibility for this."

(b) The surveyor reviewed the client oriented

W 159 (cont.)

primary RN to ensure all one-time lab orders have been obtained and completed. If more than 2-3 weeks have passed since the order was written and the specimen has not been obtained, the nurse will contact the MD/DNP for recommendations. 5-26-17

3) The nurse will note laboratory orders. For laboratory specimens that will be collected by direct support staff, the nurse will complete the lab requisition, keep it in the nursing office until the speciment is obtained, and place the order as well as any needed reminders to staff on the Medication Administration Record (MAR). The nurse will place a note to the communi-cation book on the unit, leave any needed specimen collection containers on the unit, and verbally remind staff that a specimen is needed. Once the specimen is obtained, it will be processed as outlined in Health Services Instruction #101. If the specimen has not been obtained one week after the order was written and noted, the nurse will remind staff again and ensure the needed specimen containers are on the unit. Nurse will continue to remind staff weekly for 2-3 weeks in order to obtain the specimen. All reminders will be documented in the MAR. At the end of this time period, if the specimen has not been obtained, the nurse will notify the MD/DNP of the outstanding order and MD/DNP notified will re-evaluate the need for the specimen and write

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W 159 Continued From page 6

record (COR) 4/12/17 and 4/13/17. The COR revealed a signed physician order dated 10/17/16. The signed physician orders included an order to obtain a CBC (complete blood count), UA (urinalysis) and a CMP (comprehensive metabolic panel) as well as an interdisciplinary note dated 10/17/16 that read "APE (annual physical examination) computed. No new medical problems identified. No cough, hemoptysis, fever, wt (weight) loss, pm (evening) sweats, or known TB (tuberculosis) exposures. Needs screening CBC, UA, CMP, hemoccult. Needs Prevnar 13 per CDC (center for disease control) recs (recommendations)."

The surveyor reviewed the laboratory section of the COR and found results of the CBC and CMP 10/25/16. The surveyor was unable to locate the results of the urinalysis ordered 10/17/16.

The surveyor informed the active treatment professional #1 on 4/13/17 at 7:18 a.m. of the inability to locate the results of the urinalysis. The active treatment specialist #1 stated when medical records opened at 8:00 a.m., the thinned record could be checked.

The active treatment specialist #1 stated there were no results for a urinalysis in October 2016. The surveyor then interviewed registered nurse #1 on 4/13/17 at 8:20 a.m. R.N. #1 stated that the staff had a difficult time obtaining a urinalysis on Individual #6 because of the contractures. The surveyor asked if the physician had been informed that the urinalysis had not been obtained. R.N. #1 stated that the physician would be informed today that the urinalysis ordered in October 2016 had not been obtained. R.N. #1 stated the order was still current; however, the

W 159 (cont.)

orders regarding the specimen collection. These procedures will be established and implemented by 5-26-17

4) The QIDP will schedule audits to verify that labs have been completed as ordered and the results are appropriately filed in the Client Oriented Record (COR). If labs are not in place when audited, the QIDP will verify that the MD/DNP has been notified and has re-evaluated the need for the lab, and that written recommendations by the MD/DNP regarding the specimen collection are in the COR. 5-26-17

5) The Chief Nursing Executive (CNE) will in-service the nursing staff and the Program Managers will in-service the QIDPs on the steps outlined in steps 2-4 above. 5-26-17

Part B.2 - Failed to ensure COR accurate for treatment (blank boxes on PRN Form for enemas).

1) The BM Chart for client #6 will be checked daily by DSPs to ensure BM status is recorded. If "no BM" is recorded for two consecutive days, the DSP will notify the nurse and enter an ID note documenting notification. The nurse will ensure a fleet enema is provided before the end of the third day of no BM, and this action will be documented on the PRN medication record and in the ID notes. The results will be documented on the BM Chart and in the ID notes. If no BM results the MD/DNP will be contacted, instructions

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W 159 Continued From page 7

signed physician orders in the COR dated 3/21/17 through 4/18/17 had no current orders for a urinalysis.

(c) The client oriented record for Individual #6 had a physician order dated 10/28/13 for a t-shirt pad to right clavicle to protect from pressure from hand. The order of the wording of the physician order was not corrected from 10/28/13 through 4/12/17.

The clinical record of Individual #6 was reviewed 4/12/17 and 4/13/17. The signed physician order from 3/21/17 through 4/18/17 contained an order that read "10/28/13 T-Shirt pad to right clavicle to protect from pressure from hand."

The surveyor interviewed medication technician #1 and direct service provider #1 on 4/12/17 at 8:30 a.m. about the "T shift pad" for Individual #6. Both the medication technician #1 and DSP #1 checked Individual #6 for the pad and were unable to find the pad.

The surveyor interviewed the activity instructor on 4/12/17 at 11:08 a.m. about the t-shirt pad. The activity instructor wasn't sure what the t-shirt pad was either and stated she would check with the physical therapist.
The surveyor met the activity instructor during Individual #6's outing to a local park on 4/12/17 at 1:55 p.m. The activity instructor stated part of Individual #6's ISP (Individual Support Plan) for the period 9/12/2016 through 9/30/17 was the use of a Tee shirt to be worn to protect the right shoulder from the hand pressure. The activity instructor stated the wording on the physician order was out of sequence. The activity instructor provided the surveyor with a corrected physician

W 159 (continued)
provided, and treatments administered and documented, until results are obtained and documented. 5-26-17
2) The BM Chart for each individual will be checked daily by DSPs to ensure BM status is recorded. If "no BM" is recorded for two consecutive days (or for one day if order specifies "every other day") the DSP will notify the nurse and enter an ID note documenting notification. The nurse will ensure constipation treatment is provided before the end of the third day (or second day if order specifies "every other day") of no BM, and this action will be documented on the PRN medication record and in the ID notes, if no constipation treatment is ordered before the end of the third day, the nurse will contact the MD/DNP for treatment recommendations. The results will be documented on the BM Chart and in the ID notes. If no BM results the MD/DNP will be contacted, instructions provided, and treatments administered and documented, until results are obtained and documented. 5-26-17
3) Whenever nurse is notified of need for an enema based on physician's orders she/he will administer enema and ensure results are both written in ID notes and on the PRN record. Nurses are to be reminded that it is not acceptable to leave blanks on enema entries on the PRN record. Health Services Instruction #84-Enemas

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W 159 Continued From page 8

order dated 4/12/17 that read to discontinue (D/C) order M16. T-shirt pad to right clavicle @ (at) this time 2° (secondary) no reported incidents. Clarification-Wedge to bend of right upper extremity (UE) to ? (decrease) tone pattern and right clavicle /AC (antecubital) against pressure."

The activity instructor stated the order should have been updated.

In an interview with service coordinator #1on 4/12/17 at 8:50 a.m., SC #1 stated she was responsible for all aspects of Indiviudal #6's care.

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated 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 observation, staff interview, and clinical record review, the facility QIDP failed to develop an active treatment program for 1 of 11 Individuals in the survey sample (Individual #11).

The findings include:

1. The QIDP failed to develop an active treatment program for Individual (Ind) #11 for the use of a geri chair lap top table for activities.

W 159 (cont.)
will be revised to reflect under Key points #6 to always chart results of any of these procedures (enemas) in both the ID Notes and on the PRN record. SWVTC Instruction 414 will be revised to clarify requirements for monitoring, notification, treatment, and documentation of BMs. All nurses and DSPs will be retrained in documenting, detecting, and responding to BM patterns and the rationale and need for prompt treatment as prescribed. 5-26-17
4) QA/RM to develop and implement an audit system to assure the protocol outlined in 1-3 is followed. The audit process will consist of randomly sampling individuals, checking BM charts for actual BM frequency, and audits of ID notes and PRN medication records to verify documentation of notifications, treatments, and results. 5-26-17
Part C - Failed to correct order for t-shirt pad
1) Physician to discontinue order dated 10/28/13 for t-shirt pad to right clavicle of client #6 to protect from hand pressure; it is no longer needed due to lack of reported incidents.
2) QIDP to coordinate with IDT to review CORs of all individuals receiving treatment for medical problems and identify and notify nurse of clients: a) receiving treatment that is no longer needed, and b) receiving treatment that is needed but not currently listed on treatment or plan implementation sheets. On receiving notification the nurse will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

W 249 Continued From page 9

Ind #11 was admitted to facility on 9/30/86 with diagnoses of spastic cerebral palsy, profound intellectual disability, epilepsy, autism, bipolar disease, and obsessive -compulsive disorder.

Ind #11 was observed on 4/11/17 at 4:40 p.m. sitting in the dayroom of the cottage where he resides. Ind #11 was sitting in a geri chair with a locked table top attached to the geri chair. The direct care staff stated the table top was there because the Individual falls and the Ind. was to be kept in line of sight by staff. Ind #11 was walked to dining room for dinner by 2 staff and also walked to the bathroom by 2 staff with use of a gait belt. While in the geri chair , the staff sat near the Ind. and supplied him with "toys" consisting of balls, plastic toys and an Ipad so he could punch the buttons and listen to music.

Ind #11 was observed on 4/12/17 at 7:15 a.m. sitting in the geri chair listening to music on his Ipad with staff near . The Ind asked to sit in his wheel chair and was ambulated by 1 staff member to sit in the wheel chair. The active treatment service staff member stated the table top was to be used for activities because the Ind. kept his Ipad in his lap and it would slide to the floor and he would lean over to pick it up and fall resulting in injury. The active treatment service staff member stated he was not to stay in the chair all the time and was to ambulate with assistance. The active treatment service staff member stated the Ind had been very sick in December and became weak and sitting in the geri chair helped him to not fall. The Ind was also seen by physical therapy weekly for strengthening.

The QIDP was ill and unavailable for interview at

W159 (cont.)
remove items no longer needed from list and establish treatment and implementation sheets for items needed. 5-26-17
3) RN to review medical summaries every 30 days to determine if current treatment for medical problems continues to be needed, and request discontinuation or relist as indicated. MD/DNP to re-evaluate new orders within 2-6 weeks after entry, and document discontinuation or extension in progress notes. 5-26-17
4) The QIDP will check CORs to verify new orders have corresponding treatment and implementation sheets filed and consistently used to document treatment administration. The QIDP will note in the next quarterly QIDP summary the date the new order was entered and treatment and implementation sheets were checked, in place, and consistenly document treatment administation as required by the MD/DNP. The Senior QIDP will review quarterly QIDP summaries to verify checks for new orders were completed and documented. 5-26-17

W249 Program Implementation
1. QIDP to coordinate with IDT to develop an active treatment program for client #11 that specifies the rationale, location, schedule, and methods for use of geri chair laptop table for activities. Physical Therapist to evaluate client #11 for ways to reduce and eliminate reliance on the lap top table, obtain shoes, and develop

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

W 249 Continued From page 10
this time.

The Individual Support Plan for Ind #11 was reviewed. There was no active treatment plan for the use of the geri chair table top. The active treatment coordinator came in and reviewed the support plan and agreed there was no plan developed. The active treatment coordinator stated he knew the table top was discussed in discharge plan meetings, but failed to include it in the plan.

The physician was interviewed on 4/12/17 at 2:00 p.m. and stated he was aware of the table top use and a written order was obtained on 12/27 /16 for "Lap tray to geri chair for table top activities". The physician stated he expected and discussed with staff that the Ind. was to be ambulated often to regain his strength and was not to be just kept in the chair all the time. He stated this was temporary and planned to discontinue the use of the geri chair and table top as the Ind. regained his strength.

W 325 483.460(a)(3)(iii) PHYSICIAN SERVICES

The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to obtain a laboratory test as ordered by the physician for 1 of 11 Individuals in the sample survey, Individual #6.

W 249 (cont.)
an ambulation plan. Plans will be approved by the ID Team and documented in the IPP. The QIDP will assign responsibility and ensure all responsible persons are trained to implement the active treatment program for client #11. Training will be documented on the training log, which will be forwarded to the Staff Development Department.
The QIDP will observe client #11 during times scheduled for implementation of table top activities and ambulation plans, interview caregivers to ensure correct understanding of the plan rationale, and verify consistent plan delivery. 5-26-17
2) The MD/DNP will review all individuals for acute changes in medical condition requiring protective measures such as specialized equipment, identify those who need an active treatment program, and ensure the QIDP is notified. The QIDP will coordinate with IDT to develop and implement plans as described in step 1 above.
3) QIDPs will coordinate with the IDT to develop an active treatment program for all individuals experiencing acute changes in medical condition requiring protective measures as identified by the MD/DNP. Each plan will specify the rationale, loction, schedule, and methods for implementation, and the QIDP will ensure each responsible person is trained in plan implementation. 5-26-1
4) The QIDP will observe each individual identified during times scheduled for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

W 325 Continued From page 11
The findings included:

Individual #6 was admitted to the facility on 5/3/1976 with diagnoses of profound mental retardation, gastroesophageal reflux disease, Parkinson's disease, Vitamin D deficiency, disruptive behavior, and allergic conjunctivitis.

The surveyor reviewed the client oriented record (COR) 4/12/17 and 4/13/17. The COR revealed a signed physician order dated 10/17/16. The signed physician orders included an order to obtain a CBC (complete blood count), UA (urinalysis) and a CMP (comprehensive metabolic panel) as well as an interdisciplinary note dated 10/17/16 that read "APE (annual physical examination) computed. No new medical problems identified. No cough, hemoptysis, fever, wt (weight) loss, pm (evening) sweats, or known TB (tuberculosis) exposures. Needs screening CBC, UA, CMP, hemoccult. Needs Prevnar 13 per CDC (center for disease control) recs (recommendations)."

The surveyor reviewed the laboratory section of the COR and found results of the CBC and CMP 10/25/16. The surveyor was unable to locate the results of the urinalysis ordered 10/17/16.

The surveyor informed the active treatment professional #1 on 4/13/17 at 7:18 a.m. of the inability to locate the results of the urinalysis. The active treatment specialist #1 stated when medical records opened at 8:00 a.m., the thinned record could be checked.

The active treatment specialist #1 stated there were no results for a urinalysis in October 2016. The surveyor then interviewed registered nurse

W249 (cont.)

plan implementation,
interview caregivers to ensure
correct understanding of the plan
rationale,verify consistent plan
delivery, and document observations
in the next quarterly QIDP review.
The Senior QIDP will review quarterly
QIDP summaries to verify observations
are completed and documented, check
the IPP document to verify plan
contents, and confirm with the Staff
Development Department that training
has been received and documented. 5-26-17

W325 Physician Services
1. This order for client #6 was
referred to the Physician on 4/14/2017
and the order was discontinued as it
was no longer indicated. 5-26-17
2. Medical Summaries for all indi-
viduals will be reviewed by the
primary RN to ensure all one-time
lab orders have been obtained and
completed. If more than 2-3 weeks
have passed since the order was written
and the specimen has not been obtained,
the nurse will contact the MD/DNP for
recommendations. 5-26-17
3. The nurse will note laboratory
orders. For laboratory specimens that
will be collected by direct support
staff, the nurse will complete the
lab requisition, keep it in the nursing
office until the specimen is obtained,
and place the order and needed reminders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

W 325 Continued From page 12

#1 on 4/13/17 at 8:20 a.m. R.N. #1 stated that the staff had a difficult time obtaining a urinalysis on Individual #6 because of the contractures. The surveyor asked if the physician had been informed that the urinalysis had not been obtained. R.N. #1 stated that the physician would be informed today that the urinalysis ordered in October 2016 had not been obtained. R.N. #1 stated the order was still current; however, the signed physician orders in the COR dated 3/21/17 through 4/18/17 had no current orders for a urinalysis.

W 339 483.460(c)(4) NURSING SERVICES

Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and clinical record review it was determined that the facility staff failed to provide care and services as prescribed by the physician or as identified by client needs for 2 of 11 Individuals in the sample survey, Individual #7 and Individual #6.

1. For Resident #7 the facility staff failed to ensure that a physician's order to crush medications was contained in the clinical record.
2. For Resident #6 the facility staff failed to follow a physician ordered bowel protocol.

The Findings included:

1. Individual #7 was a 62 year old female who was admitted on 2/26/1980. Admitting diagnoses included, but were not limited to: profound mental

W 325 (cont.)
to staff on the Medication Administration Record (MAR). The nurse will place a note in the communication book on the unit, leave any needed specimen collection containers on the unit, and verbally remind staff that a specimen is needed. Once the specimen is obtained, it will be processed as outlined in Health Services Instruction #101. If the specimen has not been obtained one week after the order was written and noted, the nurse will remind staff again and ensure the needed specimen containers are on the unit. Nurses will continue to remind staff weekly for 2-3 weeks in order to obtain the specimen. At the end of this time period, if the specimen has not been obtained, the nurse will notify the MD/DNP of the outstanding order and MD/DNP notified will re-evaluate the need for the specimen and write orders regarding the specimen collection. 5-26-17
4. The QIDP will schedule the audits to verify that labs have been completed as ordered and the results are appropriately filed in the Client Oriented Records (COR). If not, the QIDP will verify that the MD/DNP has been notified and re-evluated the need for the lab, and that written recommendations by the MD/DNP regarding the specimen collection are in the COR. 5-26-17
5. The CNE will in-service the nursing staff and the program managers will in-service the QIDPs on the steps outlined in steps 3 and 4 above. 5-26-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 13 retardation, Schizophrenia, oral phase dysphagia, seizures and Barrett's esophagus. On April 12, 2017 at 7:35 a.m. the surveyor observed Individual #7 sitting in a merry walker in the hallway just outside of the dining area. The surveyor heard the facility staff tell Individual #7 it was time to go get her medications. The surveyor observed Individual #7 stand and walk to a doorway located in the dining room area, where the medication nurse was waiting. The medication nurse told Individual #7 that it was time to take her medicines. The medication nurse stated that Individual #7's medications were crushed. The surveyor observed the medication nurse administer the medications crushed and in applesauce. On April 12, 2017 at 8:15 a.m. the surveyor reviewed Individual #7's clinical record. Review of the clinical record produced the Individual Support Plan (ISP). The ISP identified the following areas ... "Medications & Self Administration of Records ...The Nurse will then place the crushed medication in (name of Individual name withheld) mouth ..." (sic) Continued review of the clinical record produced signed physician order sheets signed and dated 4/11/17. Signed Physician Order Sheets (POS's) included, but were not limited to: "Furosemide 20 mg tablet 6971248 Lasix 20 mg tablet take 1 tablet by mouth daily, Carbamazepine ER200mg Cap (capsule) 6972435 Carbatrol 200 mg capsule s take 1 capsule by mouth two times a day, Omeprazole 20mg 6971743 Prilosec 20mg capsule take 1 capsule by mouth two times a day, Fiber-Lax Captabs 6971742 Fibercon 625mg tablet take 1 tablet by mouth four times a day. "	W 339	Nursing Services 1. Obtain order to crush oral medications for client #7 on 4-1-17. Two of her oral medications (one seizure medication and Prilosec) cannot be crushed for administration. These medications are in capsule form. The capsules are taken apart and the granules given food but not crushed. 5-26-17 2. The CNE discused the need to have MD/DNP orders to crush oral medications with the staff nurses. Orders are to be obtained on all residents who require the crushing of oral medications for administration. 5-5-17 3. Anytime a resident requires the crushing of oral medications for administration, an order will be obtained from MD/DNP. Nurses will be updated on information related to crushing. 5-19-17 4. The QIDP will coordinate with nurses and check CORs and generate a list of individuals receiving crushed oral medications. The QIDP for individuals receiving crushed oral medications will ensure there is a current MD/DNP order to crush oral medications for administration and all related documents in the COR consistently convey this (MARs, self-administration of medication plans, service plans, and discharge plans). This will be noted in the QIDP quarterly review and verified by the Senior QIDP during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 14 (sic) The surveyor noted that the signed physician orders did not include a physician's order to crush Individual #7's medications. On April 12, 2017 at 10:05 a.m. the surveyor notified the Qualified Intellectual Disability Professional (QIDP) that the surveyor had observed Individual #7 receive her medications crushed and in applesauce. The surveyor notified the QIDP that review of the clinical record produced the ISP that documented that Individual #7 was to receive her medications crushed. The surveyor notified the QIDP that a physician's order to crush Individual #7's medications could not be located in the POS's signed and dated 4/11/17. The surveyor reviewed the clinical record with the QIDP. The QIDP could not locate a physician's order to crush Individual #7's medications. On April 12, 2017 at 10:20 a.m. the surveyor notified the QIDP and the Director of Nursing Services (DNS) that Individual #7 had a diagnoses of oral phase dysphagia and was observed received her medications crushed and in applesauce. The surveyor notified the QIDP and DNS that a physician's order to crush Individual #7's medications could not be located in the clinical record. No additional information was provided prior to exiting the facility as to why the facility staff and physician failed to ensure that a physician order to crush Individual #7's medications was contained in the clinical record. 2. Individual #6 did not have a bowel movement for 4 days. He was not administered a scheduled fleet enema (for constipation) per physician orders.	W 339	(cont.) review of quarterly QIDP summaries. W339 (cont.) No documentation of enema for client #6 on PRN medication record 1) The Bowel Movement (BM) Chart for client #6 will be checked daily by DSPs to ensure BM status is recorded. If "no BM" is recorded for two consecutive days, the DSP will notify the nurse and enter an ID note documenting notification. The nurse will ensure a fleet enema is provided before the end of the third day of no BM, and this action will be documented on the PRN medication record and in the ID notes. The results will be documented on the BM Chart and in the ID notes. If no BM results the MD/DNP will be contacted, instructions provided, and treatments administered and documented, until results are obtained and documented. 2) The BM Chart for each individual will be checked daily by Direct Support Professionals (DSP) to ensure BM status is recorded. If "no BM" is recorded for two consecutive days (or for one day if order specifies "every other day") DSP staff will notify the nurse and enter an ID note in the COR documenting notification. The nurse will ensure constipation treatment is provided before the end of the third day of no BM (or second day if order specifies "every other day"). This action will be documented on the PRN medication	5-26-17 5-26-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 15	W 339	(cont.)	

Individual #6 was admitted to the facility on 5/3/1976 with diagnoses of profound mental retardation, gastroesophageal reflux disease, Parkinson's disease, Vitamin D deficiency, disruptive behavior, and allergic conjunctivitis.

The clinical record was reviewed and contained a current physician order signed 3/21/17 to administer a phosphate enema (fleet enema) for no BM (bowel movement) x 3 days (order date 07/11/11).

The January 2017, February 2017, and March 2017 bowel movement chart was reviewed. The January 2017 bowel movement chart documented Individual #6 did not have a bowel movement on any shift on 1/2/17 through 1/5/17 and on the 1st shift on 1/6/17, 1/8/17 through 1/11/17 and on the first shift on 1/12/17, 1/20/17 through 1/23/17 and on the first shift on 1/24/17, and 3/5/17 through 3/8/17 and on the first shift on 3/9/17. For the days Individual #6 had no bowel movement, a "0" was documented for every shift indicating no bowel movement. According to the bowel record, Individual #6 did not have a bowel movement for 4 days. The physician order read to administer a fleet enema if no BM for 3 days. A review of the January 2017 prn (whenever needed) medication sheet had an entry that read "Phosphate enema (fleet enema) 07/11/11 Use as directed if needed for no BM x 3 days 8a.m." All boxes on the January 2017 prn medication form were blank in the entry about the enemas. There was no documentation on the March 2017 prn medication record that Individual #6 had received a fleet enema on 3/8/17.

The Individual Support Program (ISP) for

record and in the ID notes. The results will be documented on the BM Chart and in the ID notes. If no BM results from the administered treatment, the MD/DNP will be contacted, instructions provided, and treatments administered, until results are obtained and documented. 5-26-17

3) Steps 1 and 2 above will be instituted and follwed daily for each individual to ensure BMs are documented and failure to have a BM is addressed in a timely manner for every occurrence of constipation. The record of every individual with constipation identified as a problem on the Problem List will be reviewed and if none exist, MD/DNP orders will be written to document the maximum amount of time allowed without a BM before treatment. This will be documented on the BM Chart for the individual for convenient and expedient reference. All nursing and DSP staff will be retrained in documenting, detecting, and responding to BM patterns and the rationale and need for prompt treatment as prescribed. 5-26-17

4) QA/RM to develop and implement an audit system to assure the protocol outlined in 1- 3 is followed. The audit process will consist of randomly sampling individuals with constipation identified as a problem, checking for presence of MD/DNP orders specifying minimum BM frequency, cross checks of BM Charts for actual BM frequency,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G006	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VIRGINIA TRAINING	160 TRAINING CENTER ROAD/HARRISON CIRCLE HILLSVILLE, VA 24343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 16 9/12/2016 -9/30/2017 was reviewed. The ISP noted under Health and Safety that the plan included fleet enema as directed if needed for no bowel movement every three days. The surveyor interviewed the Service Coordinator #1 on 4/12/17 at 8:50 a.m. The Service coordinator stated the direct service providers were to notify the nurses when an individual had no bowel movements for three days. The nurses then document their findings in the interdisciplinary notes as well as in the nurses' data base. A review of the data base for 1/5/17, 1/11/17, 1/23/17 and 3/8/17 had no documentation that Individual #6 had received the physician ordered fleet enemas. The service coordinator also stated the living unit had different staff the last several months that were not familiar with Individual #6 needs. The service coordinator stated "I take full responsibility for this."	W 339	(cont.) and audits of ID notes and PRN medication records to verify the documentation of notifications, treatments, and results.	5-26-17