| STATEMENT AND PLAN DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 49G004 | A BUILDING _____ B. WING _____ | 07/21/2016 |

| NAME PROVIDER OR SUPPLIER | STREET ADDRESS. CITY, STATE. ZIP CODE |
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| **ST MARY'S HOME FOR DISABLED CH** | **6171 KEMPSVILLE CIRCLE NORFOLK, VA 23502** |

| 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) |
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W 000 **INITIAL COMMENTS**

W 000

The unannounced annual 55 Fundamental Medicaid survey was conducted on 07/19/16 through 07/21/16. 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 100 bed facility at the time of the survey was 98. The survey sample consisted of 10 current Individual records (Individual #1 through #10).

W 148 483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &

W 148

The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

This STANDARD is not met as evidenced by:
Based on observations, record review, staff interview and facility documentation, the facility staff failed to notify 1 of 10 individuals (Individual #2), in the survey sample, of a peer to peer incident that resulted in injury.

Individual #2 bit the nose of a peer. Individual #2's parent was not notified of the incident.

The findings included:

Individual #2 was admitted to the Intermediate Care Facility for Individuals with Intellectual disabilities (ICF/IID) on 9/10/12 with diagnoses

Individual #2's parents were informed of the incident, and if there are any similar incidents in the future involving their child, they will be contacted as soon as possible, but no later than 24 hours after the incident.

7/21/16

Parties of all individuals involved including parents, authorized representatives, legal guardians will be promptly notified of any significant incidents, including but not limited to serious seizure activity, hospitalization, serious illness, accident, death, allegations of abuse, neglect or mistreatment, unauthorized absences or any notification the parent, authorized representative or legal guardian requests.

7/21/16



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

CEO | 8/22/16

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 148 Continued From page 1

that included severe intellectual disability, seizures, attention deficit hyperactivity disorder, abnormal gait disturbances and sleep disorder.

Review of another Individual's Event Form information dated 6/17/16 revealed I#2 had bitten to nose of the individual that resulted in injury. A CHRIS (Comprehensive Human Rights Information System) report was generated on 6/21/16 for the incident.

On 7/20/16 at 2:15 p.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) #1 and the Director of Social Services (DSS). The QIDP stated 1#2 bit another peer during dinnertime. Both the DSS and the QIDP stated the parents of both the victim and perpetrator should have been notified immediately of the biting incident. The DSS stated it was her responsibility to have notified I #2's parent of the injury he inflicted on his peer, but she only notified the family of the peer that was bit.

The review of the 30 day family meeting for review of I#2's ISP dated 5/19/16 indicated that "mom wishes to be notified of all things."

On 7/21/16 at 9:20 a.m., the DSS and the QIDP stated they called and notified Individual #2's parent of the biting incident that occurred on 6/17/16.

Individual #2 was observed during camp hours on 7/20/16 at 9:00 through 12:30 p.m. The Individual was observed during arts and crafts, music time, leisure time, quiet zone and during the lunch meal. When not involved in the *above* activities, he walked non stop. He required and was

W 148

All notification to families is entered into the State Human Rights database within 24 hours of the significant incident by the Social Work Department. A report from this database will be provided by the Social Worker at the monthly Quality Improvement meeting to ensure that all reportable events have been entered into the system within 24 hours.

7/21/19

Minutes of QI meetings will be reviewed by the Compliance Office quarterly to ensure that timelines have been met for the CHRIS reporting system.

9/1/16

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W 148 Continued From page 2

observed to receive 1:1 supervision and support from a Direct Support Professional (DSP).

On 7/21/16 at approximately 2:00 p.m., a meeting was conducted with the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and the Chief Compliance Officer (CCO). No further information was provided prior to the survey exit.

W 159 483.430(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 observations, record review, staff interviews and facility documentation, the facility staff failed to ensure the Qualified Intellectual Disability Professional (QIDP) coordinated the active treatment plan to include any recommendations for programs or modifications to the program to meet the needs of 1 of 10 individuals (Individual #2) in the survey sample.

Individual #2 bit the nose of a peer. The QIDP failed to develop and coordinate a behavioral support plan for the biting behavior.

The findings include:

Individual #2 was admitted to the Intermediate Care Facility for Individuals with Intellectual disabilities (ICF/110) on 9/10/12 with diagnoses that included severe intellectual disability, seizures, attention deficit hyperactivity disorder, abnormal gait disturbances and sleep disorder.

Review of another Individual's Event Form

W 148

W 159

A behavioral Support Plan for I #2's biting behavior has been developed and the ISP has been modified.

7/21/16

All other individuals living at the facility will be re-assessed for biting behaviors by the QIDPs, and noted in the electronic health record. If behaviors are noted, a behavioral Support Plan will be developed and the QIDPs will monitor each month.

9/1/16

Event reports regarding biting behavior will be given to the QIDP for program modification and to the compliance office for follow up.

8/10/16

The compliance office will review program modifications and submit a report to the Quality Improvement Committee.

9/1/16

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| W 159 | Continued From page 3<br>information dated 6/17/16 revealed I#2 had bitten the nose of the individual that resulted in injury. A CHRIS (Comprehensive Human Rights Information System)report was generated on 6/21/16 for the incident.<br><br>Review of I#2's most recent Individualized Program Plan (IPP) and Individual Support Plan (ISP) dated 7/19/16 did not reveal a plan to address the biting behavior.<br><br>On 7/20/16 at 2:15 p.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) #1 and the Director of Social Services. The QIDP stated 1#2 bit another peer during dinnertime and it was a new behavior that had not been included in the individual's IPP/ISP, but there should have been one. She stated it was her job to develop and coordinate all program plans. The QIDP stated I #2 had recently been "mouthing" the arms of the staff, which a plan had not been developed for this related behavior.<br><br>Individual #2 was observed during camp hours on 7/20/16 at 9:00 through 12:30 p.m. The Individual was observed during arts and crafts, music time, leisure time, quiet zone and during the lunch meal. When not involved in the above activities, he walked non stop. He required and was observed to receive 1:1 supervision and support from a Direct Support Professional (DSP).<br><br>On 7/21/16 at approximately 2:00 p.m., a meeting was conducted with the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and the Chief Compliance Officer (CCO). No further information was provided prior to the survey exit. | W 159 | | |

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| W 159 | Continued From page 4<br><br>The facility's policy and procedure titled "Facility Staffing QIDP" dated 3/2016 indicated the QIDP would observe behaviors, collect and review data and progress, and develop, implement and revise programs for each individual at living at the facility. The QIDP would oversee the integration of all services delivered at the facility, as well as those offered by school/day programs and/or external consultants. | W 159 | | |
| W 186 | 483.430(d)(1-2) DIRECT CARE STAFF<br><br>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.<br><br>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review, staff interviews and facility documentation, the facility staff failed to ensure 1:1 staff was consistently available to manage and supervise 1 of 10 individuals (I #2).<br><br>Individual #2 was not provided 1:1 supervision from Direct Support Professional Staff which resulted in a biting injury to a peer.<br><br>The findings included:<br><br>Individual #2 was admitted to the Intermediate Care Facility for Individuals with Intellectual disabilities (ICF/IID) on 9/10/12 with diagnoses that included severe intellectual disability, | W 186 | I #2 is consistently scheduled for 1:1 supervision, and staff training has been provided regarding the expectations for this position.<br>7/25/16<br><br>All staff, scheduled to provide 1:1 supervision with individuals requiring this support, will be provided with the necessary instruction to ensure they understand the needs of the individual.<br>9/1/16<br><br>New staff will meet with the QIDP on the unit where they are scheduled to work and will acknowledge that they received the instruction. Paperwork will be sent to Staff Development and Scheduling.<br>8/12/16 | |

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| W 186 Continued From page 5 | W 186 | | |

seizures, attention deficit hyperactivity disorder, abnormal gait disturbances and sleep disorder.

Review of another Individual's Event Form information dated 6/17/16 revealed I#2 had bitten the nose of the individual that resulted in injury. A CHRIS (Comprehensive Human Rights Information System) report was generated on 6/21/16 for the incident.

The Individual Program Plan (IPP) for I#2 dated 6/18/16 indicated he required 1:1 supervision when walking and in the community of others, staff to stay within 3 feet of him.

On 7/20/16 at 2:15 p.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) #1 and the Director of Social Services. The QIDP stated 1#2's behavioral support plan required 1:1 supervision at all times when he was awake. The QIDP said when the DSP assigned to 1#2 at dinner time went out to retrieve the dinner tray, he was left unsupervised at which time he approached another peer and bit her nose, causing injury. According to the QIDP, he sent out a message to the DSP's that they were to ensure they implemented his plan to maintain 1:1 staff supervision for the individual and stay within 3 feet of him, but if they had to walk away, another staff must be assigned to him.

Individual #2 was observed during camp hours on 7/20/16 at 9:00 through 12:30 p.m. The Individual was observed during arts and crafts, music time, leisure time, quiet zone and during the lunch meal. When not involved in the above activities, he walked non stop. He required and was observed to receive 1:1 supervision and support

Random audit will be completed by the compliance office to ensure that staff have received training.

9/1/16

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| W 186 | Continued From page 6<br>from a Direct Support Professional (DSP).<br><br>On 7/21/16 at approximately 2:00 p.m., a meeting was conducted with the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and the Chief Compliance Officer (CCO). No further information was provided prior to the survey exit.<br><br>The facility's policy and procedure titled "Guidelines for the Supervision of Individuals" dated 11/19/15 indicated individuals and groups are to receive supervision from DSP consistent with the individual needs. One to one (1:1) supervision required constant, uninterrupted, focused, visual observation of an individual by a least one staff member who is not performing any other duties and has no other assignments. | W 186 | |
| W 206 | 483.440(c)(1) INDIVIDUAL PROGRAM PLAN<br><br>Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to:<br>(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and<br>(ii) Designing programs that meet the client's needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to develop an individual program plan designed to meet the needs on 1 of 10 individuals (1#2) in the survey sample. | W 206 | A Behavioral Support Plan for I #2 has been developed and his ISP has been modified.<br>(need date)<br><br>All other individuals living at the facility will be re-assessed for biting behaviors by the QIDPs, and noted in the electronic health record. If behaviors are noted, a behavioral Support Plan will be developed and the QIDPs will monitor each month.<br>9/1/16<br><br>Event reports regarding biting behavior will be given to the QIDP for program modification and to the compliance office for follow up.<br>8/10/16 |

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| W 206 | Continued From page 7<br>The facility staff failed to develop a individualized program plan for Individual #2's biting behavior.<br><br>The findings include:<br><br>Individual #2 was admitted to the Intermediate Care Facility for Individuals with Intellectual disabilities (ICF/IID) on 9/10/12 with diagnoses that included severe intellectual disability, seizures, attention deficit hyperactivity disorder, abnormal gait disturbances and sleep disorder.<br><br>Review of another Individual's Event Form information dated 6/17/16 revealed I#2 had bitten the nose of the individual that resulted in injury. A CHRIS (Comprehensive Human Rights Information System) report was generated on 6/21/16 for the incident.<br><br>Review of I#2's most recent Individualized Program Plan (IPP) and Individual Support Plan (ISP) dated 7/19/16 did not reveal a plan to address the biting behavior.<br><br>On 7/20/16 at 2:15 p.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) #1 and the Director of Social Services. The QIDP stated 1#2 bit another peer during dinnertime and it was a new behavior that had not been included in the individual's IPP/ISP, but there should have been one. The QIDP stated I#2 had recently been "mouthing" the arms of the staff, which a plan had not been developed for this related behavior.<br><br>Individual #2 was observed during camp hours on 7/20/16 at 9:00 through 12:30 p.m. The Individual was observed during arts and crafts, music time, leisure time, quiet zone and during the lunch | W 206 | The compliance office will review program modifications and submit a report to the Quality Improvement Committee.<br><br>9/1/16 | |

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| W 206 | Continued From page 8<br>meal. When not involved in the above activities, he walked non stop. He required and was observed to receive 1:1 supervision and support from a Direct Support Professional (DSP).<br><br>On 7/21/16 at approximately 2:00 p.m., a meeting was conducted with the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and the Chief Compliance Officer (CCO). No further information was provided prior to the survey exit.<br><br>The facility's policy and procedure titled Active Treatment/Individual program Plan dated 6/2016 indicated at Interdisciplinary team meetings, needs would be determined, as well as any behavioral support plans would be developed as a part of the IPP and ISP. A copy to implement any new or changed plans would be available to all relevant staff, including those working with the individual from other agencies. | W 206 | | |
| W 240 | 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN<br><br>The individual program plan must describe relevant interventions to support the individual toward independence.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review, and staff interviews, the facility staff failed to include relevant supports in the Individual Program Plan (IPP) necessary to assist the individual function with greater independence.<br>The facility staff failed to include the chest harness/seatbelt supports and table tray to the IPP for one individual (Individual #10) in the survey sample of 10. | W 240 | The ISP for I # 10 has been modified to include all relevant supports, including the chest harness/seatbelts and tray table. Staff have received documented training for the correct implementation of this plan.<br>8/19/16<br><br>All residents requiring adaptive equipment have been identified. The supports will be added – with all details - to the ISP profile in the electronic health record. Staff will be made aware of any additions and training will be completed if needed.<br>9/1/16 | |

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| W 240 | Continued From page 9<br><br>The findings included:<br><br>Individual #10 was admitted to the facility on 4/5/16 with diagnoses that include profound intellectual disabilities, cytomegaloviral disease, seizure disorder, spastic quadriplegia, cerebral palsy, cortical blindness, tracheostomy, gastrostomy, and GERO (gastroesophageal reflux disease).<br><br>Individual #10 was observed on 7/20/16 at 11:00 a.m., and 7/21/16 at 11:45 a.m.., in classroom #1 seated in a wheelchair with adaptive devices. Individual #10 was wearing a chest harness/seatbelt which intersected at the waist, attached to the seat, came up between the legs and connected at the waist. It also included a footrest, a headrest, lateral positioners and a table tray.<br><br>The Occupational Therapy assessment dated 5/3/16 revealed Individual #10 had an Iris tilt in space wheelchair,* It included a planar seat and back, 2 right sided lateral trunk pads, 1 left sided lateral trunk pads. Large hip knee guides, a calf strap, two point seat belt, chest harness and I to I style headrest with a whitmeyer large plush (head supports), drop foot rests down and back for knee extension issues, create a larger calf pad and realign his right lateral pads. It included tie down brackets but no anti tippers or a tray. Recommendations stated fit and adjust wheelchair and upper extremity othotics as necessary, explore likes and dislikes to create fun | W 240 | For all new admissions, a list of current adaptive equipment will be created during pre-admission meetings and given to the physician so that orders may be approved for their use.<br>8/12/16<br>OT/PT will ensure notification to the QIDPs if modifications or additions are made to the adaptive equipment.<br>8/12/16 | |

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and interactive leisure activities.

An Iris tilt in space wheelchair is a specialized wheelchair with a seat frame that can rotate around the user's center of gravity.

The Physician's Order Summary (POS) included an order dated 4/5/16 and renewed 7/5/16 which read: Chair straps may be worn at all times when up in chair for postural purposes and OT there please provide Benik neoprene elbow extremity splints.

Individual #10 IPP Profile information report indicated the adaptive equipment/assistive technology included: wheelchair, hand splints, elbow splints, suction machine, pulse oximeter, percussion vest and cough assist.

Individual #10 IPP program information was com prised of goals and services for use of the night splints to the legs only. **No** other adaptive equipment was included in the IPP.

On 7/21/15 at 10:45 a.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) concerning the chest harness/seatbelt. The QIDP stated the chest harness/seatbelt is in place to provide support for the individual while seated in the wheelchair. Copies of the physician's orders was provided. There was no order for the table tray.

During an interview on 7/21/15 at 11:45 a.m. with the classroom teacher it was stated the chest

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harness/seatbelt are in place when the student arrives to the classroom and if concerns are identified the nursing staff is notified. The teacher stated the school system would be providing Physical therapy services later to address the limit upper extremity movement.

On 7/21/16 at approximately 3:00 p.m. the above information was shared with the Chief Executive Officer, Chief Nursing Officer, and Chief Compliance Officer during the pre-exit briefing. No additional information was provided.

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 observations, record review and staff interviews, the facility staff failed to implement Individual Program Plans (IPP'S) for five individuals (Individual #2, #3, #4, #5, and #7) in the survey sample of 10 individuals.

Individual's #2 and #3 had Program Plans for Pica behavior that were not implemented.
Individual's #5 and #7 had Program Plans for Transfers that were not implemented.
Individual #4 had Program Plans for wearing eye

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I #2 and I #3's ISPs have been modified to include behavioral support plans for diagnoses of PICA and staff have received documented training on these plans.
7/20/16

The diagnoses of all other individuals have been reviewed. Those with a PICA diagnosis will have their ISP modified to include behavioral support in this area.
9/1/16

All staff will be in-serviced on all PICA behavior plans, and these plans will be added to behavior training for new staff.
9/1/16

Staff re-training on correct transfer procedures for I # 5 and I #7 has been completed.
8/12/16

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glasses that were not implemented.

The findings included:

1 Individual #3 was admitted to the facility on 1/14/13 with diagnoses which included Developmental Delay, seizures, Refractory Epilepsy, right hearing deficit, Gray Matter Heterotopia* and Pica,** Individual #3 was found with a key in her mouth.

*Heterotopia- The appearance of a cluster of normal cells in an abnormal location.

**Pica is a pattern of eating non-food materials, such as dirt or paper (https://medlineplus.gov/ency/article/001538. htm).

Individual #3 was assessed as putting inedible items in her mouth. Individual #3 is able to independently transition to stand without a support and walk independently (feet lightly pronated).

An Incident Report dated 6/16/16 at (3:38 P.M.) indicated: "Individual #3 was observed to spit. The spit looked really large. Direct care Staff walked over to her and pointed out she spit out a key. The nurse was called to assess Individual #3."

An Individual Program Plan dated 1/5/16 indicated: "PICA- Program Text- Please record any incidents of Individual #3 attempting to put inappropriate things in her mouth. Program Help: If you see her doing this, redirect her to an appropriate activity/chew toy. If you see

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Staff Development has increased the amount of time spent training on correct transfer procedures and all newly hired staff are assigned a preceptor to model correct procedures for specific individuals.

8/12/16

Supervisors, other professional staff and the quality improvement nurse will spontaneously observe transfers and report to the chief nursing officer, who will compile a report for the monthly Quality Improvement Committee. This report will determine if further training is needed.

9/1/16

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something in her mouth that shouldn't be there, try to take it out.
Frequency: Every day (All Shifts).

Alert- She explores her environment by putting inedible items in her mouth. Her environment is kept as clean as possible to prohibit her from finding inedible items to put in her mouth. And when she is seen putting something in her mouth, it is taken out and she is redirected to something appropriate.
She is monitored by staff when she has small things in her environment that she could put in her mouth (like if we are doing an art project)."

During an interview on 7/21/16 at 10:30 A.M. with the assigned Qualified Individual Developmental Professional (QIDP) for Individual #3, she was asked where did the key come from. The QIDP stated, they think from school. When asked if school was in-session at that time, the QIDP stated "let me check." The QIDP stated, "No, school was out on 6/16/16 at 1: P.M. we are not sure where the key came from."

2. Individual #5 was admitted to the facility on 3/11/14 with diagnoses of Profound Intellectual disabilities, Spastic quadriplegic, Cerebral Palsy, seizures muscle spasm and Lordosis*, and age-related osteoporosis w/o (without) current pathological fracture. Individual #5 sustained an injury of unknown origin.

*Lordosis is abnormal anterior convexity of the lumbar spine.

An Incident Report dated 2/12/16 indicated: "Swelling noted below **(R)** right-eye possible

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allergies. No one observed any trauma to eye occurring. Reported during shift change report oncoming nurse."

A Progress Note dated 2/12/16 indicated: "During change of shift report with (RN) Registered Nurse (DSP) Direct Service Professional came to nurses station and told RN that resident's eye was red and puffy. I asked which eye. DSP stated the (R) one. Upon initial assessment the area below resident's lower eye noted to be grayish/purple in color. No (s/s) signs or symptoms of distress.
Upon assessment at 1730 (5:30 P.M.) resident's R lower eye noted to be very swollen and blue in color. Small abrasion noted to (R) lower/outer eye. Bruised swollen area measuring 8 (cm) centimeters from inner to outer (R) lower eye."

A Nursing note dated 2/14/16 at 2:07 A.M. indicated: "A CT scan did not detect a fracture. Bruised area around eye measures approx. 6.0 cm. no redness is evident to right shoulder or right neck. Resident has a right orbital contusion."

A Physical Therapy Assessment dated 2/23/16 Indicated: Individual #5 was assessed as dependent on others for activities of daily living, transfers, mobility, positioning, and personal hygiene care.

In the area of Musculoskeetal- Gross Motor Skills- Individual #5 is able to turn her head freely in all positions to attend to her surroundings although staff reported concerns about possible tightness turning her head to the right and a tendency to laterally flex her neck to her left side.

During an interview on 7/20/16 at 2:30 P.M. with

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the assigned QIDP for Individual #5, she was asked how did Individual #5 sustain a black eye from an injury of unknown origin. The QIDP stated, "We think it came from staff transferring her incorrectly." When asked how was Individual #5 transferred incorrectly, the QIDP stated, she needed two staff to transfer her and only one transferred her on this date during a change while toileting."

An Individual Program Plan dated 9/12/14 indicated: "I need to be lifted by a mechanical lift when transferred at all times by trained staff. Frequency (every day- all shifts).

Alert- A mechanical lift is used at all times with 2 people assisting when ever she is transferred. Two persons must be present for all bathing, dressing, and toileting activities."

During the interview of 7/20/16 at 2:30 P.M. with the assigned QIDP she stated, their investigation indicated Individual #5 hit her eye on her knee during the transfer. Staff were re-trained on the use of mechanical lifts and Program Plans.

3. Individual #7 was not transferred via Hoyer Lift with two person per IPP.

Individual #7 was admitted to the facility on 12/01/08. Diagnoses for this Individual included Profound Intellectual Disabilities, Cerebral Palsy, Hydrocephalus, and Scoliosis. The facility staff failed to transfer Individual #7 in accordance with his IPP utilizing a two person transfer.

An Abuse Allegation Report dated 10/23/15

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indicated: "Nurse was assisting DSP with the transfer of Individual #7 to his chair. Nurse relayed that DSP was rushing throughout the entire process and was not adhering to the policy of Hoyer usage. Nurse reported that DSP had positioned the wrong wheelchair for Individual #7 usage. The nurse caught the mistake and they transferred him using the Hoyer to his chair. Nurse reported that the DSP yanked the sling from behind Individual #Ts back instead of following procedure for removing the sling. Nurse stated that the DSP also lowered the lift bar onto his legs and she had to squeeze her hands under the bar while telling the DSP to lift it up."

A 3/25/15 Orthopedic Assessment indicated Individual #7 with scoloiosis and a left hip dislocation and a right hip that is well located. Individual #7 has a significant kyphotic curve. Individual #7 has limitations in ROM (Range of Motion) including (B) both shoulder flexion, (B) hip extension and (B) knee extension. He is dependent of all AOL'S (activities of daily living) transfers, and mobility.

An IPP dated 10/16/15 indicated: Qualities of Those who Support Me: "I like it best when people that are supporting me are patient and calm and provide me with cues before they move or touch me.

Alert- The safest way to transfer me from one positioning device to another is by using the Mechanical lift at all times. During personal care 2, staff are required."

A review of a letter dated 10/29/15 to the parents of Individual #7 indicated: "Due to rushing, the

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DSP initially placed Individual #7 in the wrong chair. When transiting him to the correct chair, the DSP did not follow policy when removing the sling from behind him and failed to protect his head as he accidentally bumped his head on the Hoyer bar as he leaned forward."

During an interview on 7/21/16 at 9:45 A.M. with the assigned Social Worker, she stated staff transferred Individual #7 into the wrong chair alone without two staff per IPP and failed to follow the policy when removing the sling from behind him."

A Lifting Policy dated December 2014 and reviewed 3/2016 indicated: "Lifting Policy Purpose: To promote optimum comfort and safety for residents during lifting and transfers. 2. To reduce the risk of injury to all staff members during lifting and transfers or residents.
3. To ensure that all staff members have a comprehensive understanding of proper body mechanics necessary for the prevention of injuries.

Two person lift- All residents weighting between 35 and 70 pounds (31.81 kg) must be lifted by two (2) staff members."

A Progress Note dated 12/7/15 indicated Individual #7 weight was (41 KG).

4. The facility staff failed to implement Individual #2's Behavioral Support Plan (BSP) related to PICA* behaviors and keep out of reach inedible object. 1#2 ingested blue foam rubber, cotton balls and attempted to place plastic wrappings of food items in his mouth.

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*Pica is a pattern of eating non-food materials, such as dirt or paper (https://medlineplus.gov/ency/article/0Q1538. htm).

Individual #2 was admitted to the Intermediate Care Facility for Individuals with Intellectual disabilities (ICF/IID) on 9/10/12 with diagnoses that included severe intellectual disability, seizures, attention deficit hyperactivity disorder, abnormal gait disturbances and sleep disorder.

Review of I#2's most recent Individualized Program Plan (!PP) and Individual Support Plan (ISP) dated 7/19/16 and Qualified Intellectual Disabilities Professional (QIDP) Quarterly Review Report dated 5/19/16 indicated I#2 had PICA behaviors and he was to be encouraged to improve his interest in eating by mouth during all scheduled mealtimes, only approved toys and activities. There would be no clothing with small items, such as buttons, snaps and other decorations which could possibly be removed and put into his mouth and swallowed. 1#2 also required 1:1 supervision at all times for his safety. There were 8 episodes recorded on QIDP's Quarterly report of I #2 putting inedible objects in his mouth over the last 30 days.

An event report dated 6/29/16 revealed the following:
On 6/29/16 at 9:00 p.m., while on leave of absence with family, the father of Individual #2 observed blue foam in his stool. On 6/29/16 at 2:00 p.m., during science and nature class, cotton balls were used to demonstrate cloud types and food coloring was used for each cloud. I#2 grabbed some cotton balls and ingested them. The DSP's attempts to retrieve the cotton

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balls from his mouth were unsuccessful.

Individual #2 was observed during camp hours on 7/20/16 at 9:00 through 12:30 p.m. The Individual was observed during arts and crafts, music time, leisure time, quiet zone and during the lunch meal. When not involved in the above activities, he walked non stop. He required and was observed to receive 1:1 supervision and support from a Direct Support Professional (DSP). During observation of I #2's lunch meal, Direct Support Professional #10 unwrapped cookies, cheese and crackers. After I #2 had eaten the food items, she did not remove the plastic wrappers of these items from his reach and he was observed constantly grabbing the wrappers trying to place them in his mouth.

On 7/20/16 at 2:15 p.m., an interview was conducted with the Qualified Intellectual Disability Professional (QIDP) #1 and the Director of Social Services. The QIDP stated 1#2 had ingested the cotton balls and the blue foam on the same day and the father observed the blue foam in the individual's stool later the same evening at 9:00 p.m. The QIDP stated during the investigation of the event, the DSP was behind the individual during the class activity and she instructed her to be beside her to observe closer. She stated she did not assess whether the cotton balls and blue foam items were unsafe for I#2 to use, or that there was a safer substitute for I#2 to create the same project.

On 7/21/16 at approximately 2:00 p.m., a meeting was conducted with the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and the

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Chief Compliance Officer (CCO). No further information was provided prior to the survey exit.

The facility's policy and procedure titled "Active Treatment/Program Implementation" dated 6/2016 indicated the purpose of the policy was to ensure that the ISP/IPP created for each individual was correctly implemented.

5. The facility staff failed to implement Individual #4's individual program plan (IPP) for the use of eyeglasses.

Individual #4 was admitted to the facility on 6/30/08 with a re-admission from the hospital on 5/3/16. Individual #4's diagnoses included profound intellectual disabilities, a gastrostomy (a tube inserted into the stomach for feedings) and myopia (nearsightedness) requiring eyeglasses.

The general physician order dated 9/28/08 read, in part; Resident to wear eyeglasses.

The individual program report evidenced the program name: Eyeglasses, with a start date of 9/11/14 and no end date. The Program Text read, in part: "Please put my eyeglasses on me when you get me ready in the morning. Please take my eyeglasses off when I get ready for bed."

On 7/20/16 from 10:50 a.m. to 11:45 a.m., Individual #4 was observed sitting up in a specialized wheelchair inside classroom #2, attending the onsite school program. The Individual did not have eyeglasses on. Part of Individuals #4's activity was sitting in front of a computer screen watching and listening to a book

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being read. At 12:45 p.m., Individual #4 was observed awake sitting up in the specialized wheelchair in her living unit/room directly in front of the TV without eyeglasses on.

On 7/20/16 at 3:45 p.m., the primary nurse for unit 1 was interviewed. The above findings was shared. The primary nurse stated Individual #4 is "supposed to wear them (eyeglasses) when she is up in the chair, and off when in bed". The primary nurse stated she was not made aware of the eyeglasses being unavailable for use and would go and locate them. Several minutes later, at 4:35 p.m., the unit 1 primary nurse brought the eyeglasses into the conference room to show this inspector that the eyeglasses were available. The primary nurse stated the glasses were found on the shelf behind the head board.

The facility's Active Treatment Policy titled Program Implementation revised 6/2016 read, in part:
"Purpose: To ensure that the ISP (Individual Service Plan) created for each individual is correctly implemented.
Procedures:
1. After the QIDP (Qualified Intellectual Disabilities Professional) has formulated the individual's ISP, each individual will receive a continuous active treatment program consisting of the interventions and services, in sufficient number and frequency, as described, outlined, a supported in the ISP."

The above findings was shared with the Chief Executive Officer, the Chief Nursing Officer, the Chief Compliance Officer and the Social Services Director during a pre-exit meeting conducted on 6/21/16 at 1:50 p.m. An opportunity to provide

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| W 249 | Continued From page 22<br>additional information for review was provided at this time.<br><br>No additional information was provided prior to exit. | W 249 | | |
| W 368 | 483.460(k)(1) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>This STANDARD is not met as evidenced by:<br>2. The facility staff failed to follow physician's orders in the administration of medications for Individual #6.<br><br>An 11 to 7 Licensed Practical Nurse (LPN) #23 reported on 4/5/16 she had noticed that on 3/31/16 and 4/1/16, 4/4/16, and 4/5/16 that an extra dose of Diazepam* 2 milligrams (mg) was administered. The dose had been changed on 3/20/16 from three times a day (TIO) with doses at 6:00 a.m., 3:00 p.m., and 10:00 p.m. to doses administered at 6:00 a.m. and 6:00 p.m. only. The LPN (#24) had signed on the controlled medication utilization record for these days for a Diazepam 2 mg tablet as follows: 2 mg with no time on 3/31/16, at 9:00 p.m. on 4/1/16, at 9:07 on 4/4/16 and at 9:02 on 4/5/16.<br><br>*Diazepam is used to relieve anxiety, muscle spasms, and seizures and to control agitation caused by alcohol withdrawal ( https://medlineplus.gov/druginfo/meds/a68204 7. html). | W 368 | Physician orders were clarified for I #4. No further discrepancies have occurred. The staffing agency was notified.<br>7/25/16<br><br>Following hospital discharges, all orders will be verified with the primary care physician before administration occurs. Any re-admission to the facility will have a medication audit completed by the primary nurse within 24 hours<br>8/12/16<br><br>The staffing agency will provide their policy regarding medication administration, re-training, competency check sheets and measures for corrective action to the facility.<br>8/30/16<br><br>The facility will provide classroom orientation and the medication administration policy that includes the 6 rights to all new nurses, both agency and facility employees.<br>7/21/16 | |

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On 4/17/16 at 5:30 p.m. a Disabilities Support Professional (DSP) reported seeing a syringe full of an unidentified solution in it on 4/16/16. The syringe was observed on the middle shelf of Individual #6's bed.

During an interview with Quality Initiative/Infection Control Nurse on 7/20/16 at 3:35 p.m., she stated I #6 had an antacid 200 mg in a 5 milliliter (ml) ordered 6/2/14 by the physician at 6:00 a.m., 4:00 p.m. and 10:00 p.m., that would have been a white solution administered in a syringe, and it had a minty smell. She said other medications may have been in it because Individual #6 had other medications due at 6:00 a.m. and 9 mis of liquid was in the syringe. She stated it was discovered the error was made by LPN #24.

On 4/22/16, it was reported by an LPN working on the 11/7 shift that when she checked Individual #6's *transderm patch to verify placement, she found the patch was the one she had placed on the Individual 4/17/16 behind her right ear. LPN #24 had documented she placed a new transderm patch on the Individual 4/20/16, but it could not be located on the Individual's body.

Individual #2 had a physician's order dated 3/29/16 for Transderm-Scop 1.5 mg (1 patch every three days). *Transderm Scop is indicated in adults for prevention of nausea and vomiting (https://dailymed.nlm.nih.gov/dailymed/drug Info.cf m?setid=f6fdc88b-ea00-4694-8f21-b8d 15dbb339 e).

On 7/21/16 at approximately 2:00 p.m., a meeting was conducted with the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and the

All current medication nurses, both agency and facility employees will be retrained and requested to sign off on the medication administration policy.

8/30/16

Random medication audits will also be performed by primary nurses.
The chief nursing officer will monitor all audit sheets to determine further training needs.

8/12/16

A report of the audits will be provided to the Quality Improvement Committee.

9/1/16

| STATEMENT AND PLAN DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49G004 | A. BUILDING _____ B. WING _____ | 07/21/2016 |

| NAME PROVIDER OR SUPPLIER | STREET ADDRESS. CITY. STATE. ZIP CODE |
|---|---|
| ST MARY'S HOME FOR DISABLED CH | 6171 KEMPSVILLE CIRCLE NORFOLK, VA 23502 |

| 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) | COMPLETION DATE |
|---|---|---|---|---|
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Chief Compliance Officer (CCO). No further information was provided prior to the survey exit.

Based on staff interviews, record review and facility document review the facility staff failed to administer medications in accordance with physician orders for 2 of 10 Individuals in the survey sample, Individual #4 and #6.

The findings included:

1. Individual #4 was admitted to the facility on 6/30/08 with a re-admission from the hospital on 5/3/16. Individual #4's diagnoses included profound intellectual disabilities, gastrostomy (a tube inserted into the stomach for feedings) GERO (gastroesophageal reflux disease) and a recent surgical procedure, a Nissen fundoplication, to address respiratory concerns.

Surgery for GERO may involve a procedure to reinforce the lower esophageal sphincter called Nissen fundoplication. In this procedure, the surgeon wraps the top of the stomach around the lower esophagus. This reinforces the lower esophageal sphincter, making it less likely that acid will back up in the esophagus. Http://www. mayoclinic.org/diseases-conditions/gerd/multimedia/gerd-surgery/img-20006950.

Individual #4 was discharged from the hospital on 5/6/16 with a prescription for the medication diazepam 3 mg (milligrams)=3ml (milliliters) daily at 2100 (9 pm) dispense 90 ml.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49G004 | A. BUILDING _____ B. WING _____ | 07/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST MARY'S HOME FOR DISABLED CH | 6171 KEMPSVILLE CIRCLE NORFOLK, VA 23502 |

| 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 |
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Diazepam is used to relieve anxiety, muscle spasms, and seizures. Https://medlineplus.gov/druginfo/meds/a682047.html.

Review of the facility Event Form dated 5/11/16 evidenced the facility staff failed to follow the physician order for diazepam that resulted in a medication error for Individual #4. The medication error occurred for four days, 5/7, 5/8, 5/9 and 5/10/16. The Individual was administered 15 mg of diazepam daily, instead of the physician ordered 3 mg.

Further investigation of the medication error evidenced the pharmacy claimed they did not receive the hard copy prescription from the facility when the nurse called on 5/7/16 due to the medication not being available. The nurse then called the attending physician. The physician then phoned in the order to the pharmacy. The order that was phoned in was a different concentration then what was originally entered on the Electronic Medication Administration Record (E-MAR) by the nursing staff on 5/6/16. The physician's phone order to the pharmacy was for diazepam intensol 5 mg /ml oral concentrate. The dose changed to 0.6 ml to be administered to equal 3 mg.

Further investigation of the medication error evidenced the staff who administered the diazepam on 5/7, 5/8, 5/9/ and 5/10/16 failed to read the pharmacy label on the medication and the Controlled Medication Utilization Record that both read, 5 mg/1 ml oral concentration, give 0.6 ml (3 mg) via gast-tube at 2000 (8 pm).

Instead, the nurses read only the original E-MAR

| STATEMENT AND PLAN DEFICIENCIES CORRECTION | (X 1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49G004 | A. BUILDING _____ B. WING _____ | 07/21/2016 |

| NAME PROVIDER OR SUPPLIER | STREET ADDRESS, CITY STATE ZIP CODE |
|---|---|
| ST MARY'S HOME FOR DISABLED CH | 6171 KEMPSVILLE CIRCLE NORFOLK, VA 23502 |

| ID 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) | DATE |
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entry that had not been changed. It still read: Diazepam 5 mg/5 ml (1 mg/ml) oral solution SIG: give 3 milligrams (3 ml) by g-tube route once daily.

The Event Report indicated the medication error was found by the 3-11 nurse working on 5/11/16. The nurse changed the order on the E-MAR to reflect the need to administer only 0.6 ml for the required 3 mg. The physician was notified and the Individual was monitored for adverse effects. The individual attended her regular school day and other activities without interruption.

On 7/20/16 at 3:55 p.m., the QI/IC (Quality Improvement-Infection Control) nurse was interviewed. The QI/IC nurse completed the Event Form. She stated part of the medication error was a result of the nursing staff failing to read the pharmacy label for the diazepam prior to administering the medication.

The facility policy titled "Medication Administration Policy" revised 6/13/12 read, in part: Purpose: To provide guidelines for administration and charting of medications and treatments utilizing the medication and treatment records.
B. Medication administration guidelines.
d. The 6 rights of medication administration will be followed at all times:
i. Right patient/resident
ii. Right medication
iii. Right form
iv. Right dose/strength
v. Right route
vi. Right time
NB: verify the correct dosage by double-checking the prescribed dose against the provided medication strength/preparation.

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|---|---|---|---|
| | 49G004 | A. BUILDING _____ B. WING _____ | 07/21/2016 |

| NAME PROVIDER OR SUPPLIER | STREET ADDRESS. CITY. STATE. ZIP CODE |
|---|---|
| ST MARV'S HOME FOR DISABLED CH | 6171 KEMPSVILLE CIRCLE NORFOLK, VA 23502 |

| ID 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) |
|---|---|---|---|
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The above findings was shared with the Chief Executive Officer, the Chief Nursing Officer, the Chief Compliance Officer and the Social Services Director during a pre-exit meeting conducted on 6/21/16 at 1:50 p.m.