STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING ______ B. WING ______	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/18/18 through 7/20/18. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No Emergency Preparedness complaints were investigated during the survey.	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power	E 006	1) The facility's existing Hazard Vulnerability Assessment (HVA) was completed on 11/15/17 and identified potential risk of 9 naturally occurring events, 15 technological events, 7 human related events and none involving hazardous materials. Facility Policy #920 Emergencies includes procedures that address the rated risk events identified by the HVA. The HVA will be reviewed by the Residential Emergency Management Team (REMT) and any revisions will be addressed. The REMT will review the HVA for all hazards approach. 2) The REMT will incorporate all hazards in the Emergency Preparedness Plan. 3) The facility's HVA will be updated annually by the REMT, using the most recent Kaiser-Permanente HVA tool, with review/input from the local health district emergency planner (if available), for review and approval by the WTCSB Emergency Management Committee (WTCSB EMC). The REMT will update the emergency plan to include all risk events. Facility Policy #920 "Emergencies" will be revised to "Emergency Preparedness" and any additional items from the HVA will be added to the emergency preparedness plan. 4) The HVA and emergency plan will be reviewed by the facility's REMT on a biannual basis and the WTCSB EMC annually for any revisions. The Utilization Review Supervisor or designee will audit during annual facility inspections that the facility HVA and emergency plans	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Director (X6) DATE: 8/7/18

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

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E 006 Continued From page 1

failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.
This STANDARD is not met as evidenced by:
Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to identify and document facility-based and community-based risk, utilizing an all-hazards approach.

The findings included;

An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated, they did not have documentation to demonstrate they addressed emergency events identified by the risk assessment.

E 007 EP Program Patient Population
CFR(s): 483.475(a)(3)

[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]

(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**

*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.]
This STANDARD is not met as evidenced by:
Based on review of the facility's emergency

E 006

are updated and reviewed as required.
5) Completion Date: 8/31/18

E007 1a) The individual assessments required for an ICF/IID include the Comprehensive Functional Assessment (CFA), Life Safety Code (LSC), Virginia Individual DD Eligibility Survey (VIDES), and the Person-Centered Plan (PCP). The Residential Emergency Management Team (REMT) will develop individualized Personal Emergency Plans (PEP) for each resident based in part on their CFA, LSC, VIDES, and PCP. The assessments identify unique vulnerabilities and indicate that residents are at risk during an emergency due to the needed level of support required to maintain their safety. The PEPs will outline the level of supports required for each resident in various emergency situations. Facility staff will conduct a team assessment of each resident's needs to develop support strategies in the event of those emergencies.

E 007 1b) The REMT will review the existing procedures (Policy #920 Emergencies and Policy #921 Emergency Evacuation) for ensuring means of transport are accessible and available for effective and timely evacuations. Any revisions will be addressed, including a method of ensuring that those involved in transport are aware of the procedures to evacuate. 1c) The REMT will develop written procedures to add to Policy #920 Emergencies, for the type and continuity of services the facility will be able to provide during emergencies.
2) The REMT will review available pre-admission assessment information when developing the PEP for residents newly admitted to the facility.
3) All current facility staff and residents will be trained on the development and use of PEPs and will practice during evacuation drills. The facility QIDP will ensure that staff document that the PEP was accessed and used appropriately during evacuation drills. The facility's QIDP will ensure the PEPs are updated when changes occur which require revision, and at least annually. All staff at this facility will be trained at least annually and/or when the PEP has been revised. The PEPs will be maintained and readily accessible to ensure the information is always with the resident: a copy in the resident's "go-bag' at the residence; in designated

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E 007	Continued From page 2 preparedness plan and staff interview, the facility staff failed to have systems in place to specify their population, identify individuals with unique vulnerabilities and to address persons at risk. The findings included; An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated, they did not have documentation to ensure systems were in place to identify individuals who would require additional assistance, ensure that means for transport are accessible and available and that those involved are aware of the procedure to evacuate and identify types of services that the facility would be able to provide in an emergency	E 007	Emergency Preparedness Binders located in the residence and day support programs; and copies for the resident's wallet, purse or backpack. Facility Policy #920 "Emergencies" will be revised to "Emergency Preparedness" and include revisions noted above related to PEPs, accessible and available transport, and services provided during an emergency. All facility staff will be trained on the revisions to the policy. All new staff will receive training at hire and annually thereafter as part of required emergency preparedness training. Evidence of staff training will be maintained in training records on site that include training content, attendance sheets, and materials. 4) The Interdisciplinary Team (IDT) will review quarterly that each resident's PCP includes emergency planning, evident by a current and appropriately developed PEP. The facility's QIDP will ensure the PEP is reviewed quarterly at staff meetings and at the resident's QIDP review to go over with the resident what a "go-bag" is for and determine if the resident wants any changes. The revised Policy #920 Emergency Preparedness will be reviewed by the WTCSB EMC. 5) Completion Date: 8/31/18	
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and	E 009	1) Facility Policy #920 Emergencies was reviewed by the Residential Emergency Management Team (REMT). Necessary revisions will be made related to documenting an integrated response process. The CSB Emergency Services Clinical Administrator joined the Health Care Coalition (HCC) and attends offered meetings. 2) The CSB Emergency Manager will disseminate information from the HCC meetings and external emergency management partners to the facility staff on a quarterly basis. 3) Facility Policy #920 "Emergencies" will be revised to "Emergency Preparedness" and will include procedures for maintaining periodic contact with internal and community/public agencies. In addition, the facility will utilize the on-line Virginia Healthcare Alerting and Status System (VHASS) to document communication of an integrated response during a disaster with both jurisdictional Emergency Operations Center and the Regional Healthcare Coordination Center. The facility will also upload its current Emergency Preparedness Plan in VHASS. The QIDP will document meetings with internal and external partners, the CSB Emergency Services Clinical Administrator's integration	

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E 009	Continued From page 3 Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation including their integrated response process in its emergency plan. The findings included: An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated, the facility had no documentation showing they periodically contact officials they collaborate with in the event of a disaster.	E 009	with external emergency management partners and the documentation will maintained in a designated binder at the facility. 4) As a participating member of the WTCSB EMC, the Clinical Services Administrator will ensure resource contacts are current, and will keep abreast of available collaborative and cooperative emergency planning opportunities. Evidence of staff training will be maintained in training records on site that include training content, attendance sheets, and materials. The Utilization Review Supervisor or designee will audit during annual facility inspections that the facility's integrated response process is being documented. 5) Completion Date: 8/31/18	
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:	E 015	1) Facility Policies #920 Emergencies, #921 Emergency Evacuation Procedures, and #923 Emergency Preparedness Response were reviewed by the Residential Emergency Management Team (REMT). Necessary revisions will be made related to determining supply needs for the duration of an emergency. The method used to calculate supply needs will be based on the facility's maximum bed capacity that the facility is licensed for annually, and the facility's current staffing patterns based on the shift with the highest ratio of staff. The method will include consideration of minimum quantity and type of needs	

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E 015 Continued From page 4

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This STANDARD is not met as evidenced by:
Based on review of the facility's emergency

E 015 necessary for resident's staff, families and volunteers , as well as purchasing, and storage and maintenance of supplies on site designated for emergencies only.
2) The method for determining supply needs will include calculation for individuals from another WTCSB ICF/IID residence.

3) Facility Policy #920 Emergencies will be revised to "Emergency Preparedness". A procedure will be added for determining supply needs for the duration of risk events identified in the facility's HVA. The policy will clearly identify supply needs for staff and residents whether they evacuate or shelter in place. The facility is equipped with a generator to supply alternate sources of energy to maintain temperature, emergency lighting, fire and alarm systems as well as sewage. In the event of generator failure facility staff should utilize the guidance found in Emergency Preparedness Response Policy #920. All facility staff will be trained on the revisions to the policy. All new staff will receive training at hire and annually thereafter as part of required emergency preparedness training.

4) The revised Policy #920 Emergency Preparedness will be reviewed provided to the WTCSB EMC for review. The policy will be reviewed and updated annually. Evidence of staff training will be maintained in training records on site that include training content, attendance sheets, and materials.

5) Completion Date: 8/31/18

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E 015	Continued From page 5 preparedness plan and staff interview, the facility staff failed to ensure a system was in place to determine their supply needs during an emergency. The findings included: An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated, they did not have documentation to demonstrate their supply needs; food, pharmaceuticals, medical supplies, fire detection including extinguishing and alarm systems as well as sewage and waste disposal.	E 015		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.475(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an	E 024	1) Facility Policy #920 "Emergencies" was reviewed by the Residential Emergency Management Team (REMT) and revisions will be made to address the use or non-use of volunteers during an emergency. 2) The facility will review and revise the above policy for additional volunteers if changes occur during the year. 3) Facility Policy #920 "Emergencies" will be revised to "Emergency Preparedness". Procedures for emergency staffing will be added to address the use of volunteers during an emergency, distinguishing between established WTCSB volunteers. All facility staff will be trained on the revised policy. All new facility staff will be trained at hire and annually thereafter as part of required emergency preparedness training. 4) The revised Policy #920 Emergency Preparedness will be provided to the WTCSB EMC for review. The REMT will review and update the policy annually.	

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

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E 024	Continued From page 6 emergency and other emergency staffing strategies to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop policies and procedures for the use or non-use of volunteers during an emergency. The findings included: An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated the facility had not developed policies and procedures for the use of volunteers during emergency preparedness activities.	E 024	Evidence of staff training will be maintained in training records on site that include training content, attendance sheets, and materials. 5) Completion Date: 8/31/18	
E 029	Development of Communication Plan CFR(s): 483.475(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility staff failed to have a written communication plan which includes how they will interact and coordinates with emergency management agencies to protect patient health and safety during a disaster. The findings included; An interview was conducted on 7/20/18 at 11:15 a.m., with the Intermediate Qualified Intellectual Disabilities Professional (QIDP). The QIDP	E 029	1) The Residential Emergency Management Team (REMT) will review the HVA and revise the emergency preparedness Communication Plan. The WTCSB emergency will be updated to include communication to residents, families, staff, volunteers, and upper management. 2) The REMT determined there are no new residents slated for admission to the facility prior to the scheduled development of a Communication Plan. 3) The REMT will develop a written emergency preparedness Communication Plan following recommendations provided by the local health planning district. Facility Policy #920 Emergencies will be revised to "Emergency Preparedness" and will expand to include procedures for the Communication Plan. All facility staff will receive training on the plan and participate in practice implementation. New staff will be trained at hire and annually thereafter as part of required emergency preparedness training. 4) The emergency preparedness Communication Plan will be provided to the WTCSB EMC for review. Evidence of staff training will be maintained in training records on site that include training content, attendance, and materials. 5) Completion Date: 8/31/18	

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E 029 Continued From page 7

stated, we don't have a written communication plan.

E 029

E 030 Names and Contact Information
CFR(s): 483.475(c)(1)

[(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]

(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [facilities].
(v) Volunteers.

*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Next of kin, guardian, or custodian.
(iv) Other RNHCIs.
(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.

E 030

1) The REMT will revise the Communication Plan inclusive of all required elements, including all facility staff, family and resident contact information.

2) The REMT determined there are no new individuals slated for admission prior to the scheduled development of the Communication Plan.

3) The REMT will compile a list of all facility contact information for inclusion in the Communication Plan.
3a) The list will include any vendors providing service to the facility during an emergency, such as utilities, medical providers, generator service, etc. All facility staff will be trained on the use and maintenance of the lists.

4) The QIDP will ensure the list is updated at time of incoming and departing staff or residents, and throughout the year as information changes for other entities on the contact list. The REMT will review the list at least annually to ensure it is current and accurate. The emergency preparedness Communication Plan will be provided to the WTCSB EMC for review. The Utilization Review Supervisor or designee will check the Communication Plan for all components during annual facility inspections.

5) Completion Date: 8/31/18

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E 030 Continued From page 8 — E 030

(iii) Patients' physicians.
(iv) Volunteers.

*[For Hospices at §418.113(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Hospice employees.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Other hospices.

*[For OPOs at §486.360(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Volunteers.
(iv) Other OPOs.
(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).
This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have all facility contact information in the communication plan.

The findings included:

An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP was asked for names and contact information for all facility staff, as well as entities providing services under agreement during an emergency. The contact information did not include vendors providing services to the facility during an emergency.

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E 032 Continued From page 9

E 032 Primary/Alternate Means for Communication
CFR(s): 483.475(c)(3)

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(3) Primary and alternate means for communicating with the following:
(i) [Facility] staff.
(ii) Federal, State, tribal, regional, and local emergency management agencies.

*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.
This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to develop an emergency preparedness communication plan which included alternate means of communication in an emergency.

The findings included:

An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated, the facility had no alternate means to communication.

E 032

1) The REMT will develop a written emergency preparedness Communication Plan inclusive of all required elements, including alternate means of communication in an emergency.

2) The REMT determined there are no new residents slated for admission prior to the scheduled development of the Communication Plan.

3) The REMT will develop written procedures outlining alternate means of communication during an emergency. The facility is registered with the VHASS. Procedures will address the use of back up cellphones, maintaining a landline, and recharging phones by generator and/or portable chargers. Procedures will outline when and how to use identified alternate methods, and will specify roles and responsibilities for doing so. Procedure for a "boots on the ground" alternative will be included to implement in the event of total loss of contact. The procedures will be included in the emergency preparedness Communication Plan. All facility staff will be trained on the Communication Plan and will practice implementation. All new staff will be trained at hire and annually thereafter.
4) Maintenance of alternate communication equipment will be tracked on the weekly facility building inspection form. The QIDP will review the form and ensure that any noted required equipment maintenance is facilitated. The Communication Plan will be provided to the WTCSB EMC for review. The Utilization Review Supervisor/designee will audit the Communication Plan for all components during annual facility inspections.
5) Completion Date: 8/31/18

E 033 Methods for Sharing Information
CFR(s): 483.475(c)(4)-(6)

[(c) The [facility] must develop and maintain an emergency preparedness communication plan

E 033

1) The REMT will develop a written emergency preparedness Communication Plan inclusive of all required elements, including a method for sharing information and medical documentation to maintain continuity of care.

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E 033 Continued From page 10

that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]

(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.

*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have documentation that the communication plan included a method for

E 033

2) The REMT determined there are no new residents slated for admission prior to the scheduled development of the Communication Plan. Information and medical documentation for any new admission will be added to their Emergency Packet.

3) The REMT will develop written procedures outlining a method for sharing information and medical documentation with other health providers in order to maintain continuity of care during an emergency, whether evacuating or sheltering in place. Procedures will specify information to be included in an Emergency Packet for each resident. Duplicates of the Emergency Packet will be included in the resident's "go bag" as well as readily accessible to staff. All facility staff will be trained on the emergency preparedness Communication Plan, including procedures for sharing information and medical documentation. All new staff will be trained at hire and annually thereafter.

4) The QIDP will ensure Emergency Packets for all individuals are current and accurate by reviewing them quarterly. The REMT will review the emergency preparedness Communication Plan annually and will provide it to the WTCSB EMC for review. The Utilization Review Supervisor/designee will audit the plan for all components during annual facility inspections. Evidence of staff training will be maintained in training records on site that include training content, attendance sheets, and materials.

5) Completion Date: 8/31/18

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E 033	Continued From page 11 sharing information and medical documentation to maintain continuity of care. The findings included: An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated, they did not have documentation for sharing information and medical care needs for residents in an alternate care site.	E 033		
E 034	Information on Occupancy/Needs CFR(s): 483.475(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or	E 034	1) The REMT will develop a written emergency preparedness Communication Plan inclusive of all required elements, including a means of providing information about occupancy, needs, and ability to provide assistance. This information will be reported to the Incident Commander in the event of a disaster, when changing to the ICS systems and/or every 12 hours during an event. 2) The REMT determined there are no new residents slated for admission prior to the scheduled development of the Communication Plan. In the event of incoming and departing residents or staff, the facility's occupancy, needs, and ability to provide assistance will be adjusted accordingly. 3) The REMT will develop a script to be included in the emergency preparedness Communication Plan that documents the facility's occupancy, needs, and ability to provide assistance during an emergency. In the event of an emergency the facility will update the clinical status on the LTC board with the VHASS. The script will help facilitate the facility's ability to provide assistance in real time. It will include the facility's occupancy at the time and the ability to provide assistance, based in part on that occupancy. The script will also specify the types of needs the facility has at that time. It will be updated whenever there is a change and will be maintained in the Emergency Preparedness Binder. All facility staff will be trained on this reporting process of the Communication Plan, to include practice using the report. All new staff will be trained at hire and annually thereafter.	

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E 034 Continued From page 12

designee.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have documentation about the facility's occupancy needs and its ability to provide assistance.

The findings included:

An interview was conducted on 7/20/18 at 11:15 a.m., with the Qualified Intellectual Disabilities Professional (QIDP). The QIDP was asked for documentation for identifying the needs of the facility, including the residents as well as the facilities ability to provide assistance to the Incident Command Center. The QIDP stated, the facility had not identified the needs of the residents nor how the facility would provide assistance.

E 034 (Plan of Correction)

4) The QIDP will ensure the script is maintained in the emergency preparedness binder. The Utilization Review Supervisor will audit the Communication Plan during annual facility inspections for all components. The Communication Plan will be provided to the WTCSB EMC for review. Evidence of staff training will be maintained in training records on site that include training content, attendance, and materials.
5) Completion Date: 8/31/18

E 035 LTC and ICF/IID Sharing Plan with Patients
CFR(s): 483.475(c)(8)

[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have a method for sharing information of the Emergency Preparedness Plan with clients, representatives and families.

E 035 (Plan of Correction)

E035 1a) The facility shared information about the Emergency Preparedness Plan with each resident's AR/guardian via letter sent in February 2018. The letter provided the address of WTCB's designated Command Center and explained that in the event of an evacuation to the command center or other site, they would be contacted via telephone with information regarding the evacuation site, emergency numbers to contact facility staff, and the intended duration of the evacuation. A copy of the letter is located in the correspondence section of each resident's record. 1b) The facility provides information about the Emergency Preparedness Plan to families/ARs/Guardians within 30 days prior to admission per Policy #837 Admission Overview. Facility staff review the Individual Orientation Checklist which includes goal #4: "Explanation of Fire Detection System and equipment including identification of evacuation exits, fire alarm pull stations, audio/visual alarms and smoke detectors. Also shown location of evacuation site." Information is also shared via the PCP, developed at admission and updated at least annually. Part I of the PCP, Essential Information, includes emergency contact information. Also, the "Back up Plan" section of Part I includes description of "plans that will be followed if support cannot be provided as agreed (such as when staff are unavailable or in the event of an emergency)." The REMT will expand the method for sharing information of the Emergency Preparedness Plan with residents, their AR/Guardian, and families. It will include alternate forms of communication for residents. The method will be included in the facility's emergency preparedness Communication Plan.

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E 035	Continued From page 13 The findings included: An interview was conducted on 7/20/18 at 11:15 a.m., with the Intermediate Qualified Intellectual Disabilities Professional (QIDP). The QIDP stated, the facility had not informed residents and families about the emergency preparedness plan and currently the facility staff had no method to share information of the emergency preparedness plan with residents and families.	E 035	2) The REMT determined there are no new residents slated for admission prior to the scheduled development of the Communication Plan. In the event of any new admissions, the facility will inform the resident, their AR/Guardian, and family about the emergency preparedness plan at date of admission and annually thereafter. 3) The REMT will determine information from the Emergency Preparedness Plan that is appropriate for sharing with residents and their families and/or AR/Guardians. Information about the revised plan will be shared at each resident's next annual IDT meeting. The facility will provide a Fact Sheet to individuals, their AR/Guardians and families of pertinent sections of the emergency preparedness plan. 4) The QIDP will ensure documentation of informational letters mailed to the residents' families and AR/Guardians about the emergency preparedness plan. The emergency preparedness Communication Plan with all components will be provided to the WTCSB EMC for review annually. 5) Completion Date: 8/31/18	
W 000	INITIAL COMMENTS The unannounced Fundamental Medicaid re-certification survey was conducted 7/18/18 through 7/20/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Disabilities. (ICF/IID) Federal Regulations. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 10 bed facility at the time of the survey was 10. The survey sample consisted of 3 current Individual records (Individual #1 through #3).	W 000		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on observation, staff interviews, and clinical record review, the facility staff failed to revise the individual program plan (IPP) at least	W 260	1) The psychologist consultant was notified to review Client #1's Behavior Support Plan (BSP) with regard to medication refusal and update as necessary based on available data. The revised BSP written 7/25/18 includes Procedure #4d "If there are repeated refusals of any particular medication the Nurse should contact the prescribing Physician to inquire as to whether the medication might be prescribed in a different form or according to a different schedule". Client #1's Person Centered Plan (PCP) medication outcome	

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W 260 Continued From page 14
annually for 1 of 3 clients (Client #1), in the survey sample.

The facility staff failed to revise Client #1's IPP for refusal of medications after the current plan interventions had been ineffective for 3 years.

The findings included:

Client #1 was originally admitted to the facility 7/19/12. The current diagnoses included; severe intellectual disability and bipolar 1 disorder. The Client makes her needs known by gesturing.

During the medication pass and pour observations on 7/18/18 at approximately 5:05 p.m., Residential Technician #3 asked Client #1 from the door if she was going to take her medications. Client #1 made some mumbling sounds and waved Residential Technician #3 to move on. Residential Technician #3 then removed 5 medications form the packaging, put them in a medication cup and attempted to administer the medications to Client #1, by handing the cup to the client. Client #1 was observed waving her hands for the Residential Technician #3 to leave her room because she wasn't willing to accept the medications.

Review of Client #1's most recent Behavioral Support Plan dated 8/21/15 for Targeted behaviors: Refusal of staff requests (including medications and meals). Procedure 5f., read; If (name of client) refuses medications at the beginning of the time of the "medication window" staff should say nothing to her but should return once every 30 minutes to ask again. Staff should continue to ask her to take her medications every 30 minutes during the "medication window".

W 260 references existing physician orders that Client #1 "may receive medications and treatments outside of med room for medical necessity" and "only when resident refuses meds may be given outside the scheduled time orders. Morning meds maybe given until 12 noon and afternoon meds may be given until 12 midnight." This could support Client #1's potential preferences for staff members who work various hours.

2) BSPs for any other residents in the facility who have one will be reviewed to ensure that any changes related to target behaviors of the BSP which occurred since the last PCP have been addressed.

3) Target behavior data for all individuals with a BSP is reviewed and reported monthly by the psychologist consultant. Staff input is also solicited and reported. The report is reviewed by the IDT at quarterly meetings and as necessary or at request of any team member to ensure the Individual's PCP is responsive to the individual's needs and desires. The QIDP reviews the status of PCP outcomes monthly. Recommendations from any team member for changes, additions, or evaluations is solicited and implemented as recommended. The QIDP and Residential Counselor will ensure staff are accurately recording target behavior data. All facility staff will receive a review of related Policy #857 Interdisciplinary Team. #815 Specially Constituted Committee.

4) BSPs will continue to be reviewed and approved by the Specially Constituted Committee (SCC) which identifies targeted behaviors to decrease/eliminate or increase, specifies any plans to reduce the use of restrictive devices (BSPs), and examines the number of targeted behavior occurrences since the last review.

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Procedure 5g. read; Staff may offer to bring her medications to (name of client) in her room, but must administer the medications following the same instructions that pertain to the administration of medications in the medication room. Procedure 5h., read; If (name of client) has not taken her medication within the time window, staff will document this as a refusal and will contact the Nurse on Call. Procedure 5i., read; The Physician or Psychiatric Nurse Practitioner may write orders stating that some medications can be given at any time of the day. Staff should give these medications at any time that (name of the resident) indicates that she is willing to take them.

An interview was conducted with Residential Counselor #1, on 7/19/18 at approximately 5:10 p.m. Residential Counselor #1 stated Client #1 refuses her medications daily but there are several staff members who works various hours, she is likely to accept the medications from when they approach her. Residential Counselor #1, also stated no other interventions have been tried to improve the client's compliance with medication acceptance but; the Behavioral Support Plan interventions are followed as written. Residential Counselor #1 stated the client's new plan takes effect 8/1/18 and it continues the same medication support plan interventions.

On 7/20/18, the above findings were shared with the Clinical Administrator, the Qualified Intellectual Disabilities Professional, Residential Counselors and Licensed Practical Nurse. The above facility staff acknowledged that the Behavior Support Plan needs to be reviewed and revise with new interventions and the

W 260 The Clinical Services Administrator will review all BSPs as they are developed and approved by SCC prior to implementation. Evidence of staff training will be recorded in training records of the personnel files.

5) Completion Date: 8/31/18

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Psychologist would be notified to updated the plan.

W 260

W 323 PHYSICIAN SERVICES
CFR(s): 483.460(a)(3)(i)

The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.

This STANDARD is not met as evidenced by:
Based on staff interviews, clinical record review, and review of the facility's policy the facility staff failed to obtain annual physical examinations for 2 of 3 residents (Client #1 and 2), in the survey sample.

1. The facility staff failed to ensure Client #1 received an annual hearing evaluation.

2. The facility staff failed to ensure Client #2 received an annual hearing evaluation.

The findings included:

1. Client #1 was originally admitted to the facility 7/19/12. The current diagnoses included; severe intellectual disability and bipolar 1 disorder. The Client makes her needs known by gesturing. Client #1 has a history of receiving education at the Virginia School for the Deaf and Blind, where she learned how to sign somewhat.

A Speech Language Pathologist (SLP) Evaluation Report dated 7/9/18, revealed this was the client's annual SLP assessment but her "hearing was not

W 323

1) A hearing evaluation has been scheduled for Client #1 with an audiologist on 9/5/18 at 9:45 am at Connect Hearing. Client #2 received an examination on 2/22/17 by an audiologist. Treatment received included cerumen removal bilateral, and it was determined ears/nose/throat was within normal limits. The audiologist recommended Debrox monthly, and a follow up audiogram in 2 years. A hearing evaluation has been scheduled for Client #2 with an audiologist on 10/25/18 at 10:00am at EVMS.

2) A review of all residents records was conducted to determine if annual hearing evaluations have been performed. Hearing evaluations will be scheduled for each resident.

3) The facility form "WTCSB Physical Examination" will be modified to include the baseline established by the audiologist evaluation, the physician's screening, and any follow up examinations or referrals ordered as indicated by the screen.

4) The facility Nurses will report when the hearing evaluations are completed and follow up with any orders/recommendations. Reports will be reviewed by the IDT quarterly and as necessary. The QIDP will ensure resident records include documentation of hearing evaluations as recommended/ordered by the physician annually.

5) Completion Date: 8/31/18

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formally assessed, but informal observation indicated that she may have hearing deficits".

A hearing evaluation for Client #2 was not observed in the clinical record and one couldn't be located by the facility staff.

2. Client #2 was originally admitted to the facility 6/24/13. The current diagnoses included; profound intellectual disability, cerebral palsy with quadriplegia and contractures, epilepsy, blindness and use of a gastrostomy tube related to dysphagia. The staff reports the client is non-verbal.

A SLP Evaluation Report dated 5/17/18, revealed this was the client's annual SLP assessment. Under hearing the SLP noted, "there are no reports hearing deficits. (name of client) is known to enjoy listening to lullabies and music.

A hearing evaluation for Client #2 was not observed in the clinical record and one couldn't be located by the facility staff.

On 7/20/18, the above findings were shared with the Clinical Administrator, the Qualified Intellectual Disabilities Professional, Residential Counselors and Licensed Practical Nurse. The above facility staff acknowledged that there were no hearing evaluations for the above clients; they stated they would began arranging a hearing evaluation along with other annual evaluations.

W 460 FOOD AND NUTRITION SERVICES
CFR(s): 483.480(a)(1)

Each client must receive a nourishing, well-balanced diet including modified and

W 460 — 1) The facility nurse notified the Registered Dietitian on 7/19/18 for guidance to ensure Client #2 was receiving a nutritionally balanced diet after a medical order suspended "pleasure feedings" pending clearance by the Speech Therapist. The RD provided a new

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specially-prescribed diets.

This STANDARD is not met as evidenced by:
Based on observation, staff interviews, and clinical record review, the facility staff failed to ensure 1 of 3 clients, (Client #2), in the survey sample; received a nourishing, well-balanced diet.

The facility staff failed to ensure Client #2 received a 1200 calorie diet daily and notify the Registered Dietitian for guidance to ensure the client was receiving a nutritionally balanced diet after medical complications were identified.

The findings included:

Client #2 was originally admitted to the facility 6/24/13. The current diagnoses included; profound intellectual disability, cerebral palsy with quadriplegia and contractures, epilepsy, blindness and use of a gastrostomy tube (G-tube) related to dysphagia and esophageal reflux. The staff reports the client is non-verbal.

Client #2 annual nutrition assessment dated 6/10/18 revealed the following nutritional information; 1200 calorie diet (8 ounces of Jevity 1.0 administered via G-tube in 10-15 minute bolus feed 3 times per day. Before each meal followed by 100 milliliters (ml) of water flush). "Pleasure feed" 3 times each day at meals of up to 2 tablespoons of 3 puree appropriate food items which may be selected from the regular house menu if appropriate. Approximately 100 calories and 1 item must be a protein source.

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assessment for temporary feeding recommendations to modify the tube feed schedule to account for the calories lost from the omitted pleasure feeds. Client #2 was weighed weekly per the RD's recommendation until feeding recommendations were determined, then weekly weights were continued as per the physician order.

2) All residents records will be reviewed by facility nursing, the QIDP, and the Residential RN Consultant to ensure that nutritional needs are being provided per recommendations made by the RD and ordered by the physician.

3) Facility Nursing developed policy for the "Return of Individual after Hospital Discharge". Procedures list facility services to be provided upon return from hospital to include but not limited to: "a. complete head-to-toe body assessment of individual to include vital signs and weight"; and e. "consultations and assessments provided by appropriate consultants to include dietitian, occupational therapist, physical therapist, or speech therapist. The outcome of that information will be conveyed to the primary care physician to determine if any new physicians orders are needed or existing orders to be modified"; and "g. follow-up/referral with healthcare provider to include specialist as recommended/ordered by hospital physician and/or PCP". All facility staff will be trained on the policy when approved.

4) The facility QIDP and/or the Residential Nursing Coordinator will review all hospital discharges to ensure appropriate facility services are provided per policy. The Residential RN Consultant will review hospital discharges monthly.

5) Completion Date: 8/31/18

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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
	49G056	A. BUILDING ______ B. WING ______	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	**PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439**

(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
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Puree diet consistency is a smooth texture, no sticky or gummy foods; example peanut butter and jelly sandwich, no thin liquids. Liquids by mouth thickened to a soft pudding consistency using thickening instructions on dining guide , may use clear diet soda, water or apple juice, give 4-5 teaspoons after each meal ; 8 a.m., 1 p.m., 6 p.m. Low calorie evening snack; 4 ounces of smooth flavors of pudding or yogurt. Additional water flushes via G-tube following the recommended time and volume schedule, (6 a.m., 130 ml, with medications, 8 p.m., 240 ml). Recommend room temperature water and Jevity 1.0 administered slowly to decrease risk of discomfort. 24 french G-tube currently used, (10 french or larger is recommended for Jevity feeds); Nylon coated spoon for by mouth foods. The "meal plan provide 1200 + evening snack. Protein 40 grams daily minimum, fluid minimum 1730 ml daily (goal 7 x 8 ounce cups daily".

Client #2 presented to the hospital with cough, congestion and a low grade fever 7/4/18. The client was hospitalized 7/4/18 through 7/9/18; "for sepsis, pneumonia of the right lower lobe and a urinary tract infection. The discharge summary stated; High risk for recurrent aspiration. Diet as follows; tube feedings only for nutrition for now until seen and cleared by speech therapy in the outpatient setting for pleasure feeding."

The electronic medication record (e-mar) Physician Order revealed, Client #2 received Jevity 1.0; 1 can (8 ounces) bolus via G-tube 3 times daily. The Jevity container; read 8 fl oz/237 ml and 250 calories and 10.4 Grams of protein per 8 ounce serving.

On 7/19/18 at 12:05 p.m., an observation of the

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tube feeding via G-tube was conducted. Client #2 received 1 container of Jevity 1.0 and 100 ml of water flush via peg tube after G-tube placement was confirmed.

During meal observations; 7/18/18 at 5:30 p.m. and 7/19/18 at 5:15 p.m., Client #2 was not observed receiving "pleasure meals".

Client #2's last recorded weight was 119 pounds 6/2018. The facility staff didn't obtain a weight upon readmission from the hospital. A weight was obtained 7/19/18 and presented as 119.4 pounds.

Client #2 was evaluated by the speech therapist 7/16/18. The speech therapist stated Client #2 had a persistent cough after her meal and pleasure feedings be reduced to 1/2 cup of pureed per day not per meal and staff continue to document daily if a delayed cough is evident. The new plan was not started on 7/16/18 because Client #2's sister desired to think about the recommendations to reintroduce by mouth intake.

An interview was conducted with on 7/19/18 with Licensed Practical Nurse (LPN) #1. LPN #1 stated Client #2 was not accepting any nutritional intake by mouth because they were waiting for the sister to authorize the speech therapist recommended plan. LPN #1 stated Client #2 was receiving 3 containers of Jevity 1.0 via G-tube only at 8 a.m., 12:00 p.m., and 4:00 p.m. LPN #1 also stated the Registered Dietitian (RD) hadn't involved in Client #2's care during the changes because no one said the RD should be contacted.

It was brought to LPN #1's attention 7/19/18, at approximately 4:45 p.m., that the annual

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nutritional assessment completed on 6/10/18, stated that Client #2 should receive 1200 calories and 40 grams of protein per day and currently she was receiving only 750 calories and 31.2 grams of protein each day because the pleasure meals were on hold.

On 7/20/18, at approximately 11:30 a.m., the facility staff presented a new assessment dated 7/19/18, from the RD regarding Client #2's nutritional recommendations. The document read; Temporary Feeding Recommendations for (name of client) while nothing by mouth (NPO). The RD documentation stated it is necessary to modify Client #2's Jevity tube feed schedule to account for the calories lost from the omitted pleasure feeds. The RD stated the pleasure feeds provided approximately 300-400 calories daily and as a temporary measure, it is recommended that an additional Jevity tube feed of 240 ml/1 can be added in the evenings around 7-8 p.m. Further instructions stated the 7-8 p.m., feed should be followed by a water flush of 100 ml, this would replace the 240 ml at 8 p.m. The RD also stated while the 4 Jevity feedings only totaled 1,000 calories per day, it was only a temporary measure and if the client remained NPO beyond 7/27/18 that she be notified for recommendations of an additional 200 calories would be provided. The RD asked that Client #2 be weighed weekly for the time being, until final feeding recommendations had been determined and well established.

On 7/20/18, the above findings were shared with the Clinical Administrator, the Qualified Intellectual Disabilities Professional, Residential Counselors and Licensed Practical Nurse #1. The above facility staff was offered the opportunity to

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	49G056	A. BUILDING ______ B. WING ______	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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

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present additional information but; stated they had nothing further to present.

Definitions:

gastrostomy tube; a tube inserted through the abdominal wall and into the stomach for feeding or drainage.

dysphagia; difficulty swallowing

W 468 MEAL SERVICES
CFR(s): 483.480(b)(1)

Each client must receive meals at regular times comparable to normal mealtimes in the community.

This STANDARD is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to ensure mealtimes didn't result in gross time variations for 1 of 3 residents (Resident #2), in the survey sample.

The facility staff failed to ensure Client #2 did not exceed 14 hours between the evening meal and breakfast.

The findings included:

Client #2 was originally admitted to the facility 6/24/13. The current diagnoses included; profound intellectual disability, cerebral palsy with quadriplegia and contractures, epilepsy, blindness and use of a gastrostomy tube (G-tube) related to dysphagia and esophageal reflux. The staff reports the client is non-verbal.

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1) The facility nurse notified the Registered Dietitian on 7/19/18 for guidance to ensure Client #2 was receiving a nutritionally balanced diet after a medical order suspended "pleasure feedings" pending clearance by the Speech Therapist. The RD provided a new assessment for temporary feeding recommendations to modify the tube feed schedule to account for the calories lost from the omitted pleasure feeds. The RD contacted Client #2's Authorized Representative (AR) on 7/23/18 for approval of the 10 day reduced pleasure feed trial recommended by the Speech Therapist. The trial was initiated 7/25/18. Client #2's weight is 121lbs. Facility nurse notified the RD at completion of the trial. The RD recommended to add 2 oz. to the current Jevity 1.0 feedings qid (4 times a day), until such time an order for Jevity1.2 is received, then begin Jevity 1.2 qid (4 times a day) and weigh weekly.

2) All the residents records will be reviewed by facility QIDP and Nurse for evidence that there is not more than 14 hours between a substantial evening meal and breakfast of the following day for any resident.

3) The Utilization Review Supervisor will provide a review of ICF/IID standards for Food and Nutrition Services to the RD and all facility staff.

4) The RN Nursing Coordinator will review all diet

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Client #2 annual nutrition assessment dated 6/10/18 revealed the following nutritional information; 1200 calorie diet (8 ounces of Jevity 1.0 administered via G-tube in 10-15 minute bolus feed 3 times per day. Before each meal followed by 100 milliliters (ml) of water flush). "Pleasure feed" 3 times each day at meals of up to 2 tablespoons of 3 puree appropriate food items which may be selected from the regular house menu if appropriate. Approximately 100 calories and 1 item must be a protein source. Puree diet consistency is a smooth texture, no sticky or gummy foods; example peanut butter and jelly sandwich, no thin liquids. Liquids by mouth thickened to a soft pudding consistency using thickening instructions on dining guide , may use clear diet soda, water or apple juice, give 4-5 teaspoons after each meal ; 8 a.m., 1 p.m., 6 p.m. Low calorie evening snack; 4 ounces of smooth flavors of pudding or yogurt. Additional water flushes via G-tube following the recommended time and volume schedule, (6 a.m., 130 ml, with medications, 8 p.m., 240 ml). Recommend room temperature water and Jevity 1.0 administered slowly to decrease risk of discomfort. 24 french G-tube currently used, (10 french or larger is recommended for Jevity feeds); Nylon coated spoon for by mouth foods. The "meal plan provide 1200 + evening snack. Protein 40 grams daily minimum, fluid minimum 1730 ml daily (goal 7 x 8 ounce cups daily".

Client #2 presented to the hospital with cough, congestion and a low grade fever 7/4/18. The client was hospitalized 7/4/18 through 7/9/18; "for sepsis, pneumonia of the right lower lobe and a urinary tract infection. The discharge summary stated; High risk for recurrent aspiration. Diet as

W 468 orders for each resident monthly, to ensure there are not more than 14 hours between substantial evening meals and breakfast of the following day. The Residential RN Consultant will review all diet orders during her monthly audit.

5) Completion Date: 8/31/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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follows; tube feedings only for nutrition for now until seen and cleared by speech therapy in the outpatient setting for pleasure feeding."

The electronic medication record (e-mar) Physician Order revealed, Client #2 received Jevity 1.0; 1 can (8 ounces) bolus via G-tube 3 times daily. The Jevity container; read 8 fl oz/237 ml and 250 calories and 10.4 Grams of protein per 8 ounce serving.

On 7/19/18 at 12:05 p.m., an observation of the tube feeding via G-tube was conducted. Client #2 received 1 container of Jevity 1.0 and 100 ml of water flush via peg tube after G-tube placement was confirmed.

During meal observations; 7/18/18 at 5:30 p.m. and 7/19/18 at 5:15 p.m., Client #2 was not observed receiving "pleasure meals".

Client #2 was evaluated by the speech therapist 7/16/18. The speech therapist stated Client #2 had a persistent cough after her meal and pleasure feedings be reduced to 1/2 cup of pureed per day not per meal and staff continue to document daily if a delayed cough is evident. The new plan was not started on 7/16/18 because Client #2's sister desired to think about the recommendations to reintroduce by mouth intake.

An interview was conducted with on 7/19/18 with Licensed Practical Nurse (LPN) #1. LPN #1 stated Client #2 was not accepting any nutritional intake by mouth because they were waiting for the sister to authorize the speech therapist recommended plan. LPN #1 stated Client #2 was receiving 3 containers of Levity 1.0 via G-tube only at 8 a.m., 12:00 p.m., and 4:00 p.m. LPN #1

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also stated the Registered Dietitian (RD) hadn't involved in Client #2's care during the changes because no one said the RD should be contacted.

It was brought to LPN #1's attention 7/19/18, at approximately 4:45 p.m., that the annual nutritional assessment completed on 6/10/18, stated that Client #2 should receive an evening snack each day but that wasn't occurring because the pleasure meals were on hold. Client #2 wasn't receiving any nutritional intake from the time of administration of the 4:00 p.m. tube feeding until the 8:00 a.m. tube feeding was administered; totaling approximately 16 hours.

On 7/20/18, at approximately 11:30 a.m., the facility staff presented a new assessment dated 7/19/18, from the RD regarding Client #2's nutritional recommendations. The document read; Temporary Feeding Recommendations for (name of client) while nothing by mouth (NPO). The RD documentation stated it is necessary to modify Client #2's Jevity tube feed schedule to account for the calories lost from the omitted pleasure feeds. The RD stated the pleasure feeds provided approximately 300-400 calories daily and as a temporary measure, it is recommended that an additional Jevity tube feed of 240 ml/1 can be added in the evenings around 7-8 p.m. Further instructions stated the 7-8 p.m., feed should be followed by a water flush of 100 ml, this would replace the 240 ml at 8 p.m. The RD also stated while the 4 Jevity feedings only totaled 1,000 calories per day, it was only a temporary measure and if the client remained NPO beyond 7/27/18 that she be notified for recommendations of an additional 200 calories would be provided. The RD asked that Client #2

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be weighed weekly for the time being, until final feeding recommendations had been determined and well established.

On 7/20/18, the above findings were shared with the Clinical Administrator, the Qualified Intellectual Disabilities Professional, Residential Counselors and Licensed Practical Nurse #1. The above facility staff was offered the opportunity to present additional information but; stated they had nothing further to present.

Definitions:

gastrostomy tube; a tube inserted through the abdominal wall and into the stomach for feeding or drainage.

dysphagia; difficulty swallowing

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