STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 000	INITIAL COMMENTS The unannounced annual Medicaid survey was conducted on 03/08/16 through 03/10/16. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities (ICF/IID) Federal Regulations.The Life Safety Code survey report will follow. The census in this 24 bed facility at the time of the survey was 20. The survey sample consisted of 7 current individual records (Individuals #1 through #7).	W 000	RECEIVED APR 0 1 2016 VDH/OLC	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review, and staff interview the facility staff failed to provide training to staff following a medication error involving one Individual (Individual #1) and one Individual {Individual #2) medications were not available, in the survey sample of eight (8) individuals. The findings included: 1. Individual #1 was admitted to the facility on 6/17/08 with diagnoses of Traumatic brain injury, organic mental disorder, moderate intellectual disability, left hemiplegia, hiatal hernia, seizures and erosive esophagitis. Individual #1 received two flu shots in a period of 30 days. The facility staff failed to provide staff training to enable staff	W 189	All Nursing staff received a documented training regarding this incident on January 21, 2016. The particular nurse involved in the duplicate administration was counseled by the Nurse Manger in December 2015. Overnight staff preparing the medical consultations for the next day's appointments , as well as day shift staff, will be re-trained to review the consultation request with the nurse on duty prior to departing for appointments. Facility will review and restructure, as needed, the healthcare binder to allow for easier sorting and identification of information. All immunizations will be recorded into the Electronic Health Record within 72 hours to ensure ample documentation and verification opportunities.	1/21/16 4/22/16 4/22/16 4/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPUER REPRE5ENTATIVES' SIGNATURE	TITLE	(X6) DATE
Tim Capodo	Facility Manager	3/31/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	C. BUILDING _____ D. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 189	Continued From page 1 to perform their duties effectively, efficiently and competently. An 11/16/15 Incident Report indicated: "A review of Individual #1's medical chart at (0007) on 11/16/15 indicated he had received a flu shot from his primary care physician on 10/13/15 and then another flu shot on 11/15/15 at a local pharmacy. Individual #1 was accompanied by facility staff when he received the second flu shot on 11/15/15. Both flu shots were documented in his medical chart." A Person Centered Review Plan dated 10/13/15 through 1/15/16 indicated: "Health Care-Neurology-No seizures for quite a long lime, Redness to eye; diagnosed as dermatitis." A Facility Shift Report dated 10/12/15 (6:00A.M.-2:30P.M.) Indicated:"Called for appointment for yearly flu shot (to be given) 10/13/15 at 11:00 A.M... Shift Report 10/13/15 (6:00 A. M.-2:30 P.M.), Shift Report 10/13/15 -(2:30P.M.- 10:30 P.M.) Flu shot to right Deltoid; 10/13/15 (10:00 P.M. -7:00A.M.) Flu shot given to right Deltoid. Shift Report- 10/14/15 (6:00A.M. -2:30P.M.) Flu shot given right Deltoid. A Medical Consultation form dated 10/13/15 Indicated: "Individual #1 was assessed by the doctor in check up and prescribed a cream and medication prescriptions to filled and also a Flu shot was given (Right Arm)." An Immunization Record indicated: "Flu Vaccine named Pharmacy" 11/15/15. During an interview with the Nurse Manager on 03/10/16 at 10:30 A.M. she stated, we did not	W 189	A documented training occurred with all nursing staff on February 17, 2016. A separate training occurred with direct care staff on March 2, 2016 that included ensuring medication availability and staff signed a memo which discussed incident reporting. Bulk medications inventoried weekly will be marked with an anticipated re-order date and/or triggers for re-ordering, i.e., when there are only ten pills remaining, and/or when there is half a bottle remaining, etc, these triggers will be set based on historical use of the medication and delivery method of the medication. Anticipated re-order dates or triggers will be clearly visible to all staff administering the medication and/or completing the inventory. For individuals that have medications that are ordered on an as needed basis will have all relevant medication orders reviewed and medication packages marked with an anticipated re-order date as noted above. All staff will be trained on the re-ordering dates and/or triggers. Medication Inventory Policy will be updated to include identifying the anticipated re-order date and/or trigger for all bulk medications. All staff will be trained on the follow up procedure for ordering needed medications or supplies. Procedures will include that the item in question will be reported out each shift and will be addressed each shift by the Nurse on duty or by the shift leader and the Registered Nurse on call, if necessary. If medication is not received an incident report will be completed for each missed dose of medication.	3/9/16 4/22/16 4/22/16 4/2216

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	E. BUILDING _____ F. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 189	Continued From page 2 re-train staff following this incident. During an interview on 3/10/16 at 1:30 P.M. with the House Manager she stated, we did not re-train staff nor change policy. Staff took Individual #1 to get a second flu shot without checking with the Nurse Manager. 2. Facility staff failed to provide staff training following a medication not being reordered timely for Individual #2. Individual #2 was admitted to the facility on 8/27/08. Diagnoses for this Individual included Quadriplegic, Cerebral palsy; G-tube (gastric tube- tube into abdomen), Profound intellectually disabled, Nissen- Wrap (procedure to reinforce esophageal sphincter), scoliosis, Gerd (gastroesophageal reflux disease), seizures, perinatal Asphyxia (deficient supply of oxygen), meconium Aspiration, Coronary artery fistula- heart murmur. An Incident Report dated 2/1/16 indicated: "On 1/31/16 at (0900) and (2100) Benefiber was not given due to unavailability on 1/31/16. Evening Nurse reported unavailability for (0900) dosage and (2100) dosage on the MAR (medication administration record). Benefiber Powder (fiber supplement) was ordered from pharmacy via fax on 1/30/16; but was not received." An Action Plan dated 3/9/16 indicated: "Client did not receive Benefiber on 1/31/16 at (0800-1900) sic. Nursing will be responsible for logging the inventory of Benefiber and calculating the anticipated re-order date based on the amount provided. A bottle label will indicate the date when the bottle is opened and the anticipated date to	W 189	During the weekly nursing audits, nursing staff will review all anticipated re-order dates to ensure there is enough medication to last until the anticipated re-fill date.	4/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	G. BUILDING _____ H. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 189	Continued From page 3 re-order. All staff will be re-educated regarding their responsibility to ensure that the supply of needed medications is available. All staff will be re-educated regarding their responsibility for incident reporting which will be documented through a memo that all staff are required to sign." During the survey a request was made for the facility staff to provide the training and reeducation staff signatures. No signatures or training information was provided during the survey. During an interview with the Nurse Manager on 03/10/16 at 10:30 A.M. she stated, we did not re-train staff following this incident. We were to start this week. During an interview on 3/10/16 at 1:30 P.M. with the House Manager she stated, we did not re-train staff nor change policy. We were to start training this week. The facility staff failed to train staff to perform their duties effectively, efficiently and competently.	W 189		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, staff interviews, facility documentation reviews and clinical record reviews the facility staff failed to ensure that physician orders were followed for two (2) individuals (Individuals #4 and #5) of an eight (8)	W 368	Staff member involved in the medication administration of Individuals #4 and #5 is no longer employed, but all other staff will be re-trained on medication administration proceudres. Quarterly observations of unlicensed staff performing medication administration will include a verbal read back by the unlicensed staff and verification by the licensed staff of any instructions that are specific to an individual.	4/22/16 4/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 368	Continued From page 4 individual survey sample. 1. For Individual #4 physician orders were not followed for the administration and flushing of a Mic Key Button (direct stomach access) during a Medication Pass observation performed on 03/09/16. 2. For Individual #5 physician orders were not followed for the administration and flushing of a Mic Key Button during a Medication Pass observation performed on 03/09/16. The findings included: 1. Individual #4 was originally admitted to the facility on 05/06/2008. Diagnoses included but were not limited to Profound Intellectual Disability, Seizure Disorder, Legally Blind, Scoliosis which caused the Individual to receive enteral feedings and fluids via a MicKey Button (a surgically inserted gastrostomy tube (G-tube) is a special tube in the stomach that will help deliver food and medicines https://www.nlm.nih.gov/medlineplus). On 03/09/16 at approximately 7:10 a.m., a Medication Pass was observed with MR/Assistant (Mental Retardation) #1. In preparation for Individual #4's Medication Pass MR/Assistant #1 was observed placing 5 cc (cubic centimeters which equals about 1 teaspoon) of water into each of five (5) souffle cups which could hold 30 cc (equals about one ounce) each. MR/Assistant #1 then crushed four tablets separately and put each crushed tablet into the one of the souffle cups which contained 5 ccs of water. The capsule was opened and the contents put into the remaining souffle cup with 5 cc of water. She then swished each medication around in the water solution to create a liquid	W 368	All licensed and unlicensed staff performing medication administration will be required to sign off annually on each individuals medication administration instructions. Facility will continue quarterly medication observations of unlicensed staff and semi-annual competency reviews for all the unlicensed staff being delegated the task of medication administration, feeding either continuous or bolus and flushes via a Gastrostomy Tube, to include any specialized instructions for each individual. Gastrostomy Tube Policy will be updated.	4/22/16 4/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	C. BUILDING _____ D. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 368	Continued From page 5	W 368		

mixture. Prior to administering the crushed medications MR/Assistant #1 attached tubing to the Mic Key Button and with a 60 cc syringe and checked for stomach content residual which was approximately 20 cc. MR/Assistant #1 then raised the tubing (gravity technique) with the 60 cc syringe attached which drained the residual of stomach contents back into Individual #4's stomach. No initial flush of water was administered. She then proceeded to administer the physician ordered medications as follows:
Baclofen 10 mg {milligrams) (a muscle relaxant) one (1) lime a day which was followed by 5 ccs of water for a flush.
Oxcarbazepine 300 mg (anticonvulsant to prevent seizures) one (1) time a day which was followed by 5 ccs of water for a flush.
Vitamin D3 400 units (vitamin supplement) one (1) time a day which was followed by 5 ccs of water for a flush.
Lorazepam 0.5 mg (antianxiety) mixed in 5 ccs of water followed by 5 ccs of water for a flush.
Zonisamide Capsule 100 mg (antiseizure) one (1) time a day which was followed with 20 ccs of water for the final flush.
MR/Assistant #1 was then asked after the completion of the Mic Key button administration of the medications how the amounts of water were determined for an initial flush, flush between all medications and the final flush. She stated: "Individual #4 has a fluid restriction and that is the amount of water we use when he gets his medications." When asked how long she had been administering medications at the facility she stated: "For quite a while. This is my last week here and I will be starting work at the (another job named)."
An interview was conducted on 03/09/16 at approximately 11:25 a.m., with the house LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	E. BUILDING _____ F. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 368	Continued From page 6	W 368		

(licensed practical nurse). The aforementioned was discussed with the LPN. When asked if the correct amount of water had been used for Individual #4's Mic Key button administration of his fluids was according to the policy of the facility she stated: "No. There is no set facility policy for administering medications via a Mic Key button. The doctor writes the protocol and and signs it as an order." The LPN then opened Individual #4's medical binder and reviewed the Physician's Order G-tube dated 12/22/15, which noted: "Medication Administration via G-tube: 1. Flush with 30 cc of water to ensure patency of the tube. 2. Crush-meds and mix with 15 cc of water to ensure med will not block the tube. 3. Give one med at a time. 4. Flush with 30 cc of water when all medication is administered." When the LPN was informed of the observations of the Medication Pass administration of individual #4's medication she stated: "MR/Assistant did not follow the doctor's orders."

2. Individual #5 was originally admitted to the facility 10/08/13. Diagnoses included but were not limited to Profound Intellectual Disability, Seizure Disorder, a significant history of UTIs (urinary tract infections), Epilepsy, Dysphagia with silent aspiration (difficulty swallowing) and Spastic Cerebral Palsy.
During observations of a Medication Pass with MR/Assistant (Mental Retardation) #1 on 03/09/16 at approximately 8:05a.m., the following was observed:
After applying the tubing to the Mic Key button and attached a 60 cc syringe, MR/Assistant #1 checked the residual stomach contents and found it to be approximately 30 ccs. The MR/Assistant proceeded to raise the gastrostomy tubing with the syringe still attached so the stomach contents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	G. BUILDING _____ H. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 368	Continued From page 7	W 368		

was returned to Individual #5's stomach. MR/Assistant #1 then proceeded to administer the following medications without doing an initial water flush. The following physician ordered liquid medications were observed to be administered:
Carbamazepine 100 mg/5 ml-(an antacid and calcium supplement) 20 ml (milliliters) to be given three times a day, less than 5 cc of water was used as a flush.
Cervite Liquid 15 ml (a vitamin supplement) to be given via gastrostomy tube twice a day, followed with less than 5 cc of water used as a flush.
Colace Liquid 10 ml (a stool softener and laxative to prevent constipation) twice a day, followed with less than 5 cc of water used as a flush.
Ergocalcciferol1 ml (liquid Vitamin D supplement once a day, followed with less than 5 cc of water used as a flush.
Phenobarbital 20 ml (an anticonvulsant to prevent seizures), followed with less than 5 cc of water used as a flush.
Potassium Chloride 20 mEq (milliequivalent)/15 ml (potassium supplement in 15 ml of fluid) twice a day, followed with less than 5 cc of water used as a flush.
Metoprolol 25 mg (a blood pressure control medication) every day, followed with less than 5 cc of water used as a flush.
The following medications were mixed in separate souffle cups in 5 cc of water:
Baclofen 2.5 mg (a muscle relaxant) crushed three times a day, followed with less than 5 cc of water used as a flush.
Zonisamide 100 mg (antiseizure) capsule contents mixed in 5 cc of water. When the 5 cc water solution with the capsule contents were administered via the gastrostomy tube via the Mic Key button the tubing clogged and would not go into the stomach. The MR/Assistant then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	I. BUILDING _____ J. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 368	Continued From page 8	W 368		

disengaged the gastrostomy tubing, rinsed the tubing out in the sink with water, obtained another capsule and mixed in 10 cc of water, administered the medication. The MR/Assistant then did a final flush of 5 cc of water and removed the gastrostomy tubing from Individual #5's Mic Key button.
The MR/Assistant then was asked about the amounts of water given between each medication, the lack of a initial flush and also the given 5 ccs of water given as a final flush. She stated: "That's how we are supposed to do it."
An interview was conducted on 03/09/16 at approximately 11:25 a.m., with the house LPN (licensed practical nurse). The aforementioned medication administration observations were discussed with the LPN. When asked if the correct amount of water had been used for Individual #4's Mic Key button administration of his medications was the policy of the facility she stated: "No. There is no set facility policy for administering medications via a Mic Key button. The doctor writes the protocol and signs it as an order." The LPN then opened Individual #4's medical binder and reviewed the Physician's Order G-tube dated 12/22/15, which noted: "Medication Administration via G-tube: 1. Flush with 30 cc of water to ensure patency of the tube. 2. Crush meds and mix with 15 cc of water to ensure med will not block the tube. 3. Give one med at a time. 4. Flush with 30 cc of water when all medication is administered." When the LPN was informed of the observations of the Medication Pass administration of Individual #4's medication she stated: "MR/Assistant (name) did not follow the doctor's orders."
The interview continued and the LPN was informed of the observations during the Medication Pass for Individual #5 and was then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	K. BUILDING _____ L. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 368	Continued From page 9	W 368		

asked if the correct amount of water had been used for Individual #5's Mic Key button for the medication administration she opened Individual #5's clinical record and found the validated signed physician's order which noted: "Physician's Order G-Tube dated 02/24/16 noted the following: Medication Administration via G-tube. 1. Flush with 30 cc of water to ensure patency of the tube.; 2. Crush meds and mix with 15 ccs of water to ensure med will not block the tube.; 3. Give one med at a time.; 4. Flush with 30 cc of water when all medication is administered." After review of the signed physician's order the LPN stated: "MR/Assistant (name) did not follow the doctor's orders."
An interview was conducted on 03/09/16 at approximately 1:30 p.m., with the House Manager/Clinician II and Clinician II/QIDP (Qualified Intellectual Disabilities Professional). The Medication Pass issues were shared regarding the observations that were made and of the signed physician orders that MR/Assistant had not followed regarding the ordered amount of water to be used when administering medications to Individual #4 and Individual #5 for the initial and final water flushes.

An interview was conducted on 03/09/16 at approximately 2:05p.m., with the RN (registered nurse) Nurse Manager. The observations of the Medication Pass and the orders were shared and the RN. The RN agreed with the LPN that MR/Assistant #1 did not follow the signed physician orders regarding the amounts of water to be used for Individuals #4 and #5 regarding the initial and final water flushes. The RN was then asked about the qualifications of a MR/Assistant to be able to administer medications, especially . through a Mic Key Button. She stated: "Before a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	M. BUILDING _____ N. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 368	Continued From page 10	W 368		

MR/Assistant is able to administer any medications I personally instruct them and do observations myself of how medication is administered. I especially pay close attention to g-tube administration as it is a more difficult procedure and has more adverse outcomes if not followed correctly. MR/Assistant (name) is experienced and is checked off annually." The RN then submitted the facility's policy and procedure for Medication Administration

Review of the Medication Administration policy noted the following:

"3. Definitions: Medication Administration-is the safe physical application of medication into or onto the body, according to the physicians' orders, by licensed nursing personnel or unlicensed staff according to Delegation regulations. It shall include all processes necessary to assure compliance with the "5 Rights" of medication administration: Right Person, Right Medication, Right Dose, Right Route and Right Tim.

Delegation of Medication Administration-is the transfer of responsibility for administration for medication by a Registered Professional Nurse to trained, competent unlicensed personnel in selected situations according to the Virginia Nursing Practice Act. Medication administration by qualified personnel is required for all individuals with ID/DD (Intellectually Disabled/Developmentally Disabled) who do not possess the skills needed for assisted self-administration of medication or independent medication management."

An interview was to be done with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	O. BUILDING _____ P. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 368	Continued From page 11 MR/Assistant however, she was not available 03/09/16 after the interview with the RN Nurse Manager nor was she available 03/10/16, the last day of the survey. Administration which consisted of House Managers from both houses, QIDPs from both houses, the RN Nurse Manager and several other staff members were informed of the findings at a briefing on 03/10/16 at approximately 2:45 p.m. No additional information was submitted for review.	W 368		
W 455	483.470(1)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, staff interviews and facility documentation review the facility staff failed to ensure proper hand washing technique was used to prevent infection and the spread of infections during medication administrations. The findings included: On 03/09/16 at approximately 7:10a.m., the Medication Pass with MR/Assistant (Mental Retardation) #1 was observed. 1.MR/Assistant #1 was observed preparing to administer medications by washing her hands. It was observed that after she applied soap to her hands, she rubbed her hands together for three (3) seconds, rinsed the soap off of her hands with water, dried them with paper towels and applied	W 455	Staff member involved in the medication administration of individuals #4 and #5 is no longer employed by the Facility. The Infection Control Policy will be updated to include the amount of time hand washing should occur and prioritization of medication administration for different body systems. Quarterly observations of unlicensed staff performing medication administration will include an observation of hand-washing procedures. Staff observing will use a clock or watch to confirm proper procedures and staff will be asked to repeat the procedure should they fail to complete the task properly. The annual review for all medication trained staff will include prioritization of medication administration of different body systems. Facility will perform periodic spot checks of Infection Control Procedures for all staff outside of the existing observation windows.	4/22/16 4/22/16 4/22/16 4/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	Q. BUILDING _____ R. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 455	Continued From page 12	W 455		

clean gloves and prepared the ordered medications by crushing and mixing the medications individually. MR/Assistant #1 then attached the gastrostomy tube with a 60 cc (cubic centimeter) syringe, check residual stomach content and administered medications via tubing attached to the Mic Key button (a surgically inserted gastrostomy tube (G-tube) is a special tube in the stomach that will help deliver food and medicines https://www.nlm.nih.gov/medlineplus).

At 7:37a.m., it was observed part way through the administration of medications MR/Assistant #1 removed her gloves and proceeded to wash her hands. It was observed that after she applied soap to her hands she only rubbed her hands together for four (4) seconds, rinsed the soap off of her hands with water, dried them with paper towels and applied clean gloves. She then proceeded to administer medications.

At 7:42a.m., she removed her gloves and washed her hands. It was observed that after she applied soap to her hands she only rubbed her hands together for five (5) seconds, rinsed the soap off of her hands with water, dried them with paper towels and prepared for a treatment to the individual's MicKey button by putting on clean gloves. She did not clean the area around the site before she applied the ordered A & D ointment around the Mic Key button site with a toothette (a small sponge at the end of a hard paper applicator) and then applied a split 2 x 2 (2 inches by 2 inches) split gauze under the Mic Key button. She then proceeded to administer a physician ordered eye ointment without changing her gloves. The individual became resistant to the eye ointment and kept turning his head back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	S. BUILDING _____ T. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 455	Continued From page 13	W 455		

and forth. MR/Assistant #1 touched the individual's face multiple times as well as trying to open the individual's eyes. It was observed that after she removed her gloves, soap was applied to her hands, she rubbed her hands together for three (3) seconds, rinsed the soap off of her hands with water, dried them with paper towels and applied new gloves.
2. At 7:55a.m., after administering the ordered medications to a different individual, MR/Assistant #1 was observed removing her gloves, applied soap to her hands, only rubbed her hands together for three (3) seconds, rinsed the soap off of her hands with water, dried them with paper t towels and applied clean gloves.

3. 8:05a.m., after preparing the medication and applying the tubing to the a different individual's Mic Key button MR/Assistant #1 was observed removing her gloves, applied soap to her hands, rubbed her hands together for four (4) seconds, rinsed the soap off of her hands with water, dried them with paper towels and applied new gloves.

During the administering of this individual's medications the tubing became clogged and had to be removed and the medication was flushed out and the tubing reattached to the Mic Key button.

At 8:32p.m., MR/Assistant #1 completed the individuals medication pass, removed her gloves, applied soap to her hands, rubbed her hands for three (3) seconds, rinsed the soap off of her hands with water, dried them with paper towels which ended the Medication Pass observations. At no time during the entire Medication Pass of three different individuals was MR/Assistant #1 observed using hand sanitizer in place of hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	U. BUILDING _____ V. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 455	Continued From page 14	W 455		

washing.

An interview was conducted on 03/09/16 at approximately 11:25 a.m., with the house LPN (licensed practical nurse). The aforementioned observations of MR/Assistant #1's hand was technique was discussed with the LPN. When asked if the hand washing technique which had been observed was the policy of the facility she stated: "No. The MR/Assistant is experienced and should have known the correct technique." She went on further and stated: "She should also have removed her gloves and washed her hands prior to administering the ordered eye ointment."

An interview was conducted on 03/09/16 at approximately 1:30 p.m., with the House Manager/Clinician II and Clinician 11/QIDP (Qualified Intellectual Disabilities Professional). The Medication Pass observations of MR/Assistant #1's hand washing technique was shared. The House Manager/Clinician II stated: "MR/Assistant #1 (name) has been with the facility and should have used the appropriate technique."

An interview was conducted on 03/09/16 at approximately 2:05p.m., with the RN (registered nurse) Nurse Manager. The observations of the Medication Pass regarding MR/Assistant #1's hand washing technique was shared and the RN agreed with the LPN that the MR/Assistant did not use the proper technique and should have changed gloves and washed her hands properly and using a fresh pair of gloves before applying the individual's eye medication after using the same gloves that were used when she applied the ointment to the individuals stomach area and around the Mic Key button. The facility's policies

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
	49G045	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 455	Continued From page 15	W 455		

and procedures were requested.

An interview was to be done with the MR/Assistant; however, she was not available 03/09/16 after the interview with the RN Nurse Manager nor was she available 03/10/16, the last day of the survey.

Review of the facility's policy noted: "Healthcare Services Subject: Infection Control III. Hand Washing. A. Staff Will:

1. Wash hands using CDC (Center for Disease Control) procedural guidelines that are posted in facility.
2. May use hand rub sanitizers if hands are not visibly soiled following CDC procedural guidelines that are posted.
5. Will clean hands after PG (gastrostomy tube) changes.
7. Will clean hands before assisting with medications. They will also clean hands when changing routes of administration with the same resident. (i.e.. (for example) Oral route to ophthalmic route.)"

Review of the posted CDC guidelines which included pictures which was in the medication administration area noted the following: "Duration of the entire procedure: 40-60 seconds 0. Wet hands with water; 1. Apply enough soap to cover all hand surfaces; 2. Rub hands palm to palm; 3. Right palm over left dorsum with interlaced fingers and vice versa; 4. Palm to palm with fingers interlaced; 5. Backs of fingers to opposing palms with fingers interlocked; 6. Rotational rubbing of left thumb clasped in right palm and vice versa; 7. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa; 8. Rinse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XE) COMPLETION DATE
W 455	Continued From page 16	W 455		

hands with water; 9. Dry hands thoroughly with a single use towel; 10. Use towel to turn off faucet; 1. Your hands are now safe."

Administration which consisted of House Managers from both houses, QIDPs from both houses, the RN Nurse Manager and several other staff members were informed of the findings at a briefing on 03/10/16 at approximately 2:45p.m. No additional information was submitted for review.