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
	49G057	A. BUILDING _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRYFIELD RESIDENCE	111 HORSE MOUNTAIN VIEW COVINGTON, VA 24426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 4	W 368		

On 11/09/2016 at approximately 1:00 p.m. the Administrator was interviewed concerning the above mentioned missed medications. The Administrator stated, "That morning was very chaotic. They were getting ready to leave on a Special Olympics trip. Normally they don't leave that early. (Name) Individual #1 was up there (medication room) ready for his meds, but left and went back to his room. The Med Tech (medication technician), (Name) thought he had gave meds and didn't realize he hadn't until after he (Individual #1) had left."

The Administrator further stated, "He (Med Tech) received a day of training with the RN (registered nurse) who teaches the medication class (Name). He had to do five supervised med passes with myself or the RN after that before he could administer medications alone. He has had no further medication errors since that time."

No further information or documentation was received prior to the exit conference on 11/09/2016.

Merryfield ICF/IID will conduct random medication administration pass audits on all medication aides to provide additional training, mentoring and monitoring of medication passes at the facility. This will be conducted by the nurses and/or administrator. Medication Administration pass audits will be done no less than once monthly at different medication times, days and during times of preparation for outings. Additional trainings will be provided to medication aides bi-annually as a refresher course for medication administration to promote accuracy and expand on medication administration knowledge. In the event that a medication aide produces a medication error, the medication aide will have additional 1:1 training with the Medication Administration Training nurse where she will provide training and 1:1 medication pass. Upon completion of this training, medication aide will have five supervised medication passes with the nurse and/or administrator of Merryfield ICF/IID before permitted to pass medications without supervision. All implementations of this plan of correction have been completed as of today, November 23, 2016.

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W 368	Continued From page 3 No further information or documentation was provided prior to the exit conference on 11/09/2016.	W 368		

2. Facility staff did not administer Seroquel XR, Divalproex Sod, Metoprolol Tartrate or a Multivitamin as ordered by the physician to Individual #1.

Findings were:

2. During the incident/accident review conducted 11/08/2016, it was identified that facility staff did not administer Individual #1's medications, Seroquel XR, Divalproex Sod, Metoprolol Tartrate or Multivitamin on 07/23/2016, as ordered by the physician. The medications had been missed one day during the month of July 2016.

Individual #1 was admitted to the facility on 09/04/2012 with the following diagnoses: mild intellectual disability, attention deficit hyperactivity disorder, depression and hyperkinesis.

The electronic medical record included a physician's order dated July 2016 that contained the following: "...Quetiapine ER (extended release) 300mg (milligrams) po (oral) QD (everyday). Metoprolol 100mg po tid (three times a day). Divalproex 250mg po tid. Essential One (multivitamin) one tablet po QD..."

The MAR (medication administration record) for July 2016 was reviewed. According to documentation on the MAR Individual #1 did not receive the a.m. (morning) medications the morning of 07/23/2016.

Merryfield ICF/IID will ensure that all pill form of medications are sent from the pharmacy in a bubble pack to ensure accuracy. Merryfield ICF/IID will contact pharmacy of the need for new medication, refill or change in medication to ensure that all pill form medications are received at the requested bubble pack with correct dosage in each bubble as well as correct information on the label per physicians order. Medication administration passes will be conducted in the medication room to ensure privacy. Medication administration passes will be done in a quiet setting to provide an atmosphere to medication aides that promote accuracy. In the event of any chaotic situations, the medication aide will remove distractions before beginning a medication administration pass.

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W 368	Continued From page 2	W 368		

beside her couch. The pill "looked old because it had already started to decompose and had started changing color." The pill was identified as "Vimpat" by the DSP (direct service provider). The facility staff was unable to identify when the missed dose of Vimpat had occurred. The physician was notified.

The program director was interviewed on 11/09/2016 at approximately 12:45 p.m., regarding the medication errors for Individual #4. She stated, "We changed pharmacy in June [2016]...during the transition we wanted everything bubble packed...for some reason due to insurance we couldn't get a thirty day supply of the Vimpat...instead we got a five day supply that was not bubble packed, it was in a bottle. When the medication was given she [Individual #4] got one pill instead of two." The program manager was asked how the bottle had been labeled from the pharmacy. She stated, "The label said to give two." She was asked what had caused the error. She stated, "When the medication was given the label was not compared to the MAR [medication administration record]" The program manager was then asked about the pill that was found in Individual #4's floor. She stated, "[Name of Individual #4] has started to pack and pick...she packs food in her mouth...she acts like she is eating and then picks the food out of her mouth and flicks it...Evidently she packed the med [Vimpat] in her mouth and she picked it out...she won't open her mouth when she is asked to...we try to give her meds in applesauce or yogurt to make it easier for her to swallow it...we have started holding her hand to calm her and giving her more water and applesauce to get the medications down

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W 368	Continued From page 1 2. Facility staff did not administer Seroquel XR, Divalproex Sod, Metoprolol Tartrate or a Multivitamin as ordered by the physician to Individual #1. Findings were: 1. Individual # 4 was admitted to the facility on 01/10/2013 with the following diagnoses, but not limited to: Severe MR (mental retardation), Asperger's syndrome, generalized nonconvulsive epilepsy, anxiety and esophageal reflux. During the review of incident/accident reports on 11/08/2016 at approximately 2:00 p.m., it was identified that on 06/29/2016, Individual # 4 received the wrong dose of Vimpat. Individual #4 had physician orders to receive two 50 mg (100 mg total) Vimpat tablets twice a day. Per the accident/incident report the following occurred: "During controlled med count at 2 pm, additional pill [Vimpat] discovered. Count should be 6 tablets, 7 were found in the bottle....DSP [direct service provider] called Lifeskills Center and spoke with [name of staff] asking if she has noticed any erratic behaviors and she said that [name of Individual #4] had been 'bouncing off the walls'..." The supervisor comments were listed as: "Controlled medication count reviewed and found that med count at 2 pm was incorrect....CAP [Corrective action plan] completed and awaiting to be presented to employee..." The physician was notified that the incorrect dosage of medication had been given. Also identified during review of the accident/incident reports was an occurrence on 08/10/2016. Per the report at 8:30 p.m., a pill was found in Individual #4's room on the floor	W 368	Merryfield ICF/IID will ensure that all residents receive their medication per physician order at all times following the five rights of medications for all residents who reside at the facility. The facility will monitor changes in behavior that would prevent an effective medication administration pass such as, but not limited to, packing and picking of food, medications or other substances and immediately find solutions to promote the administration and delivery of physician ordered medications. In the event of a swallowing difficulty, medication aides, nurses and administrator will provide additional assistance to ensure each medication is administered per physicians order. In order to ensure that medications are administered, medication aide will provide more water for effective swallowing of medications, medications can be given one at a time, given in applesauce or other physician approved substance to ensure all medications are swallowed at the time of administration.	

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W 000	INITIAL COMMENTS	W 000		

An unannounced annual Medicaid Certification survey was conducted 11/08/2016 through 11/09/2016. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Individuals with Intellectual Disabilities. The Life Safety Code survey report will follow. No Complaints were investigated.

The census in this nine bed facility was nine at the time of the survey. The survey sample consisted of four current Individual reviews (Individuals #1 - #4).

W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

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 clinical record review, staff interview, and facility document review, the facility failed to dispense medication as ordered by the physician for two of 4 individuals in the survey sample, individuals #1 and #4.

1. The facility staff failed to ensure that Individual #4 received her physician ordered doses of Vimpat (a seizure medication) on two different occasions. On 06/29/2016, Individual #4 received one 50 mg (milligram) tablet of Vimpat instead of the physician ordered dose of two 50 mg tablets. On 08/10/2016 a pill believed to be a Vimpat was discovered in Individual #4's room on the floor.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Curry	Quality Assurance Manager	11/23/2016

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.

Correction/completion dates must be within forty-five (45) days from the day of the inspection. If you have been cited for physical plant or Life Safety Code deficiencies that will require more than 45 days to correct and you intend to request an exception, you must provide a specific reason for the request and the expected completion date.

After signing and dating your Plan of Correction, retain one copy of the Report for your files and return the original to this office within ten (10) calendar days from receiving the report. You will be notified if your Plan of Correction is not acceptable.

Failure to return your Plan of Correction within the time frame specified above can result in a loss of Medicaid reimbursement.

A copy of the completed form (CMS-2567) will be kept on file in this office and will be available for public review. This Division is required to make copies of this report available to other Federal and State regulatory or reimbursement agencies upon request.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions, please call me at (804) 367-2100.

Sincerely,

Paul Wade

Paul Wade, LTC Supervisor
Division of Long Term Care Services

Enclosures

cc: Jaime Desper, Department of Medical Assistance Services (Sent Electronically)
Susan Elmore, Department of Behavioral Health and Developmental Services

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Office of Licensure and Certification

TYY 7-1-1 OR
1-800-828-1120

9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
FAX: (804) 527-4502

November 15, 2016

Nancy Curry, Director
Merryfield Residence
111 Horse Mountain View
Covington, VA 24426

RE: Merryfield Residence
Covington, Virginia
ICF/ID: 49G057

Dear Ms Curry:

An unannounced Medicaid survey, ending November 9, 2016 was conducted, by the VDH Office of Licensure and Certification staff. All references to regulatory requirements are found in Title 42, Code of Federal Regulations

Survey Results and Plan of Correction

Enclosed is the CMS-2567, Statement of Deficiencies, for the Fundamental Health Survey. This document contains a listing of the deficiencies found at the time of this inspection. [Any deficiencies found as a result of a Life Safety Code inspection will be mailed separately from the office of the State Fire Marshall.]

You are required to file a plan for correcting these deficiencies. Your statements shall reflect the specific detailed actions you will take to correct deficiencies, prevent a recurrence of the deficiencies, and measures implemented to maintain compliance. You must also give the specific calendar date on which correction for each deficiency is expected to be completed. The response "Corrected" is not an acceptable response. That kind of response does not fulfill the requirement to provide information on preventing recurrence or maintaining compliance. The response "will train staff" is not an acceptable response unless specific information is given on the plan for frequency and methods to evaluate results.