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 |
|---|---|---|---|
| | 49G065 | A. BUILDING 01 - ROSS DRIVE<br>B. WING | 05/16/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROSS DRIVE | 5604 ROSS DRIVE<br>FREDERICKSBURG, VA 22407 |

| (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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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 29282<br>The facility is one story on a basement of type V construction and is fully sprinklered.<br><br>An unannounced life safety code recertification survey was conducted on 5/16/2018 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facility for Persons with Mental Retardation. The facility was surveyed for compliance using the LSC 2012 Existing Regulations. The facility was not in compliance with the requirements for participation for Medicare and Medicaid.<br><br>The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, Part 483.150 and 410 to 480 (Life Safety from Fire.) | K 000 | | |
| K0511 | Utilities - Gas and Electric<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code.<br>32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2<br>This Standard is not met as evidenced by:<br>Surveyor: 29282<br>Based on observation it was determined that the facility failed to prevent utility related hazards.<br><br>The Findings Include:<br>On 5/16/2018 at approximately 9:12 AM, it was revealed by observation there was excessive accumulation of lint inside the electric dryer in the basement. | K0511 | K0511<br>1. The excessive accumulation of lint inside the electric dryer in the basement has been removed, the motion detector in the basement has been reattached and gaps have been sealed, batteries were replaced in the emergency lights in the living room to ensure they are working properly, and the waterproof electrical outlet covers on the exterior have been replaced.<br><br>2. Any excess accumulation of lint was removed from the only other electric dryer in the facility, all other motion detectors in the facility were checked to ensure they were not hanging from their power supply wires, batteries in all emergency lights have been replaced to ensure they are all working properly, and all other exterior electrical outlets were checked to ensure they were protected by waterproof covers. | 6/1/18 |

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

ID Residential Coordinator | 5/31/18

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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| | 49G065 | A. BUILDING 01 - ROSS DRIVE<br>B. WING _____ | 05/16/2018 |

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| K0511 | Continued From page 1<br>On 5/16/2018 at approximately 9:15 AM, it was revealed by observation there was a motion detector in the basement hanging from it power supply wires.<br><br>On 5/16/2018 at approximately 9:26 AM, it was revealed by observation the emergency lights in the living room did not function properly.<br><br>On 5/16/2018 at approximately 9:35 AM, it was revealed by observation there were two electrical outlets on the exterior of the structure which were missing their wether proof covers. | K0511 | 3. During each monthly facility inspection, the ICF Supervisor will check all dryers for excessive lint, all motion detectors to ensure they are not hanging, all emergency lights to ensure they are functioning properly, and all exterior electrical outlets to ensure they are protected by waterproof covers. If any of these items need to be addressed, they will be rectified immediately.<br><br>4. During the annual facility inspection, the ID Residential Coordinator or designee will check all dryers for excessive lint, all motion detectors to ensure they are not hanging, all emergency lights to ensure they are functioning properly, and all exterior electrical outlets to ensure they are protected by waterproof covers.<br><br>5. 6/1/18 | |

# *COMMONWEALTH of VIRGINIA*

*Department of Health*

Office of Licensure and Certification

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

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

May 15, 2018

Mr. Darragh Walker, Program Manager
Ross Drive
5604 Ross Drive
Fredericksburg, VA 22407

RE: Ross Drive
Fredericksburg, Virginia
ICF/ID: 49G065

Dear Mr. Walker:

An unannounced Medicaid survey, ending May 3, 2018 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.

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,

Wietske G. Weigel-Delano , LTC Supervisor
Division of Long Term Care Services

Enclosures

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

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| | 49G065 | A. BUILDING _____ B. WING _____ | 05/03/2018 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 5/2/18 through 5/3/18. The facility was in compliance with 42 CFR Part 483.73, Requirement for Intermediate Care Facilities for Persons with Intellectual Disabilities. | E 000 | | |
| W 000 | INITIAL COMMENTS<br><br>An unannounced annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted 5/2/18 through 5/3/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. The Life Safety Code survey report will follow.<br><br>The census in this four bed facility was four at the time of the survey. The survey sample consisted of two current individual reviews, (Individuals #1 and #2). | W 000 | | |
| W 111 | CLIENT RECORDS<br>CFR(s): 483.410(c)(1)<br><br>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview, facility document review and residential record review, it was determined that the facility staff failed to maintain an accurate residential record for one of two individuals in the survey sample, Individual #1.<br><br>The facility staff failed to accurately document the | W 111 | W111<br>**How corrective action will be accomplished for individual #1:**<br>Facility staff will review and update the fourth quarterly for individual #1 to accurately document the condition of the outcomes.<br>**Assurance that other residents are protected from the possibility of the deficiency:**<br>The facility staff will review the quarterly reviews for each individual to ensure that they are each accurate.<br>**Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:**<br>Facility staff will ensure that each quarterly for each individual is accurate and each is a representation of what progress has been made toward outcomes.<br>**How the facility plans to monitor its performance to make sure that solutions are sustained:**<br>The Program supervisor or designee will review each quarterly for each individual to ensure that they are accurate and representative of what progress has been made toward outcomes for each individual.<br>**Date of Completion:**<br>6/1/18 | 6/1/18 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | DD Residential Coordinator | 5/17/18 |

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| W 111 | Continued From page 1 | W 111 | | |

condition of Individual #1's outcomes on the fourth quarterly person centered plan review dated 4/9/18.

The findings include:

Individual #1 was admitted to the facility on 3/9/15. Individual #1's diagnoses included but were not limited to intellectual disability, seizures and vitamin D deficiency.

Review of Individual #1's fourth quarterly person centered plan review dated 4/9/18 revealed the condition of every outcome was checked as being met.

On 5/3/18 at 10:05 a.m., an interview was conducted with ASM (administrative staff member) #1 (the ICF [intermediate care facility] supervisor) and ASM #2 (residential assistant coordinator). Review of Individual #1's fourth quarterly person centered plan review revealed the individual had not met all outcomes as indicated on the review. When asked why all outcomes were documented as being met, ASM #1 stated she had always been taught to check all outcomes as being met at the end of a plan, even if the individual did not meet all outcomes. ASM #2 stated she was taught that checking all outcomes as being met indicates a new plan is being started. When asked if the documentation of all outcomes being met on Individual #1's fourth quarterly review was accurate, ASM #1 and ASM #2 stated, "No."

On 5/3/18 at 2:50 p.m., ASM #1 was made aware the above findings were a concern.

The facility policy titled, " ICF Service: Active



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| W 111 | Continued From page 2<br>Treatment- Section 5-8: Person Centered Plan" documented, "9. Program Documentation: Accurate, systematic, behaviorally stated data about the individual's performance toward meeting the criteria stated in PCP (person centered plan) objectives serves as the basis for necessary change and revision to the program..."<br><br>No further information was presented prior to exit. | W 111 | | |
| W 159 | QIDP<br>CFR(s): 483.430(a)<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.<br>This STANDARD is not met as evidenced by:<br>Based on residential program record reviews, day program record review, facility document review and staff interview, it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate and monitor the individuals' active treatment programs for one of two individuals in the survey sample, Individuals # 1.<br><br>The QIDP failed to ensure the quarterly review accurately reflected Individual # 1's progress.<br><br>The findings include:<br><br>Individual #1 was admitted to the facility on 3/9/15. Individual #1's diagnoses included but were not limited to intellectual disability, seizures and vitamin D deficiency.<br><br>Review of Individual #1's fourth quarterly person centered plan review dated 4/9/18 revealed the condition of every outcome was checked as being | W 159 | W159<br>**How corrective action will be accomplished for individual #1:**<br>The QIDP will ensure that the fourth quarterly for individual #1 accurately documents the condition of the outcomes.<br>**Assurance that other residents are protected from the possibility of the deficiency:**<br>The QIDP will review the quarterly reviews for each individual to ensure that they are each accurate.<br>**Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:**<br>The QIDP will ensure that each quarterly for each individual is accurate and each is a representation of what progress has been made toward outcomes.<br>**How the facility plans to monitor its performance to make sure that solutions are sustained:**<br>The Program supervisor or designee will review each quarterly for each individual to ensure that they are accurate and representative of what progress has been made toward outcomes for each individual.<br>**Date of Completion:**<br>6/1/18 | 6/1/18 |



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| W 159 | Continued From page 3 | W 159 | | |

met.

On 05/03/18 at approximately 12:55 p.m., an interview was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) supervisor. After reviewing the "4th Quarter review April 19, 2018" for Individual # 2, ASM # 1 was asked if the quarterly review was accurate and if all the outcomes for Individual # 2 were met. ASM # 1 stated, "It was taught to us in training that at the end of the plan year all outcomes are marked as being met even if the outcomes are going to continue because the plan is going to end." When asked to interpret the condition "Met" on the quarterly review, ASM # 1 stated, "It means the outcome is achieved." When asked if the quarterly review was documented accurately to reflect Individual # 2's progress of the PCP outcomes, ASM # 1 stated no.

On 05/03/18 at 3:25 p.m., an interview was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) supervisor. When asked about the QIDP, ASM # 1 stated, "A QIDP was hired but he is currently in training." When asked to describe the responsibility of the QIDP, ASM # 1 stated, "To monitor the active treatment, develop person centered plan outcomes, and ensure the clinical record is accurate." When asked who was taking the QIDP's responsibilities, ASM # 1 stated, "I took over some of the responsibilities." When asked about the inaccurate documentation on Individual # 2's quarterly review, ASM # stated, "It was my responsibility."



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|---|---|---|---|---|
| W 159 | Continued From page 4<br>On 5/3/18 at 2:50 p.m., ASM #1 was made aware the above findings were a concern.<br><br>The facility policy titled, " ICF Service: Active Treatment- Section 5-8: Person Centered Plan" documented, "9. Program Documentation: Accurate, systematic, behaviorally stated data about the individual's performance toward meeting the criteria stated in PCP (person centered plan) objectives serves as the basis for necessary change and revision to the program..."<br><br>No further information was presented prior to exit. | W 159 | | |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview, facility document review and medical record review, it was determined that the facility staff failed to ensure medications were administered without error for one of two individuals in the survey sample, Individual #1.<br><br>The facility staff failed to administer the medication Gas Relief (1) with a meal, per physician's order.<br><br>The findings include:<br><br>Individual #1 was admitted to the facility on 3/9/15. Individual #1's diagnoses included but were not limited to intellectual disability, seizures | W 369 | W 369<br>**How corrective action will be accomplished for individual #1:**<br>Facility staff will administer the medication Gas Relief with a meal, per physician's order to Individual #1.<br>**Assurance that other residents are protected from the possibility of the deficiency:**<br>Facility staff will administer all medications in accordance with physician's orders for each individual.<br>**Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:**<br>The nurse manager will review administration procedures with all staff at the next mandatory staff meeting and have all staff sign off on a training record.<br>**How the facility plans to monitor its performance to make sure that solutions are sustained:**<br>The nurse manager will conduct periodic surveillance checks and supervision to ensure compliance with the procedures.<br>**Date of Completion:**<br>6/1/18 | 6/1/18 |



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and vitamin D deficiency.

Review of Individual #1's medical record revealed a physician's order dated 1/10/18 for Gas Relief 80 milligrams- one tablet four times a day with meals.

On 5/2/18 at 4:08 p.m., observation of DSP (direct support staff) #1 administering medications to Individual #1 was conducted. One tablet of Gas Relief- 80 milligrams was administered to the individual with applesauce. Individual #1 was not served a meal until approximately 5:00 p.m.

On 5/3/18 at 9:00 a.m., an interview was conducted with RN (registered nurse) #1 (the nurse manager). RN #1 was made aware of the above findings. RN #1 stated Individual #1 received a snack at 4:00 p.m., received the medication with applesauce and received a meal at 5:00 p.m. RN #1 stated medications are not administered to individuals in the dining room. When asked if a snack or applesauce was considered a meal, RN #1 stated they were food substances. RN #1 was made aware the physician's order documented to give the Gas Relief with meals. RN #1 was made aware the medication was given at 4:08 p.m. and Individual #1 did not receive a meal until approximately 5:00 p.m. RN #1 was asked when the medication should be administered. RN #1 stated the medication should be administered closer to 5:00 p.m. than 4:00 p.m.

Individual #1's person centered plan dated 4/9/18 documented, "6a- Important For (name of Individual #1) takes his medications as prescribed..."



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| W 369 | Continued From page 6 | W 369 | | |

On 5/3/18 at 2:50 p.m., ASM (administrative staff member) #1 (the intermediate care facility supervisor) was made aware of the above findings.

The facility policy titled, "Health Care- Section 7-8: Medication Administration" documented, "I. Ensure that all medications for the individual's current dosing time are accounted for by comparing the MAR to the medications that have been removed from the cabinet. m. Match the doctor's order to the bubble pack order for each medication from the top of the bubble pack to the MAR's instructions to ensure accuracy..."

No further information was presented prior to exit.

(1) Gas Relief is used to treat the symptoms of gas. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682683.html



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