PRINTED: 02/12/2018 **FORM APPROVED** 

CENTER	42 LOK MEDICAKE	& MEDICAID SERVICES			<u>OMB NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	# 22 E2	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		49G058	B. WING		01/17/2018
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/1/2010
GILBERT	ISON LODGE		l	301 BOWMAN LANE	
				NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
E 000	Initial Comments		E 0	00	The state of the s
W 149	survey was conduct 01/17/18. The facilitic compliance with 42 Condition of Particip Facilities for Individual Federal Regulations. The census in this for the survey was 4 consisted of 1 currer #1) and one closed INITIAL COMMENT.  An unannounced Fourvey was conduct 01/17/18. Correction with CFR Part 483 Individuals with Disa Regulations. No conduring the survey. Twill follow.  The census in this for the survey was 4 consisted of 1 currer #1) and one closed INITIAL STAFF TREATMEN CFR(s): 483.420(d)()  The facility must develocities and procedured.	four (4) bed facility at the time is. The survey sample ent Individual record (Individual record (Individual record (Individual #2). TS  fundamental Medicaid survey ted on 01/16/18 through an are required for compliance Intermediate Care Facilities for abilities (ICF/ID) Federal mplaints were investigated The Life Safety Code report four (4) bed facility at the time and Individual record (Individual record (Individual record (Individual #2). IT OF CLIENTS	W 0	The facility conducted an investigat which resulted in a finding of negletowards Individual #2 as a result of failure to follow Individual #2's Individualized Program Plan (IPP.) 49was determined that staff left their personal food out within reach of Individual #2 and left him unsuperval though his IPP required that he be supervised during meals. All prograstaff present at the time the incident	ct It rised : am
	This STANDARD is	not met as evidenced by:		occurred were terminated	

Based on record review and staff interview, the LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Director of Residential Sciences

TITLE

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.

(A6) DATE

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB	NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER	10.255.0054000000000000000000000000000000	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		49G058	B WING	NOTE OF THE BEST O		01/17/2018
NAME OF PROVIDER OR SUPPLIER  GILBERTSON LODGE			STREET ADDRESS, CITY, STATE ZIP CO 301 BOWMAN LANE NEWPORT NEWS, VA 23606	THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR  X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 149	facility staff failed to procedures that pro	o implement policies and phibit neglect for one individual sed record), in the survey	W 1			1/24/2017
	with supervision to consuming a muffir Individual #2 was a 5/22/13 with diagnor disability. Type II diagastroesophageal rhypothyroidism, hypseizures and paran An Annual Nutrition indicated: "Medical hypertension, GERI Schizophrenia, hypseizure disorder. Cufat, low cholesterol. ground meats. Nee cubed bread only to	ed to provide Individual #2 prevent choking while n where he later died.  dmitted to the facility on uses of moderate intellectual abetes, hypertension, eflux disease (GERD), perlipidemia, sleep apnea, oid schizophrenia.  al Assessment dated 5/10/16 Problems: Type II diabetes, D, Hypothyroidism, Paranoid erlipidemia, sleep apnea, urrent Diet: 1800 calorie low Consistency: bite size, ds: No chicken on bone and be mixed with meats, ten 8		QIDP/Residential Supervisor, Residential Nurses, and Reside Services Manager met with Gi Lodge staff on January 24, 201 review the incident involving Individual #2 with all program QIDP/Residential Supervisor a Residential Services Manager instruction for monitoring the area and storing staff food. Re Nurses provided an in-service on the administration of the He Maneuver. (See Attachment A	ilbertson 17 to 1 staff. and provided eating esidential training eimlich	1/24/2017
	ounce cups of fluids pureed-consistency A Behavioral Suppo "Target Behavior: D throwing his walker statements of wanti making verbally abu others."	s daily. For hospitalizations, a diet is recommended."  ort Plan dated 5/6/16 indicated: isruptive Behavior - Shouting, or other objects, making ng to harm himself or others, asive statements towards		QIDP/Residential Supervisor implemented the use of cue car include the instructions for sup all Individuals during meal tim accordance with their Nutrition Management Plan (see Attachr The cue cards are utilized by st during meal preparation and w supporting Individuals during to	oporting ne in nal ment J.) taff rhile	5/31/2017 And ongoing

An Individual Service Plan (ISP) dated 5/24/16 indicated: "Individual #2 receives and responds to At-table staff supervision during meal and snack

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		AND HUMAN SERVICES			FORM AP	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u> MB NO. 09</u>	338-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		IPLE CONSTRUCTION NG	(X3) DATE SE COMPLE	
		49G058	B. WING	(ale come in a consideration of the consideration o	01/17/	/2018
NAME OF	PROVIDER OR SUPPLIER	3 0 20	T I	STREET ADDRESS, CITY, STATE ZIP CODE		
ČII DED	TONLODGE			301 BOWMAN LANE		
GILDER	TSON LODGE	3 27		NEWPORT NEWS, VA 23606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFEMENCY)	DBE CO	(X5) OMPLETION DATE
W 149	Continued From pa	age 2	W 14	19		
		als and snack time, Individual	15 B 18 1	Consulting Dietitian provides training	ig to 3/1	1/2018
		supervision and redirection to		Gilbertson Lodge Staff on food	.5.0	., 2010
	eat at an acceptabl	e pace for his safety and to		consistency preparation and observe	10	
		f choking for 4 consecutive			3	
		mended that Individual #2		meal preparation during monthly		
	maintain a diet consisting of bite-sized portions with ground meats and liquids. In order to avoid			reviews. Dietitian will include	420	
		rapid rate of eating and		observation specific to each Individu	ıal	
		ne following steps are		in her monthly review notes.		
	recommended and					
		mall, single solid bites before				
	liquid drink.	, 3				
		us monitoring of food				
		ple: Individual #2's plate may		QIDP/Residential Supervisor will	3/1	1/2018
		d after each small bite in order		review the meal protocols for all		and
	choking/aspiration.	mming and possible		Individuals at the monthly staff mee		igoing
		uding applesauce) following		after each Individual's annual meeti		88
	each bite sized solid			in order to ensure that staff understa		
		ctions provided for Individual		the significance of the plan and the	·•••	
	#2 while eating. For	example: verbally instruct		importance of following the		
		est one bite-size piece at a		individualized protocol		
	time before drinking	liquids."		marvidamizou protocor		
	An Incident and Acc	ident Report dated 1/21/17 at				
		"QIDP (Qualified Intellectual				
		nal) was notified and it was				
		at while staff were in the back				
		g two individuals, Individual		QIDP/Residential Supervisor posted	1/2	4/2017
		h sleep. QIDP was informed		signage in the kitchen and dining are		and the state of
		ney walked back into the		instructing staff that the area is to be		
		noticed Individual #2 was not ore but was at the dining table		ar San		
		isked the other staff members		monitored at all times (see Attachme		
		ual #2 a snack. The two staff		F.) This requirement was reviewed v	vith	
		a blidgin line the cital		-4-CCI OIDD ID 'I .' IC '		

members responded no. Staff approached Individual #2 and asked him to hand the snack to

her. He responded by stuffing the snack in his

mouth and ambulating back to the couch. Staff

attachment A.)

staff by QIDP and Residential Services

Manager on January 24, 2017 (see

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	100 M	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G058	B WING		01/17/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS CITY, STATE, ZIP CODE	
CHEEDI	CONTODCE			301 BOWMAN LANE	
GILBERI	SON LODGE			NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
W 149	Continued From pa	ige 3	W 1	49	
1000 D DI		dividual #2 had on the table	2.2	QIDP/Residential Supervisor,	1/24/2017
		n and poured a cup of water		Residential Nurses, and Residential	
		aff heard another staff		Services Manager met with Gilberts	on
		) Individual #2 was he choking		St. Committee of the co	OII
		hat staff stated to another		Lodge staff on January 24, 2017 to	
		#2 was turning blue in the		review the incident involving	0
		the kitchen and picked up the all 911. The staff noticed that		Individual # 2 with all program staff	
	2000 commendation and the control of	ringing or had a dial tone. That		QIDP/Residential Supervisor and	
		P's office to get the cordless		Residential Services Manager provi	
		Staff ran back into the common		instruction for monitoring the eating	
		#2 and began to transfer him		area and storing staff food. Resident	ial
		on the phone with 911, staff in the dispatcher that Individual		Nurses provided an in-service traini	ng
		that she was going to		on the administration of the Heimlig	:h
		lo resuscitation). The staff		Maneuver. (See Attachment A.)	
	started to perform (			Training Services Administrator	2/28/2017
		dispatcher. Dispatcher asked		provided specific, hands-on training	to
		essions aloud as she was		program staff in order to assess	
		aff checked for Individual #2's hat he did not have one. Staff		performance of the Heimlich	
	•	r that he did not have a pulse.		Maneuver on February 28, 2017 (se	<b>A</b>
		her stated that she could not		Attachment C.)	•
		e anymore thereby staff			£ 2/20/2017
	The control of the co	o another staff member to talk		This training included the addition of	
		s she continued another set of		"Choking Charlie," a mannequin us	
		ther staff member checked a again as EMT arrived. EMT		to instruct staff on properly perform	
		nue CPR and observed as she		the procedure (see Attachment D.)	
		npressions on Individual #2.		training requires that staff perform t	
	Another set of EMT	arrived shortly after the first		Heimlich Maneuver until the item is	i
		d off with another staff		dislodged. In addition, the trainer	
	•	side. Staff called QIDP and		discussed barriers to staff performin	g
		fy of the incident. Nurse		the Heimlich Maneuver upon the fir	•
		she was on her way. QIDP		indication that someone is choking a	

informed staff that she was on her way to the home to assess the situation. Staff went back into

the house and EMT were performing CPR on

Individual #2 and were using AED to find pulse as

reiterated the universal sign of choking

to include clutching the neck and/or

pointing toward the neck or mouth.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>	MR NO. 0338-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		49G058	B. WING		01/17/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
CH DEDI	TON LODGE		-	301 BOWMAN LANE	
GILBER	TSON LODGE			NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		DBE COMPLETION
W 149	Continued From pa	₃ge 4	W 1		
	2000 1896C	ear Individual #2's airway. EMT		Residential Services Manager and	3/6/2017
	asked staff for Individual #2's medical			Registered Nurse have enhanced sta	aff
		nformed EMT of all Individual		training to add the DBHDS Health	
		tions. Nurse arrived and		Safety and Quality Alerts to the	
		to EMT. EMT was able to find all all #2 after 15 minutes of		existing Fatal Five training conduct	:ed
	performing CPR. E	MT placed Individual #2 on a		for Gilbertson Lodge with special fe	
	breathing machine	then proceeded to inform staff		on Choking/Aspiration, Pneumonia	
		ospital. EMT stated that his		and Dysphagia. This training, provi	
		le. Nurse inquired about adition from EMT but was not		by the Residential Services Manage	
		curate information about his		and Registered Nurse, is required of	
		al #2 was transferred to		current and new staff on an annual	
	hospital with one st	taff and nurse following. At the		basis.	
		dividual #2 remained at the		04310.	
	hospital."			Gilbertson Lodge staff received the	3/6/2017
	A Facility Human R	Rights Investigation (Potential		training on March 6, 2017 (see	And
		oruary 6, 2017 indicated:		attachment E.)	
	Overview - "On Jan	nuary 22, 2017, this			ongoing
		received an incident report,		This training is offered at least	
		2017. The report noted yed services at the residential		quarterly in order to train oncoming	
		le consuming a muffin. Per the		staff and provide refresher training.	is .
		n reported. Individual #2		A 442   1   1   1   1   1   1   1   1   1	
	obtained a muffin th	hat belonged to staff, which		The facility conducted an investigat	CONTRACTOR
		room table. The individual		which resulted in a finding of negle	
		fin, which resulted in him transported to the hospital,		towards Individual #2 as a result of	i A
	where he later died			failure to follow Individual #2's	
	WING ON THE TAXABLE			Individualized Program Plan (IPP.)	It
		ontacted the local Adult		was determined that staff left their	
		s on January 23, 2017 at 2:04		personal food out within reach of	
	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	ort of the incident (potential		Individual #2 and left him	
		vas taken by Adult Protective ated that this was not a		unsupervised although his IPP requ	iired
		due to the individual expiring.		that he be supervised during meals.	

Given the nature of the allegation, the three staff

members on duty at the time of the incident (DSP

program staff present at the time the

incident occurred were terminated.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	P	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G058	B. WING .		01/17/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	x 1000000 100
GII BERT	SON LODGE			301 BOWMAN LANE	
OILDLIK!	SON CODGE	- 1 K - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	87.79	NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 149	Continued From pa	ge 5	W 14	19	
	return to work for th investigation."			QIDP/Residential Supervisor, Residential Nurses, and Residential Services Manager met with Gilbertso	1/24/2017 on
	January 21, 2017, pinformation: QIDP was notified a that while staff were toileting two individu couch asleep. QIDF when they walked by they noticed [Individual #2] a sna staff asked the othe [Individual #2] a sna	it, completed by (QIDP), dated provided the following and it was reported to QIDP in the back of the house pals, [Individual #2] was on the was informed by staff that back into the common area, and it was not on the couch it the dining table with a snack, or staff members did they give ack. The two staff members if approached [Individual #2]		Lodge staff on January 24, 2017 to review the incident involving Individ # 2 with all program staff. QIDP/Residential Supervisor and Residential Services Manager provid instruction for monitoring the eating area and storing staff food. Residential Nurses provided an in-service training on the administration of the Heimlich Maneuver. (See Attachment A.)	ed al g
	and asked him to heresponded by stuffing ambulating back to the [Individual #2 hakitchen and poured #2]. Staff heard and [Individual #2] was fokay. That staff staff [Individual #2] was fran into the kitchen phone to call 911. Sarea with [Individual him on the floor. Wistaff proceeded to in [Individual #2] was found to perform CF	and the snack to her. He ing the snack in his mouth and the couch. Staff took the bag ad on the table back into the a cup of water for [Individual other staff member asked (sic) in a choking and if he was red to another staff that turning blue in the face. Staff and picked up the kitchen staff ran back into the common if #2] and began to transfer inle on the phone with 911, inform the dispatcher that choking and that she was PR. The staff started to		QIDP/Residential Supervisor, Residential Services Manager and Director of Residential Services revis Gilbertson Lodge's Staff Rest Breaks and Meal Breaks Policy (see attachm B, #5) to instruct staff on the placeme of their personal food items in order t prevent staff from leaving their food sitting out in an area that is accessible the Individuals. At no time will staff food items be left within reach of the Individuals.	ent ent to e to
		e was communicating with		A refrigerator was purchased and place	ced 2/28/2017

dispatcher. Dispatcher asked her to count

compressions aloud as she was doing them. The staff checked for [Individual #2] pulse and noticed in the staff office which is specifically

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OF IAIT	43 FUR MEDICARE	& MEDICAID SERVICES		<u>OM</u>	<u>//B NO. 0938-0391</u>
	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	The second secon	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		49G058	B. WING		01/17/2018
2	PROVIDER OR SUPPLIER  TSON LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 301 BOWMAN LANE NEWPORT NEWS, VA 23606	VIIII
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	BE COMPLETION
W 149	dispatcher that he of time, dispatcher state the staff's voice any phone to another st dispatcher as she compressions. Another staff to continuate the compression of the continuate staff to continuate performing continuate the continuate staff to continuate performing continuate staff to continuate staff	e one. Staff informed did not have a pulse. At the ated that she could not hear ymore thereby staff passed the taff member to talk to the continued another set of other staff member checked se again as EMT arrived. EMT nue CPR and observed as she impressions on [Individual #2].	W 14	Training Services Administrator provided specific, hands-on training to program staff in order to assess performance of the Heimlich Maneuv on February 28, 2017 (see Attachmen C.)  This training included the addition of	ver ut
	member to step out nurse on call to notin informed staff that is informed staff that is home to assess the the house and EMT [Individual #2] and us trying to clear [Individual #2] after to EMT. EMT was a [Individual #2] after CPR. EMT placed [Imachine then proce transfer to hospital, was stable. Nurse in condition from EMT	d off with another staff tside. Staff called QIDP and ify of the incident. Nurse she was on her way. QIDP she was on her way to the e situation. Staff went back into were performing CPR on using AED to find pulse as well idividual #2's] airway. EMT vidual #2's] medical rrived and introduced herself able to find a pulse for 15 minutes of performing Individual #2] on a breathing peded to inform staff of his EMT stated that his condition inquired about [Individual #2's] but was not able to get any in about [Individual #2]		"Choking Charlie," a mannequin used instruct staff on properly performing the procedure (see Attachment D.) The training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performing the Heimlich Maneuver upon the first indication that someone is choking an reiterated the universal sign of choking to include clutching the neck and/or pointing toward the neck or mouth.	d to the e
	condition. [Individual hospital with one stated of the shift, [Indihospital."	al #2] was transferred to aff and nurse following. At the lividual #2] remained at port to hospital [Individual #2] of was 83%. Writer, staff and		Training Services Administrator has added the Choking Charlie module to the CPR course. All Residential Services staff are required to demonstrate this skill during initial an recertification CPR training.	ongoing

program (sic) went to the hospital with EMS. Once at ER writer nor staff was allowed to go

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NA 1017/01/01 SEC.00	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
1 SECURES SE		49G058	B. WING		01/17/2018
NAME OF PROVIDER OR SUPPLIER  GILBERTSON LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 301 BOWMAN LANE NEWPORT NEWS, VA 23606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
W 149	him. ER Physician been working on [Ir IV fluids and epiner an airway with a fib because EMS was the field due to the so he is now intuba [Individual #2] had I minutes out in the f to establish an airw hypoxia which resu he is not going to b physician stated the [Individual #2] that it cardiac arrest. As fiper the ER Physicia pulses due to the vi [Individual #2's] sist	s hospital staff was working on came out and stated that he individual #2], he had given him orbine and he had established er optic invasion procedure unable to establish airway in stuff being stuck in his throat ited. Per ER Physician, been down for 1 hour and 20 field because EMS was unable ray. Which cause him to be alted in injury to the brain that e able to overcome. ER at all things was (sic) done for they would do for someone on ar as neurology that was shot an. In the ER he currently have asopressors that was given. ter was contacted by ER P.M. to discuss code status	W 1	QIDP/Residential Supervisor and Residential Services Manager have added Choking Education Posters to Kitchen, +Staff Office, Activity Roc and Hallway where all Individuals bedrooms are located in order to pro an ongoing reminder and quick refer to staff concerning responding durin choking incident. Training materials remain onsite for staff reference (see attachment I.)	om, ovide rence ag a
	and it was explain to her about the brain injury and it would not be beneficial to continue to do CPR. ER Physician explained [Individual #2's] that everything would be taken off him. [Individual #2's] sister made him a DNR. Back in the ER [Individual #2] was able to maintain his pulse and breathing on his own so he was transferred to			An AED has been purchased for the home. All staff are trained on the ust the AED during their initial and biannual CPR recertification by the Training Services Department	
	HR, and BP started that was given was [Individual #2] expir Review of the Video	at around 5:30 P.M. pulse, I dropping as the medication wearing off. Around 6:15 P.M. red and he was peaceful."		QIDP/Residential Supervisor posted signage in the kitchen and dining are instructing staff that the area is to be monitored at all times (see Attachme	eas e
	(January 24, 2017) After a review of the this investigator not	e video surveillance footage,		F.) This requirement was reviewed to staff by QIDP and Residential Servi Manager on January 24, 2017 (see attachment A.)	

"1. There were three staff present and five

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		ON	<u> 18 NO. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	500	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		49G058	B. WING		01/17/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GII BERT	SON LODGE			301 BOWMAN LANE	
OILDE				NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 149	Continued From pa	7	W 1	49	
	individuals in the ho	ome at the time of the incident.		QIDP/Residential Supervisor posted	1/24/2017
	as [Individual #2] w A staff member wa the dining room tov One individual was area.	sent on the dining room table as walking out of the kitchen. ked from the kitchen through vards the back of the house. asleep in a chair in the living		signage in the kitchen and dining areas instructing staff that the area is to be monitored at all times (see Attachment F.) This requirement was reviewed with staff by QIDP and Residential Service Manager on January 24, 2017 (see	t th
	to open the muffin. approximately 10:1 of the muffin while two minutes.  4. Direct Service St	t at the table and proceeded The first bite was taken at 3 am. He consumed four bites unattended for approximately aff #1 (DSP #1) appeared at walked to the dining table at		attachment A.) Training Services Administrator provided specific, hands-on training to program staff in order to assess performance of the Heimlich Maneuve on February 28, 2017 (see Attachment	er
	approximately 10:1 [Individual #2] to re #2] stood up and w walker, as DSP #2	5 am. DSP #1 approached trieve the muffin. [Individual alked to the couch using his and DSP #3 entered the room.		C.) This training included the addition of "Choking Charlie," a mannequin used instruct staff on properly performing the procedure (see Attachment D.) The	
	put his left fingers in approaches him an [Individual #2] conti [Individual #2] even couch and his head and DSP #3 rush in a cup of water. The #2].	s on the couch and begins to not his mouth. DSP #2 d pats him on the back. nued to dig into his mouth. tually sits back on the the slumps backwards. DSP #1 to the kitchen and return with three approach [Individual]		training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performing the Heimlich Maneuver upon the first indication that someone is choking and reiterated the universal sign of choking include clutching the neck and/or	ihe i
	she ran to the kitche DSP #2 appear to p room, and [Individual	colleagues to initiate CPR and en to call 911, DSP #3 and eanic and walk out of the al #2] is left unattended for econds while they scramble		pointing toward the neck or mouth.	

around.

Facility ID: VAICFMR62

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	PRODUCTION OF SHARES	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		49G058	B WING		01/17/2018
NAME OF	PROVIDER OR SUPPLIER	St. 25 W 1880		STREET ADDRESS, CITY, STATE ZIP CODE	2. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.
GILBER	TSON LODGE	and the second s		301 BOWMAN LANE NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDS OF THE APPR DEFICIENCY)	ULD BE COMPLETION
W 149	Continued From pa		W 14	49	
	running from the kill fast pace and comicell phone. DSP #1 and began to move At this time DSP #2 [Individual #2] to the 8. DSP #1 initiated breaths. DSP #1 ev DSP #3.  9. DSP #2 assumed	the demonstrated DSP #1 schen to the back office in a ang out of the back office on a approached [Individual #2] him to the floor to begin CPR. It assisted with moving the floor. The chest compression without the entually handed the phone to the chest compressions upon		QIDP/Residential Supervisor, Residential Services Manager and Director of Residential Services re Gilbertson Lodge's Staff Rest Breand Meal Breaks Policy (see attack B, #5) to instruct staff on the place of their personal food items in order prevent staff from leaving their foo sitting out in an area that is access the Individuals. At no time will staff	evised aks hment ement er to od ible to
	arrival of the EMT."	e Interviews DSP #2		food items be left within reach of t Individuals.	:he
	acknowledged she the muffins. That's to breakfast. "I get one but that wasn't my r DSP #2 also acknownever consume foo if the individual was	owledged she was the staff who brought in uffins. That's what I usually bring in for fast. "I get one for me and one for DSP #1, at wasn't my muffin on the dining table." #2 also acknowledged [Individual #2] should consume food unsupervised. When asked individual was ever left alone when he was ascious, she replied, "NO".  g Investigative Interviews DSP #3 owledged DSP #1 and DSP #2 were eating fast at the dining table. After we ate, I had		QIDP/Residential Supervisor and Residential Services Manager prov staff training on the updated policy procedures on February 28, 2017 ( attachment C.)	y and
	acknowledged DSP			A refrigerator was purchased and p in the staff office which is specific for staff food.	
	taking him back to he falling asleep. I ther room and when I was #2] to come to the nether told him to go sattend to another income.	nis room because he was a took another Individual to her as done, I called [Individual ned room for his eye drops. I sit on the couch, and I went to dividual in her room. I hear asking about who gave		QIDP/Residential Supervisor poster signage in the kitchen and dining a instructing staff that the area is to be monitored at all times (see Attachn F.) This requirement was reviewed staff by OIDP and Residential Service	nreas be ment I with

[Individual #2] food, so I moved up front.

During the interview, DSP #3 expressed, "He

attachment A.)

staff by QIDP and Residential Services

Manager on January 24, 2017 (see

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES		0	MB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	, , , , , , , , , , , , , , , , , , ,	49G058	B. WING_	D00 30 30	01/17/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I. Surrey
GILBER'	RTSON LODGE			301 BOWMAN LANE NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE COMPLETION
W 149	asked what could he prevent this incident should have tried the that first."  During Investigative had just completed breakfast. I then water and saw [Individual eating. I asked if and because he was eat	age 10 supervised, but wasn't." When have been done differently to ht, DSP #3 replied, "I feel we he HeimlichI regret not doing le Interviews DSP #1 stated, we I the morning hygiene after alked into the common area I #2] sitting at the dining table hyone gave him a snack ating and it wasn't snack time and asked him what he was		4QIDP/Residential Supervisor, Residential Services Manager and Director of Residential Services revised Gilbertso Lodge's Staff Rest Breaks and Meal Breaks Policy (see attachment B, #5) to instruct staff on the placement of their personal food items in order to prevent staff from leaving their food sitting out an area that is accessible to the Individual At no time will staff food items be left within reach of the Individuals.	on to nt nt in duals.
The second secon	eatingthat's when in his mouth. I remo and told him to go to	n he shoved some of the food oved the food from his hand to the couch. I put the food in on went to get water to help him		A refrigerator was purchased and place the staff office which is specifically for staff food.	
	DSP #1 indicated the the home by DSP #2 have been done diffinitional incident, DSP #1 sta	hat the muffin was brought into #2. When asked what could ferently to prevent this ated, "monitor him more should have started the		QIDP/Residential Supervisor and Residential Services Manager provide staff training on the updated policy and procedures on February 28, 2017 (see attachment C.)	d
	mouthsomething b just remembered in compressions were him breathsI tried to couldbut I felt like I	besides just standing there. In the moment that more important than giving to help as best as I I was doing everything alone."		QIDP/Residential Supervisor and Residential Services Manager have ad Choking Education Posters to the Kitc Staff Office, Activity Room, and Hall- where all Individuals bedrooms are loc	chen, way
	"At 10:09 A.M. Indivi with DSP #3 At 10:12:27 A.M. Ind	1/21/17 Indicated the following: ridual #2 went into med room dividual #2 sat at dining room wrapping muffin, staff DSP #3		in order to provide an ongoing remind and quick reference to staff concerning responding during a choking incident. Training materials remain onsite for st reference (see attachment I.)	ler g

house

passed through living room going toward back of

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CENTE	COT ON MEDIONINE	G MEDIO/ ND OF ITAIOCO		<del>~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~</del>	2111D 110. 0000 000
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	0 100 50	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	Sept.	49G058	B WINC	, , , , , , , , , , , , , , , , , , , ,	01/17/2018
NAME OF PROVIDER OR SUPPLIER  GILBERTSON LODGE				STREET ADDRESS: CITY, STATE, ZIP CODE  301 BOWMAN LANE  NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLETION
W 149	muffin At 10:14:11 A.M. In (appears) to be the #1 took it from him, (Individual #2 was a 10:14:11 when eatin At 10:14:33 A.M. In sofa/3 staff were in	dividual #2 took first bite of dividual #2 had what looks 7th bite of the muffin and DSP he got up and left the table alone from about 10:12:47 to ng the muffin) dividual #2 sat down on the	W	Training Services Administrator provided specific, hands-on training program staff in order to assess performance of the Heimlich Maneur on February 28, 2017 (see Attachmet C.)	ver
	appears to be in dis At 10:15:01 A.M. Dopatting his back, Inchis mouth four time At 10:15:18 A.M. Do 911 At 10:15:25 A.M. In sofa, staff DSP #2 worving At 10:15:42 A.M. Downs moving, leaned turning blue At 10:15:49 A.M. Do appeared to be in p for 7 seconds At 10:16:01 A.M. Do #2 was moving At 10:16:11 A.M. Do #2 was moving	comfort/3 staff in room SP #2 was at his side and dividual #2 motioned toward		This training included the addition of "Choking Charlie," a mannequin use instruct staff on properly performing procedure (see Attachment D.) The training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performing Heimlich Maneuver upon the first indication that someone is choking as reiterated the universal sign of choking include clutching the neck and/or pointing toward the neck or mouth.	ed to the ne g the
	was alone for about At 10:16:14 A.M. In moving, staff drag h At 10:16:23 A.M. Co performed by DSP of At 10:19:20 A.M. EN back-up, staff DSP At 10:21:22 A.M. Fin	10 seconds) dividual #2 was no longer im to the floor empressions began,		Training Services Administrator has added the Choking Charlie module to CPR course. All Residential Services staff are required to demonstrate this during initial and recertification CPR training.	ongoing skill

EMT's observed attempting to intubate Individual

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CLITTE	NO FOR MEDICARE	G MEDICALD SERVICES			<u> </u>
	FOR DEFICIENCIES DE CORRECTION	(X1) PROVIDER:SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G058	B. WING		01/17/2018
NAME OF PROVIDER OR SUPPLIER  GILBERTSON LODGE				STREET ADDRESS, CITY, STATE, ZIP CODE 301 BOWMAN LANE NEWPORT NEWS, VA 23606	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI	LD BE COMPLETION
W 149	breathing apparatu At 10:39:20 A.M. El	MT's stop compressions, have s attached MT went out of home	W 1	QIDP/Residential Supervisor and	2/28/2017
	that EMT's were no and she questioned transferred At 10:41:20 A.M. El At 10:45:38 A.M. El #2 on stretcher	rogram nurse arrives, states t able to intubate individual why individual was not yet MT returns with stretcher MT exit home with Individual idual #2 arrives at ER dual #2 is triaged		Residential Services Manager have added Choking Education Posters to Kitchen, Staff Office, Activity Roo and Hallway where all Individuals bedrooms are located in order to proan ongoing reminder and quick reference to staff concerning responduring a choking incident. Training	o the m, ovide nding
		ardiac arrest (primary),		materials remain onsite for staff reference (see attachment I.)	
	admission, patient visubsequently choke arrest with subsequently arrest with subsequently administration of the EMS Patient has 54 minutes in the Exercised spontaneor patient to ICU	additional) In the morning of vas eating a muffin, where he do not, causing respiratory ent followed by cardiac arrest is 25 minutes prior to arrival of do a total resuscitation time of R, but finally circulation was usly and decided to admit the nough the patient does not		An AED has been purchased for the home. All staff are trained on the us the AED during their initial and biannual CPR recertification by the Training Services Department	se of And
	reflex, gag reflex Sister has decided reventually passed a	eal reflex, including corneal not to resuscitate and patient way, and patient was anuary 21, 2017 at 5:26 PM".			
	three staff members "You are receiving a written warning for A	e Counseling Record for the involved indicated: Second Group Offense buse/Neglect of an individual Personnel Policy #16 - Abuse			

and neglect, states that 'it is the policy of the

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
		49G058	B WING			01/17/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS CITY, STATE, ZIP COD		
				301 BOWMAN LANE		
GILBER	rson Lodge		4	NEWPORT NEWS, VA 23606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
W 149	free from verbal, ph Furthermore the ag identify abuse as "a employee or other p care of an individual person or program for providing service nourishment, treath necessary to the he person receiving ca "On 1/21/17, you we individual receiving while consuming a information reporter muffin that belonged dinning room table, muffin, which result transported to the he "On January 22, 20 office received the in 21, 2017 noting that choked while consu- policy, a formal inve- and you were place pending the findings the course of the individualized Progratable supervision du Specifically, the plan cramming and rapid	insure that all individuals are supplied abuse or punishment." Hency's Human Rights Policies any act or failure to act by an person responsible for the all and neglect as "failure by a facility to (sic) responsible ses to do so including ment, care, goods, or services ealth, safety, or welfare of a	W	The facility conducted an investive which resulted in a finding of netowards Individual #2 as a result failure to follow Individual #2's Individualized Program Plan (IPI was determined that staff left the personal food out within reach of Individual #2 and left him unsupalthough his IPP required that he supervised during meals. All prostaff present at the time the incidoccurred were terminated  QIDP/Residential Supervisor, Residential Nurses, and Resident Services Manager met with Gilbe Lodge staff on January 24, 2017 review the incident involving Individual Supervisor and Residential Services Manager proinstruction for monitoring the eat and storing staff food. Residential Nurses provided an in-service trathe administration of the Heimlic Maneuver. (See Attachment A.)	glect of P.) It ir f ervised be ogram ent  ial ertson to lividual d povided ing area al ining on	2/6/2017
	and suggested: Presention of small.	single solid bites before continuous monitoring of				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER: SUPPLIER: CLIA IDENTIFICATION NUMBER	18	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G058	B WING	NT B CH STANDARD	01/17/2018	
NAME OF E	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GII BERT	SON LODGE			301 BOWMAN LANE		
GILDLIN			202 11	NEWPORT NEWS, VA 23606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
W 149	Continued From pa	age 14	W 14	9		
	Liquid wash followi Verbal/visual direct	ng each bite sized solid. ions provided for Individual #2				
	while eating."			QIDP/Residential Supervisor will	3/1/2018	
	"It was further determined that the individual was left unattended with food in his reach, which he consumed unsupervised. Failure to keep food out of the reach of the individual/provide supervision while he was eating led to the individual choking."			review the meal protocols for all	and	
				Individuals at the monthly staff	ongoing	
				meeting after each Individual's annumeeting in order to ensure that staff		
				understand the significance of the pl	lan	
	"Based on the information obtained during the			and the importance of following the individualized protocol		
		was a preponderance of		marviduanzed protocor		
		ort a finding of abuse (neglect) ual. As such, the finding of				
	neglect was substa			Consulting Dietitian provides training	ng 3/1/2018	
	Competing Antion C	llen:		to Gilbertson Lodge Staff on food		
	Correction Action P "Due to the severity	of the incident, you will be		consistency preparation and observe	:S	
	terminated from yo	ur position (s) effective		meal preparation during monthly		
	immediately, signer	d and dated 2/7/17."		reviews. Dietitian will include		
	During an interview	on 1/17/18 at 10:15 A.M. with		observation specific to each Individu	ıal	
		ntial Service Director, she stated, the		in her monthly review notes.		
	facility failed to provide Individual #2 with			QIDP/Residential Supervisor	5/31/2017	
	supervision to prev	ent, "Neglect."		implemented the use of cue cards that	The second contract of the second	
	The facility staff fail	staff failed to provide supervision to		include the instructions for supporting		
	prevent neglect.			all Individuals during meal time in	-	
W 242	INDIVIDUAL PROC		W 24	accordance with their Nutritional		
	CFR(s): 483.440(c)	(O)(III)		Management Plan (see Attachment J	i.)	
		ram plan must include, for		The cue cards are utilized by staff during meal preparation and while		
	those clients who lack them, training in personal			supporting Individuals during meals		
		privacy and independence mited to, toilet training,		TIT TO THE TOTAL OF THE PROPERTY OF THE PROPER		
		lental hygiene, self-feeding,				
	bathing, dressing, g	rooming, and communication				
	of basic needs), un	til it has been demonstrated				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OI	<u>MB NO. 0938-0391</u>			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		49G058	B. WING		01/17/2018			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
C1 DED1	TOON LODGE		l	301 BOWMAN LANE				
GILBER	ISON LODGE			NEWPORT NEWS, VA 23606				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ( LEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION			
W 242	Continued From pa	ge 15	W 2	42				
	ACCUSANCE OF A STATE O	velopmentally incapable of			1/24/2017			
	acquiring them.			QIDP/Residential Supervisor, 1/24/2017 Residential Nurses, and Residential				
				Services Manager met with Gilbertso	. m			
	This CTANDADD :			Lodge staff on January 24, 2017 to	Л			
		s not met as evidenced by: eview and staff interview, the		review the incident involving				
		implement the individual		Individual #2 with all program staff.				
	program plan for or	ne individual (Individual #2), in		QIDP/Residential Supervisor and				
	the survey sample of	of two individuals.		Residential Services Manager provid	ed			
	The findings include	~ dl ·		instruction for monitoring the eating	NS 7602			
	The findings include	ed.		area and storing staff food. Resident	ial			
	The facility staff fail	ed to provide Individual #2		Nurses provided an in-service training				
		prevent choking while		on the administration of the Heimlich				
	consuming a muffin	where he later died.		Maneuver. (See Attachment A.)				
	Individual #2 was a	dmitted to the facility on		OIDD/D acidential form miner and d	1/24/2017			
		ses of moderate intellectual		QIDP/Residential Supervisor posted	1/24/2017			
		abetes, hypertension,		signage in the kitchen and dining are	as			
		eflux didease (GERD), perlipidemia, sleep apnea,		instructing staff that the area is to be				
	seizures and parane			monitored at all times (see Attachme	nt			
	•	,		F.) This requirement was reviewed				
		al Assessment dated 5/10/16		with staff by QIDP and Residential	2009			
		Problems: Type II diabetes,		Services Manager on January 24, 201	17			
		D, Hypothyroidism, paranoid erlipidemia, sleep apnea,		(see attachment A.)				
		irrent Diet: 1800 calorie low						
		Consistency: bite size,						
		ds: No chicken on bone and		Consulting Dietitian provides training	g 3/1/2018			
	cubed bread only to be mixed with meats, ten 8			to Gilbertson Lodge Staff on food				
		daily. For hospitalizations, a diet is recommended."		consistency preparation and observes	Š			
	parecu-correlaterity	dictio recommended.		meal preparation during monthly				
	A Behavioral Suppo	rt Plan dated 5/6/16 indicated:		reviews. Dietitian will include	Î			
	"Target Behavior: Di	sruptive Behavior - Shouting,		observation specific to each Individua	al			
	throwing his walker	or other objects, making		i i and opposite to each marvidu				

statements of wanting to harm himself or others, making verbally abusive statements towards

in her monthly review notes.

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CENTER	13 FOR MEDICARE	A MEDIONIO DEITOIDO		100 to 1 100	
STATEMENT OF DÉFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED	
		49G058	B. WING	01/17/2018	
NAME OF PROVIDER OR SUPPLIER GILBERTSON LODGE			STREET ADDRESS, CITY, STATE, ZIP COD 301 BOWMAN LANE NEWPORT NEWS, VA 23606	JE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
W 242	Continued From page 16 others."  An Individual Service Plan (ISP) dated 5/24/16 indicated: "Individual #2 receives and responds to At-table staff supervision during meal and snack time.  During all meals and snack time, Individual #2 will accept staff supervision and redirection to eat at an acceptable pace for his safety and to prevent episodes of choking for 4 consecutive months. It is recommended that Individual #2 maintain a diet consisting of bite-sized portions with ground meats and liquids. In order to avoid load cramming and rapid rate of eating and possible choking, the following steps are recommended and suggested:  1. Presentation of small, single solid bites before liquid drink.		Registered Nurse have enhanced staff And training to add the DBHDS Health ongoing Safety and Quality Alerts to the existing Fatal Five training conducted for Gilbertson Lodge with special		
	ingestion. For examineed to be remove to prevent food crachoking/aspiration.  3. Liquid wash (incleach bite sized solid. Verbal/visual direction).	eluding applesauce) following id. ections provided for Individual or example: verbally instruct lest one bite-size piece at a	Gilbertson Lodge staff received training on March 6, 2017 (see attachment E.)  This training is offered at least quarterly in order to train oncon staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training QIDP/Residential Supervisor with the staff and provide refresher training quantity and the staff and provide refresher training quantity and the staff and the	And Ongoing ning ing.  ill 3/1/2018	
	An Incident and Ac 4:59 P.M. indicated Disability Professio reported to QIDP the of the house toileting #2 was on the couch by staff that when the	ccident Report dated 1/21/17 at d: "QIDP (Qualified Intellectual onal was notified and it was hat while staff were in the backing two individuals, Individual ch asleep. QIDP was informed they walked back into the y noticed Individual #2 was not	review the meal protocols for al Individuals at the monthly staff meeting after each Individual's meeting in order to ensure that sunderstand the significance of the and the importance of following individualized protocol	ongoing annual staff ne plan	

on the couch anymore but was at the dining table

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER SUPPLIER/CLIA IDENTIFICATION NUMBER.		IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
	2 0000 to 2000 to 1000	49G058	B. WING	Annual Control of Cont	01/17/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,
GILBER	TSON LODGE			301 BOWMAN LANE NEWPORT NEWS, VA 23606	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFESTION (ENCY)	D BE COMPLETION
W 242	did they give Individual members responde Individual #2 and asher. He responded mouth and ambulat took the bag that Inback into the kitche individual #2. Staff I asked (sic) Individual he okay. That staff Individual #2 was turan into the kitchen phone to call 911. T	asked the other staff members ual #2 a snack. The two staff d no. Staff approached sked him to hand the snack to by stuffing the snack in his ing back to the couch. Staff dividual #2 had on the table in a poured a cup of water for neard another staff member al #2 was he choking and was stated to another staff that rining blue in the face. Staff and picked up the kitchen he staff noticed that the	W 24	QIDP/Residential Supervisor, Residential Services Manager and Director of Residential Services revised Gilbertson Lodge's Staff Re Breaks and Meal Breaks Policy (see attachment B, #5) to instruct staff or the placement of their personal food items in order to prevent staff from leaving their food sitting out in an a that is accessible to the Individuals. no time will staff food items be left within reach of the Individuals.	e n l I rea At
	staff went into QIDF phone to dial 911. S area with Individual on the floor. While o proceeded to inform #2 was choking and	ng or had a dial tone. That i's office to get the cordless taff ran back into the common #2 and began to transfer him in the phone with 911, staff the dispatcher that Individual that she was going to presuscitation) The staff PR as she was		Training Services Administrator provided specific, hands-on training program staff in order to assess performance of the Heimlich Maneuver on February 28, 2017 (see Attachment C.)	10
	communicating with her to count compre doing them. The state pulse and noticed the informed dispatcher. At the time, dispatch hear the staff's voice passed the phone to to the dispatcher as compressions. Another individual #2's pulse asked staff to continual was performing compressions.	dispatcher. Dispatcher asked ssions aloud as she was ff checked for Individual #2's at he did not have one. Staff that he did not have a pulse, were stated that she could not anymore thereby staff another staff member to talk she continued another set of her staff member checked again as EMT arrived. EMT ue CPR and observed as she pressions on Individual #2.		This training included the addition of "Choking Charlie," a mannequin use to instruct staff on properly perform the procedure (see Attachment D.) I training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performint the Heimlich Maneuver upon the first indication that someone is choking a reiterated the universal sign of choking and the staff performing the staff performing the Heimlich Maneuver upon the first indication that someone is choking a reiterated the universal sign of choking and the staff performance of the staff perfor	ed ing The he s g st and

EMT. Staff switched off with another staff

member to step outside. Staff called QIDP and

to include clutching the neck and/or

pointing toward the neck or mouth.

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CENTERS FOR MEDICARE & MEDICAID SERVICES			0	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		49G058	B WING		01/17/2018	
NAME: OF PROVIDER OR SUPPLIER GILBERTSON LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 301 BOWMAN LANE NEWPORT NEWS, VA 23606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
W 242	informed staff that sinformed staff that shome to assess the the house and EMT Individual #2 and wwell as trying to cleasked staff for Individual	ify of the incident. Nurse she was on her way. QIDP she was on her way to the e situation. Staff went back into were performing CPR on ere using AED to find pulse as ar Individual #2's airway. EMT ridual #2's medical	W 2-	Training Services Administrator has added the Choking Charlie module to the CPR course. All Residential Serv staff are required to demonstrate this skill during initial and recertification CPR training.	ices ongoing	
	#2's medical condit introduced herself to a pulse for Individual performing CPR. El breathing machine of his transfer to ho condition was stable Individual, #2's contable to get any accurate.	formed EMT of all Individual ions. Nurse arrived and o EMT. EMT was able to find all #2 after 15 minutes of MT placed Individual #2 on a then proceeded to inform staff spital. EMT stated that his e. Nurse inquired about dition from EMT but was not urate information about his 1 #2 was transferred to		QIDP/Residential Supervisor will revite meal protocols for all Individuals the monthly staff meeting after each Individual's annual meeting in order ensure that staff understand the significance of the plan and the importance of following the individualized protocol	at and ongoing	
	hospital with one staff and nurse following. At the end of the shift, Individual #2 remained at the hospital."  During an interview on 1/17/18 at 10:15 A.M. with the Residential Service Director, she stated, the facility failed to implement Individual #2's program plan to provide Individual #2 with supervision when eating to prevent choking.  The facility staff failed to implement Individual			QIDP/Residential Supervisor implemented the use of cue cards that include the instructions for supporting all Individuals during meal time in accordance with their Nutritional Management Plan (see Attachment J. The cue cards are utilized by staff during meal preparation and while supporting Individuals during meals	g ongoing  .) .ring	
		upervision to prevent choking		QIDP/Residential Supervisor posted signage in the kitchen and dining are instructing staff that the area is to be monitored at all times (see Attachme F.) This requirement was reviewed w	nt	

staff by QIDP and Residential Services Manager on January 24, 2017 (see