DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 02/08/201 FORM APPROVEI OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDO	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		49G060	B. WING		01/31/2019	
NAME OF	PROVIDER OR SUPPLIER	<del> </del>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
INDIAN	RIVER RESIDENCE -	A		2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION	
E 000	Initial Comments		E 00	0		
	Survey was conduct The facility was in a CFR Part 483.73, 4	mergency Preparedness led 1/30/19 through 1/31/19. ubstantial compliance with 42 83.475, Condition of ermediate Care Facilities for liectual Disabilities.				
111.000	investigated during t					
W 000	INITIAL COMMENT	S	W 000			
	re-certification surve through 1/31/19. Th compliance with 42 ( for Intermediate Can with Intellectual Disa Safety Code survey/	undamental Medicaid by was conducted 1/30/19 e facility was not in CFR Part 483 Requirements e Facilities for Individuals ibilities (ICF/IID). The Life report will follow. No estigated during the survey.				
	the time of the surve consisted of 3 Individent through #3).	certified bed facility was 5 at y. The survey sample lual reviews (Individuals #1				
W 251	PROGRAM IMPLEM CFR(s): 483.440(d)(3		W 251			
	plan that must be impersonnel, each clien must be implemented	ets of the individual program plemented only by ilcensed it's individual program plan d by all staff who work with rofessional, paraprofessional staff.				
	This STANDARD is i	not met as evidenced by:				

ny deficiency statement ending with an asteriak (") denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days flowing 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 tys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XIS) DATE

		I AND HUMAN SERVICES		FOR	D: 02/06/2019 RM APPROVED O: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	The state of the s	LE CONSTRUCTION (X3) D	(X3) DATE SURVEY COMPLETED	
		49G060	B. WING		1/31/2019	
NAME OF	PROVIDER OR SUPPLIER	1	1 8	STREET ADDRESS, CITY, STATE, ZIP CODE		
INDIAN C	NATE BESIDENCE	•	2	1526 LIFETIME CIRCLE		
INDIAN	RIVER RESIDENCE -	*		/IRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
W 251	Based on observa clinical record revie implement an Indivioual (Indithe survey sample.)  The facility staff faireceived nectar this meal on 1/31/19.  The findings includ Individual #2 was on 1/21/13. The cumprofound intellectus spastic quadripleging Individual #2 Physion 1/2019, revealed a with nectar thick lick than 300 milligrams hour of sleep, Bootonectar thickened lick one of Fiberson nectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep, Bootonectar thickened lick individual #2 cycle than 300 milligrams hour of sleep.	tion, staff interviews, and aw, the facility staff failed to ridual Program Plan (IPP) for vidual #2), of 3 Individuals in led to ensure Individual #2 ck liquids during the midday led:  originally admitted to the facility ent diagnoses included; al disability, cerebral palsy with a and a seizure disorder.  cian's order summary for an order for a puree low fat diet quids.  titian assessment dated isk; diet ordered puree, low fat quids.  menu read; puree, low fat, less s of cholesterol, puree snack st supplement when less than a consumed or refused meal. 2 urce daily, Kefir once a day with quids. Provide small portions	ì	Il met with the Indian River staff who were working in Residence A during the unannounced survey to review the deficiencies, as well as other recommendations shared by the Surveyors. The QIDP reviewed the diet order, including fluid consistency, of Individual #2, as well as the diet orders of all other residents of the facility. She reminded staff that the current diet order may be found along the top of each individual's cycle menu. This information will also be reviewed with all facility staff at the upcoming February staff meeting on 2/27/19  As part of the current practice at Indian River Residence A, the QIDP provides training to a facility staff on each individual's treatment plan, including the individual's diet order. This training occurs annually and whenever there is a change. In monthly supervision meeting with the facility's direct care staff throughout the month of February, the House Manager will review each resident's diet order and have staff demonstrate that they know when that information can be found.  To ensure diet orders are consistently being followed, effective immediately, the QIDP, House Manager, and/or the Behavioral Specialist will regularly monitor mealtimes. Monitoring of mealtimes will take place at least three times per week to ensure diet	h 2/28/19 r all is s	
PRÉFIX TAG	Continued From particular record review implement an Individual (Individual Individual one Individual (Individual one Individual (Individual one Individual (Individual one Individual one Individual #2 was one Individual #2 was one Individual #2 was one Individual #2 Physion Individual Physion In	age 1 stion, staff interviews, and sw, the facility staff failed to ridual Program Plan (IPP) for ridual #2), of 3 Individuals in led to ensure Individual #2 ck liquids during the midday led: originally admitted to the facility ent diagnoses included; al disability, cerebral palsy with a and a seizure disorder. cian's order summary for in order for a puree low fat diet quids. titian assessment dated isk; diet ordered puree, low fat quids. menu read; puree, low fat, less s of cholesterol, puree snack st supplement when less than is consumed or refused meal. 2 urce daily, Kefir once a day with	W 251	On 2/6/19, the facility's QIDP and Supervisor II met with the Indian River staff who were working in Residence A during the unannounced survey to review the deficiencies, as well as other recommendations shared by the Surveyors. The QIDP reviewed the diet order, including fluid consistency, of Individual #2, as well as the diet orders of all other residents of the facility. She reminded staff that the current diet order may be found along the top of each individual's cycle menu. This information will also be reviewed with all facility staff at the upcoming February staff meeting on 2/27/19.  As part of the current practice at Indian River Residence A, the QIDP provides training to a facility staff on each individual's treatment plan, including the individual's treatment plan, including the individual's diet order. This training occurs annually and whenever there is a change. In monthly supervision meeting with the facility's direct care staff throughout the month of February, the House Manager will review each resident's diet order and have staff demonstrate that they know when that information can be found.  To ensure diet orders are consistently being followed, effective immediately, the QIDP, House Manager, and/or the Behavioral Specialist will regularly monitor mealtimes. Monitoring of mealtimes will take place at	h is is js	

Ongoing

programs are being implemented as written. The observations will take place across shifts

and with varying staff. In addition, the

monthly to ensure compliance.

Facility ID: VAICFI070

Supervisor II will complete spot-checks of

meal preparation and mealtimes at least

The Individual Program Plan (IPP) dated 9/5/18,

read; (name of resident) will be offered thickened

fluids 50 ounces throughout the day and water 8

ounces, 8 times per day. Pour drink in small

tumbler cup 1/2-1/2 full and refill as needed.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

CENTERS	FUR MEDICAR	E & MEDICAID SEKACES			HIND INC. VOVO-VVO	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		49G060	B. WING		01/31/2019	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
INDIAN RIV	er residence .	<b>A</b>		2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		BE COMPLETION			

## W 251 Continued From page 2

On 1/31/19 at approximately 12:50 p.m., DSP #5 was observed preparing Individual #2 meal. She poured bottled water into the tumbler, no thick-it was added and served it along with her pureed meal.

On 1/31/19 at approximately 12:50 p.m., Individual #2 was observed seated at the dining table with her peers for the midday meal. Direct Support Personnel (DSP) #4 sat with her to assist with the meal. DSP #4 gave Individual #2 a drink from her cup, the individual began to cough, DSP #4 looked at what was in the cup and informed DSP #5 the water was not thickened, DSP #5 put some thickener in the cup but DSP #4 got up and thickened the water further. DSP #4 proceeded to aid Individual #2 to complete her meal with no further coughing episodes.

An interview was conducted with DSP #2, on 1/31/19 at approximately 3:45 p.m., she stated the staff assigned to meal preparation is responsible for ensuring the individual's diet served is what's ordered. She further stated all information regarding the meal is on the individual's personal menu. DSP #2 stated she was a full time staff and the staff assisting with helping the individuals with their meal was full time and the part time staff prepared the meal at midday.

An interview was conducted with DSP #4, on 1/31/19 at approximately 3:50 p.m., she stated when individual #2 began to cough she looked in her cup because she knew she couldn't tolerate thin liquids. She stated the water was thin and she knew she had to get it thickened to prevent the individual from choking.

W 251

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO	: 02/06/2019 APPROVED : 0938-0391
STATEMENT (	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	25 22 000000000	TIPLE CO	ONSTRUCTION	CO	TE SURVEY APLETED
		49G060	B. WING				/31/2019
	ROVIDER OR SUPPLIER			2525	ET ADDRESS, CITY, STATE, ZIP CO LIFETIME CIRCLE BINIA BEACH, VA 23456	ODE:	
INDIAN R	VER RESIDENCE -			VINC	PROVIDER'S PLAN OF COR	RECTION	(205)
(X4) ID PREFIX TAG	ATA OLA DESENDIENZA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLÉTION DATE
W 251	Continued From po	age 3	W	251			
<b>W</b> 331	Supervisor II, Adm on 1/31/19 at appr Supervisor stated individual's cycle in staff use during all. The facility's policy 11/19/12 read; it is company) to ensu appropriate diet to ideal body weight concerns. Under I read; staff will protimes to ensure si implement individ NURSING SERVI CFR(s): 483.460(	were shared with the inistrator and Nurse Manager oximately 5:05 p.m. The dietary instructions are on the neru and they are available for meal preparation.  If titled "Meal Service" dated the policy of the (name of the re individuals receive an assist them in maintaining an and address any health Dining Area and Service #4 vide supervision during meal afety, adequate intake and ual eating programs.  (CES c)  provide clients with nursing dance with their needs.	ı	331			
	Based on observational record reventify nursing state in a change in contract interventions for three individuals	is not met as evidenced by: ration, staff interviews, and riew, the facility staff failed to iff of an event which could resu- indition and/or require additions one individual, (Individual #2), o in the survey sample.	of				
	حوم والمسائنين المسائنين المسائن المس	failed to notify nursing staff that eived thin liquids which caused she should have received nect i.					

The findings included:

# THENT OF HEALTH AND HIMAAN OFDWACED

PRINTED: 02/06/2019

	CENTERS FOR MEDICARE & MEDICAID SERVICES				
ATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G060	(X2) MULT A. BUILOII B. WING		3) DATE SURVEY COMPLETED 01/31/2019
49G060  AME OF PROVIDER OR SUPPLIER  NDIAN RIVER RESIDENCE - A				STREET ADORESS, CITY, STATE, ZIP CODE 2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL.	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	

## W 331. Continued From page 4

Individual #2 was originally admitted to the facility 11/21/13. The current diagnoses included; profound intellectual disability, cerebral palsy with spastic quadriplegia and a seizure disorder.

Individual #2 Physician's order summary for 1/2019, revealed an order for a puree low fat diet with nectar thick liquids.

The registered Dietitian assessment dated 9/4/18, aspiration risk; diet ordered puree, low fat with nectar thick liquids.

Individual #2 cycle menu read; puree, low fat, less than 300 milligrams of cholesterol, puree snack hour of sleep. Boost supplement when less than 50% of the meal is consumed or refused meal, 2 ounces of Fibersource daily, Kefir once a day with nectar thickened liquids. Provide small portions and water or calorie free beverages with meals.

The Individual Program Plan (IPP) dated 9/5/18, read; (name of resident) will be offered thickened fluids 50 ounces throughout the day and water 8 ounces, 8 times per day. Pour drink in small tumbler cup 1/4 - 1/4 full and refill as needed.

On 1/31/19 at approximately 12:50 p.m., DSP #5 was observed preparing Individual #2 meal. She poured bottled water into the tumbler, no thick-it was added and served it along with her pureed meal.

On 1/31/19 at approximately 12:50 p.m., Individual #2 was observed seated at the dining table with her peers for the midday meal. Direct Support Personnel (DSP) #4 sat with her to assist with the meal, DSP # 4 gave Individual #2 a drink from her cup, the individual began to cough, DSP

## W 331

On 2/6/19, the facility's QIDP and Supervisor Il met with the Indian River staff who were working in Residence A during the unannounced survey. The QIDP reviewed the requirement to immediately notify nursing staff of any event which could result in a change in condition and/or require additional interventions for Individual #2, as well as all other residents of the facility. Staff were reminded of their responsibility to recognize and immediately report to a licensed nurse any situation that may lead to complications so the individual may be monitored. Staff were also instructed to document the information on the Shift Report so that it may be passed on to oncoming shifts. The above information, as well as examples of various events which must be immediately reported to a nurse, will be reviewed with all facility staff at the upcoming February staff meeting on 2/27/19.

DEFICIENCY)

2/28/19

As part of the current practice at Indian River Residence A, the QIDP and/or the Supervisor II provide training to all facility staff at least annually, which addresses ICF/IID regulations, program implementation, and program documentation. Information regarding the requirement to immediately notify nursing staff of any event which could result in a change in condition and/or require additional interventions, including examples of such events, as well as the requirement to document that information on the shift report, will be added to the PowerPoint training. The PowerPoint training will be reviewed with all facility staff at the upcoming February staff meeting on 2/27/19 and at least annually thereafter.

2/28/19

#### PRINTED: 02/06/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XS) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER NO PLAN OF CORRECTION A BUILDING \_ 01/31/2019 A WING 49G060 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2826 LIFETIME CIRCLE INDIAN RIVER RESIDENCE - A VIRGINIA BEACH, VA 23456 PROVIDER'S PLAN OF CORRECTION CENT SUMMARY STATEMENT OF DEFICIENCIES D (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (XA) ID PREFIX DATE PREFIX TAG DEFICIENCY TAG W 331 W 331 Continued From page 5 #4 looked at what was in the cup and informed Instructions on the Shift Report form have DSP #6 the water was not thickened, DSP #5 put been revised to instruct staff to immediately some thickener in the cup but DSP #4 got up and notify nursing staff of any event which could thickened the water further. DSP #4 proceeded to result in a change in condition and/or require additional interventions, as well as to aid Individual #2 to complete her meal with no document the information on the Shift Report further coughing episodes. 2/22/19 so that it may be passed on to oncoming An interview was conducted with DSP #2, on shifts. 1/31/19 at approximately 3:45 p.m., she stated Shift Report occurs each shift between the the staff assigned to meal preparation is oncoming and outgoing nurses and DSP staff. responsible for ensuring the individual's diet Starting immediately, to monitor that nursing served is what's ordered. She further stated all staff are consistently being notified of events information regarding the meal is on the which could result in a change in condition individual's personal menu. DSP #2 stated she and/or require additional interventions, the was a full time staff and the staff assisting with staff person conducting Shift Report will ask all helping the individuals with their meal was full staff in attendance to confirm that they have time and the part time staff prepared the meal at informed a nurse and documented any such ongoing midday. events. An interview was conducted with DSP #4, on A check box has been added to the Shift Report form to record that this discussion 1/31/19 at approximately 3:50 p.m., she stated 2/22/19 when individual #2 began to cough she looked in occurs each shift. her cup because she knew she couldn't tolerate If found that any staff person has not thin liquids. She stated the water was thin and immediately notified nursing staff of an event she knew she had to get it thickened to prevent the individual from choking. DSP #4 stated the which could result in a change in condition

nurse was next door but she had not been

notified of the coughing episode.

ongoing

and/or require additional interventions, the

staff person will promptly receive re-training

on this requirement from the Supervisor II or

RN.

Facility ID: VAICFID70

	T OF DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	X3) DATE SURVEY	
ND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		493060	B. WING		01/31/2019	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RIVER RESIDENCE -		1 -	2525 LIFETIME CIRCLE		
NUME .	WER REDIVERSE -	^		VIRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION DATE	
W 331	Continued From pa	age 6	W 331		i	
(278)	The facility's policy	titled "Acute and Chronic	ST No. 100		Į.	
	Health Conditions"	dated 9/18/17 read; procedure				
		responsible for recognizing			:	
		ealth care needs of each				
		wing the plan developed by the am to address chronic				
		ow preventative practices.				
		policy read; all staff is				
	responsible for reco	ognizing acute conditions and				
		ing including calling 911.	*** ***			
W 434	FLOORS	STREETING.	W 434			
	CFR(s): 483.470(f)	(3)		THE RESERVE OF THE PARTY OF THE	100 and 100 an	
	The facility must be	ave exposed floor surfaces and		On 2/5/19, the Supervisor II met with the supervisors of the facility's cleaning	<b>,</b>	
		t promote maintenance of		company to discuss concerns regarding	the	
	sanitary conditions.			cleantiness of the kitchen flooring, include		
				the waxy build-up observed along the		
				baseboards, behind the trash can, and	9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
		is not met as evidenced by:		throughout the kitchen floors. Within the coming week, the cleaning company's flo		
		tions and staff interview, the o ensure the environment was		crew will strip the floors to remove the	DOT	
	maintained in a san			excess wax that is causing the floors to		
	III CHI PAGNITURE III TO	many veriamen.		appear to have a dark greasy substance		
		led to ensure the kitchen floors		Once the wax build-up has been remove	5	
	were without a build	d-up of debris at the		the cleaning company will use only non- products for regular mopping of the floor		
	baseboards and be	ehind the trash can.		and will continue its current schedule of		
	The findings include	<b>e</b> :		buffing the floors monthly.	ها عما عم	
	After the mest ober	ervation on 1/30/19 at		The cleaning company submitted an acti	ion	
		p.m., an observation of the		plan to improve and maintain the cleanliness of the kitchen. The action plant		
		a large amount of dark debris		entails an initial deep cleaning of the	an	
	was noted on the w	white baseboards making them		kitchen, including removal of the waxy by	ulid-	
		ark greasy substance. This		up on the baseboards and from the		
		as observed behind the trash		floorboards where the cabinets meet the	ľ	
	can and throughout	the kitchen floors.		floor, as well as cleaning of the walls,		
	0- 40440 et enn			cabinets and appliances. This initial deep	. //IN/IN	
	On 1/31/18, at appr	roximately 9:00 a.m., the		cleaning will take place within one week.	d No and the state of the state	

PRINTED: 02/06/2019

Facility ID VAICFID70

#### PRINTED: 02/08/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING 01/31/2019 B WING 49G060 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 LIFETIME CIRCLE INDIAN RIVER RESIDENCE - A VIRGINIA BEACH, VA 23456 PROVIDER'S PLAN OF CORRECTION COST SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) TAG W 434 W 434 Continued From page 7 kitchen floors remained with the same debris as Effective immediately, the House Manager and/or Supervisor II will check the cleanliness the day before. of the kitchen floor weekly and inform the An interview was conducted with Direct Support supervisors of the cleaning company if there Personnel (DSP) #1 on 1/31/19 at approximately are any cleanliness concerns that need to be 2/15/19 3:20 p.m. DSP #1 stated 3 days per week a promptly addressed. cleaning person comes in to clean the floors. In addition, checking the cleanliness of the floors and baseboards throughout the house The above findings were shared with the has been added to the facility's Maintenance Supervisor II, Administrator and Nurse Manager Checklist, which is completed monthly by on 1/31/19 at approximately 5:05 p.m. The assigned staff. The assigned staff will be Administrator stated the Supervisor II had made aware of this addition to the identified the floor and baseboards needed Maintenance Checklist and asked to report servicing. any cleanliness concerns to a facility 2/15/19 supervisor. The facility's policy titled "Physical Environment" dated 4/21/17 read at procedure 8; maintenance The facility supervisor will immediately address and/or cleaning will be performed as needed to any cleanliness concerns with the supervisors **Ongoing** ensure safe and sanitary conditions of the of the cleaning company. residence. Under floors #3 read; Floors at the facility will be evaluated on a monthly basis by the House Manager or designee. Maintenance and/or cleaning will be performed as needed to ensure safe and sanitary conditions of the residence.

W 454 INFECTION CONTROL CFR(s): 483.470(l)(1)

> The facility must provide a sanitary environment to avoid sources and transmission of infections.

> This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility staff failed to ensure food was stored in a sanitary condition

The facility staff failed to keep the refrigerator and freezer free of debris.

W 454

On 2/5/19, the facility's Supervisor II met with the supervisors of the cleaning company to discuss concerns regarding the cleanliness of the refrigerator, freezer, and the kitchen flooring, including the waxy build-up observed along the baseboards, behind the trash can, and throughout the kitchen floors. Within the coming week, the cleaning company's floor crew will strip the floors to remove the excess wax that is causing the floors to appear to have a dark greasy substance.

2/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) D.	(X3) DATE SURVEY COMPLETED	
		49G060	B. WING			0	1/31/2019	
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP C	ODE		
MITMAN S	RIVER RESIDENCE -		9	2525	LIFETIME CIRCLE			
MUNA	KIYEK KESIDENCE -	^		VIRG	SIMA BEACH, VA 23456			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	)	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE	
W 454	Continued From pa	age 8	W 4	54				
	The findings include:			Once the wax build-up has been removed, the cleaning company will use only non-wax products for regular mopping of the floor and will continue its schedule of				
		ervation on 1/30/19 at	Duming	the noc	ors monthly.		Ongoing	
	approximately 7:00 p.m., an observation of the kitchen was made; a large amount of dark debris was noted on the white baseboards making them appear to have a dark greasy substance. This same substance was observed behind the trash can and throughout the kitchen floors.  Observation of the refrigerator revealed a large			The cleaning company submitted an action plan to improve and maintain the cleanliness of the kitchen. The action plan entails an initial deep cleaning of the kitchen, including removal of the waxy build-up on the baseboards and floorboards where the cabinets meet the floors, as well as				
				cleaning of the cabinets, walls, and appliances. This initial deep cleaning will take place within one week.  As is the cleaning company's current practice, the				
	amount of dark del freezer.	custodia Wednet						
	refrigerator and fre	roximately 9:00 a.m., ezer were observed again and the same debris as the day	twice per month, of the ba	er mont The de aseboa	will complete a deep cleaning on the second and fourth From the second and fourth From the cleaning will entail a thoroused, floorboards where the cat nets, walls, and appliances.	idays of the igh cleaning	2/15/19	
	Personnel (DSP) # 3:20 p.m. DSP #1 stated a person	onducted with Direct Support 1 on 1/31/19 at approximately is assigned to clean the ezer based on who has meal ment.	Currenti prepara up follow spilts in and Sup maintair staff wh					
	The above findings Supervisor II, Admi	unannoi reviewe staff me	2/28/19					
	on 1/31/19 at appro The facility's policy dated 4/21/17 read and/or cleaning will	The task refrigera Checklis Informed the comi- are notif	2/15/19					
	ensure safe and sa residence. Under fit facility will be evaluate House Manager or cleaning will be per safe and sanitary or	Effective the kitch maintain an inspe then onc concerns	Ongoing					

(X2) MULTIPLE CONSTRUCTION

#### PRINTED: 02/06/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER. AND PLAN OF CORRECTION A BUILDING 01/31/2019 B. WING 49G060 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2625 LIFETIME CIRCLE INDIAN RIVER RESIDENCE - A VIRGINIA BEACH, VA 23466 PROVIDER'S PLAN OF CORRECTION (005) D SUMMARY STATEMENT OF DEFICIENCIES LETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LISC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG W 460 W 460 FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) On 2/6/19, the facility's QIDP and Supervisor II met with the Indian River staff who were working Each client must receive a nourishing. In Residence A during the unannounced survey. well-balanced diet including modified and The QIDP reviewed the specially-prescribed diet specially-prescribed diets. of Individual #2, as well as the modified and specially-prescribed diets of all other residents of the facility. She reminded staff that the This STANDARD is not met as evidenced by: current diet order may be found along the top of Based on observation, staff interviews, and each individual's cycle menu. This information

clinical record review, the facility staff falled to ensure one individual (Individual #2), of three Individuals in the survey sample; received the prescribe modified and diet.

The facility staff failed to ensure Individual #2 received nectar thick liquids during the midday meal on 1/31/19.

# The findings included:

Individual #2 was originally admitted to the facility 11/21/13. The current diagnoses included; profound intellectual disability, cerebral palsy with spastic quadriplegia and a seizure disorder.

Individual #2. Physician's order summary for 1/2019, revealed an order for a puree low fat diet with nectar thick liquids.

The registered Dietitian assessment dated 9/4/18, aspiration risk; diet ordered puree, low fat with nectar thick liquids.

Individual #2 cycle menu read; puree, low fat, less than 300 milligrams of cholesterol, puree snack hour of sleep. Boost supplement when less than 50% of the meal is consumed or refused meal. 2 ounces of Fibersource daily, Kefir once a day with nectar thickened liquids. Provide small portions

will also be reviewed with all facility staff at the upcoming February staff meeting on 2/27/19.

2/28/19

As part of the current practice at Indian River Residence A, the QIDP provides training to all facility staff on each individual's treatment plan, including the individual's specially-prescribed diet. This training occurs annually and whenever there is a change. In monthly supervision meetings with the facility's direct care staff throughout the month of February, the House Manager will review each resident's modified and specially-prescribed diet and will have staff demonstrate that they know where information about the specially-prescribed diet can be found.

2/28/19

To ensure modified and specially-prescribed diets are consistently being followed, effective immediately, the QIDP, House Manager, and/or the Behavioral Specialist will regularly monitor mealtimes. Monitoring of mealtimes will take place at least three times per week to ensure modified and specially-prescribed diets are being followed and eating programs are being implemented as written. The observations will take place across shifts and with varying staff. In addition, the Supervisor II will complete spotchecks of meal preparation and mealtimes at least monthly to ensure compliance.

Ongoing

### PRINTED: 02/06/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 49G080 01/31/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2525 LIFETIME CIRCLE INDIAN RIVER RESIDENCE - A VIRGINIA BEACH, VA 23456 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (XS) (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 460 Continued From page 10 W 460 and water or calorie free beverages with meals. The Individual Program Plan (IPP) dated 9/5/18, read; (name of resident) will be offered thickened fluids 50 ounces throughout the day and water 8 ounces, 8 times per day. Pour drink in small tumbler cup 1/2-1/2 full and refill as needed. On 1/31/19 at approximately 12:50 p.m., DSP #5 was observed preparing Individual #2 meal. She poured bottled water into the tumbler, no thick-it was added and served it along with her pureed meal. On 1/31/19 at approximately 12:50 p.m., Individual #2 was observed seated at the dining table with her peers for the midday meal. Direct Support Personnel (DSP) #4 sat with her to assist with the meal. DSP # 4 gave Individual #2 a drink from her cup, the individual began to cough, DSP #4 looked at what was in the cup and informed DSP #5 the water was not thickened, DSP #5 put some thickener in the cup but DSP #4 got up and thickened the water further. DSP #4 proceeded to aid Individual #2 to complete her meal with no further coughing episodes. An interview was conducted with DSP #2, on 1/31/19 at approximately 3:45 p.m., she stated the staff assigned to meal preparation is

midday.

responsible for ensuring the individual's diet served is what's ordered. She further stated all information regarding the meal is on the individual's personal menu. DSP #2 stated she was a full time staff and the staff assisting with helping the individuals with their meal was full time and the part time staff prepared the meal at

### PRINTED: 02/05/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 01/31/2019 R WING 49G060 STREET ADDRESS. CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2526 LIFETIME CIRCLE INDIAN RIVER RESIDENCE - A VIRGINIA BEACH, VA 23456 PROVIDER'S PLAN OF CORRECTION COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES D (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE /XAI ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) W 460 W 460 Continued From page 11 An interview was conducted with DSP #4, on 1/31/19 at approximately 3:50 p.m., she stated when Individual #2 began to cough she looked in her cup because she knew she couldn't tolerate thin liquids. She stated the water was thin and she knew she had to get it thickened to prevent the individual from choking. The above findings were shared with the Supervisor II, Administrator and Nurse Manager on 1/31/19 at approximately 5:05 p.m. The Nurse Manager stated the individual always coughs when eating that may have been the reason the staff didn't notify the licensed nurse. The Nurse Manager stated it was important for the information to be shared with the licensed nurse because complications may arise. The facility's policy titled "Meal Service" dated 11/19/12 read; it is the policy of the (name of the company) to ensure individuals receive an appropriate diet to assist them in maintaining an ideal body weight and address any health concerns. Under Dining Area and Service #4

Event ID UX0R11

read; staff will provide supervision during meal times to ensure safety, adequate intake and implement individual eating programs.