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ND PLAN OF	FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G026	A. BUILDING	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	06/01/201
(X4) ID PREFIX TAG	(EACH DEFICIE	YSTATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	V SHOULD BE COMP
E 000	Initial Comments		E 000		
E 006	survey was conducted of the compliance with 42 Condition of Partici Facilities for Individual Disabilities. No conduring the survey.	Emergency Preparedness cted 05/30/18 through ons are required for 2 CFR Part 483.73, 483.475, pation for Intermediate Care duals with Intellectual implaints were investigated	E 006		
	CFR(s): 483.475(a) [(a) Emergency Pla and maintain an em that must be review annually. The plan r (1) Be based on and facility-based and co	n. The [facility] must develop bergency preparedness plan led, and updated at least must do the following:] d include a documented, permunity-based risk g an all-hazards approach.*			
(on and include a doc community-based ris	t §483.73(a)(1):] (1) Be based cumented, facility-based and sk assessment, utilizing an h, including missing residents.			
C	and include a docum community-based ris	(3.475(a)(1):] (1) Be based on lented, facility-based and sk assessment, utilizing an n, including missing clients.		F	RECEIVED
e e	(2) Include strategie vents identified by the	s for addressing emergency he risk assessment.			ILIN 2 5 2018
ic	trategies for address lentified by the risk a	18.113(a)(2):] (2) Include sing emergency events assessment, including the onsequences of power			VDHIOLC

Any deficiency-statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

0/25/18

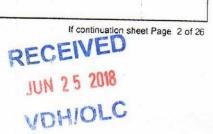
other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		49G026	B. WING		06	6/01/2018
	PROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREETADDRESS, CITY, STATE, ZIP C 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	CODE	**************************************
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 006	Continued From page	e 1	E 00	6		
	that would affect the ficare. This STANDARD is r Based on record revie	ters, and other emergencies nospice's ability to provide not met as evidenced by: ew and staff interview, the		The facility will conduct an ir assessment to identify the in risk factor related to emerge emergency evacuations. The facility will conduct indiv	dividual's potential ncy situations and	7/15/18
	facility starr failed to h facility's risk assessm strategies.	ave documentation of the ent and associated	55 200 200 200 200 200 200 200 200 200 2	assessment to identify all incrisk level.	dividuals' potential	7/15/18
	The findings included			The Comprehensive Function be updated with an Emergen section. Based on the Individual	ncy Preparedness dual's risk	
	5/31/18 at 1:30 P.M. ti Intellectual Residentia asked for documentat assessment and strate emergency events ide	Preparedness review on the Program Manager and all Service Director was tion for the facility based risk agies for addressing ntified by the risk lectual Residential Service		assessment, strategies will b staff to know how to provide emergency situations. If any change in an individual warrants an update to the risi the related strategies, the QII	supports during I's condition k assessment, and DP will make the	7/15/18 7/15/18
	Director stated, the fac identified any strategie	cility had not conducted nor es.		needed changes and forward information to the designate s maintaining the Emergency P binder. All staff will be trained	staff responsible for	
	addressing emergency risk assessment.	document strategies for y events identified by the		Emergency Preparedness po will update all Comprehensive Assessments.	licy and the QIDP	
E 007	EP Program Patient Po CFR(s): 483.475(a)(3)	opulation	E 007	No. of Contract of		
200	[(a) Emergency Plan.] and maintain an emerg that must be reviewed, annually. The plan must	The [facility] must develop gency preparedness plan and updated at least st do the following:]		The second secon		
	but not limited to, person services the [facility] has an emergency; and cor	as the ability to provide in	20 Maria 1990 Maria 19			

Event ID: 2NHZ11

Facility ID: VAICEMR11



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STATEMENT	OF DEFICIENCIES	(X1) PDC//DED//DED//DDC/			OWR	VO. 0938-0391
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG	100 miles	E SURVEY PLETED
- 78		49G026	B. WING _			010410040
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	UC	6/01/2018
KENTUC	VV AVEAUE BEAR			145 KENTUCKY AVENUE		
RENTOC	KY AVENUE RESIDEN	UE		VIRGINIA BEACH, VA 23452		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 007	Continued From pa	ana 2				
	Continued 1 Tom pa	3982	E 0	The facility will create a list of strategies	40	
	*Note: I'Dama			provide supports during emergency ever	10 nte	and the same
	hone: [Persons at	trisk" does not apply to: ASC,		based on the individuals' risk assessme	nts and	7/15/18
	FOHC or ESPO fo	IA, CORF, CMCH, RHC,		the level of supports needed.	no une	
	FQHC, or ESRD fa	clines.j				
	Based on record to	s not met as evidenced by: eview and staff interview the		The Chain of Communication section of	the	
	facility staff failed to	have documentation of the		Emergency Preparedness policy will be	updated	
	facility's nationt nor	Dulation that would be at risk		to denote the delegation of authority duri emergency: "During an unforeseen eme	ing an	
	during an emergen	cy and the strategies the		the on-site Shift Leader/Direct Support S	rgency,	
	facility have in place	e to address their needs. Also,		the authority to manage the emergency	situation	5
	the facility failed to	have written delegation of		including making emergency decisions:		7/15/18
	authority and how to	he facility plan to continue to		maintaining communication with emerge	ncy	1
	operate during an e	mergency	2	contacts; initiating purchases and use of		Î-
	,	mengency.	ä	contracts; directing staff, EMS and other		27
	The findings include	ed:		resources necessary to manage the eme	ergency,	
	3-11-11-11		3	and maintain the safety of the individuals Once the imminent danger has subsided	served.	
	During an interview	on 5/31/18 at 1:40 P.M. with		site Shift Leader/Direct Support Staff will	, the on-	1
	the Program Manac	ger and the Intellectual		the ICF Supervisor or designee for support	ort and	
	Residential Service	Director, they were asked for		directions."	art aria	
	documentation that	Individuals in the facility had				
	been identified who	were at risk and the types of		The Emergency Preparedness policy, inc	cluding	
	services needed. The	ne facility staff stated, they	ĺ	the delegation of authority, will be review	ed at	7/15/18
	had not identified inc	dividuals based on their risk		least annually.		
	nor had services be	en identified.		All staff will be trained on the updated		7/15/18
	T. 5			Emergency Preparedness policy.		7713/10
	ne Program Manag	ger and the Intellectual				
	Residential Service	Director were asked for				
	documentation for de	elegation of authority during				
	an emergency and n	ow the facility plan to				
	etaff etated thank	during an emergency. The				
	would assume onne!	not identified which staff				
	would assume speci	leg stated they did				
	a continuity of operal	lso stated, they did not have	*			- 1
	emergency.	gons han dailing au				
	The facility staff faile	d to identify at risk				
	individual's during an	emergency, have delegation				
	of authority and conti	nuity of operation during an				1





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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIA	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G026	B. WING _			06/01/2018	
	PROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREETADDRESS, CITY, STATE, 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452		00/01/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
E 007	emergency.		E0	07			
2015	Subsistence Needs CFR(s): 483.475(b)(for Staff and Patients 1) cedures. [Facilities] must	ΕO	15			
	develop and impleme policies and procedu plan set forth in para	ent emergency preparedness res, based on the emergency graph (a) of this section, risk	7				
	and the communicati this section. The poli	raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be d at least annually.] At a					
	minimum, the policies address the following	s and procedures must	***				
	and patients whether place, include, but are	ubsistence needs for staff they evacuate or shelter in e not limited to the following: cal and pharmaceutical					
	supplies (ii) Alternate sources following:	of energy to maintain the				100 mm and	
	(A) Temperatures to safety and for the safe provisions.(B) Emergency ligh	o protect patient health and and sanitary storage of ting.					
	(C) Fire detection, e systems. (D) Sewage and wa	extinguishing, and alarm	- C			K 7 01	
	Policies and procedure	e at §418.113(b)(6)(iii):] es.		THE CONTRACT OF THE CONTRACT O			
	nospice-operated inpa The policies and proce	dditional requirements for tient care facilities only, address the		Comment and the Comment and th		12 All 1	
10	following: (iii) The provision of su hospice employees an	bsistence needs for d patients, whether they	Section 2			199-1-1 (A) (1) (1) (A) (A) (A) (A) (A) (A) (A) (A) (A) (A	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		N (DENTIFICATION NUMBER: A.		MULTIPLE CONSTRUCTION (X3)		B) DATE SURVEY COMPLETED	
	8	49G026	B. WING	FAMILIE AND	0010410040		
KENTU	PROVIDER OR SUPPLIER CKY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452		6/01/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 01	5 Continued From page	: 4	E 01	5			
	imited to the following (A) Food, water, me supplies. (B) Alternate source following: (1) Temperatures and safety and for the of provisions. (2) Emergency lie	edical, and pharmaceutical es of energy to maintain the s to protect patient health safe and sanitary storage					
	(C) Sewage and wa This STANDARD is n Based on record revie	ot met as evidenced by: w and staff interview, the ave a Fire Watch Process	and the same of th	The facility will update the Facility Base Hazard Procedure section of the Emerg Preparedness policy to include the Fire procedure. The Fire Watch form will be added to the Emergency Preparedness binder.	ency Watch	7/15/18 7/15/18	
	the Program Manager Residential Service Dir documentation that the process. The Program Intellectual Residential they were working on a	rector, they were asked for a facility had a fire detection Manager and the Service Director stated a "Fire Watch Process."	Office Control of Cont	The facility has contracts through the Ci Virginia Beach with Elite Seats and Service the event of loss of sewage and waste of Elite Seats will provide handicap access portable toilets, wash stations and sewa holding tanks within 4 hours of the order hours a day. Servpro will provide emericatoration services due to fire, water an sewage damage.	/pro. In lisposal, ible ge ; 24	7/15/18	
	The staff was asked if tagreement for waste an staff stated, the facility agreement for sewage The facility staff failed the Process and written agreement.	nd sewage disposal. The did not have a written and waste disposal.		The policy and the emergency contact list updated to include these contract and emergency contact numbers. All staff will be trained on the updated Emergency Preparedness policy and contact numbers.		7/15/18 7/15/18	
E 018	Procedures for Tracking CFR(s): 483.475(b)(2)	g of Staff and Patients	E 018				

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Facility ID: VAICEMR11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G026	B. WING		00/04/0040
	ROVIDER OR SUPPLIER KY AVENUE RESIDEN		145	REET ADDRESS, CITY, STATE, ZIP CODE KENTUCKY AVENUE GINIA BEACH, VA 23452	06/01/2018
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE COMPLETION
	develop and implei policies and proces plan set forth in parassessment at para and the communicathis section. The poreviewed and update minimum, the policies address the following (2) A system to trace and sheltered paties an emergency. If or patients are relocated [facility] must docur location of the receiving facility and after an emergency the [PRTF's, LTC, 10] and after an emergency, the [PRTF's] and the receiving facility the receiving facility assessment the the receiving facility	rocedures. The [facilities] must ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ated at least annually.] At a ites and procedures must mg:] ck the location of on-duty staff and sheltered ed during the emergency, the ment the specific name and wing facility or other location. 1.184(b), LTC at §483.73(b), 5(b), PACE at §460.84(b):] ures. (2) A system to track the staff and sheltered residents in CF/IID or PACE] care during ency. If on-duty staff and are relocated during the TF's, LTC, ICF/IID or PACE] specific name and location of	E 018	DEFICIENCY	
1	Policies and procedu (ii) Safe evacuation in includes consideration needs of evacuees; in transportation; identi	ures. from the hospice, which on of care and treatment staff responsibilities; fication of evacuation ary and alternate means of			The second of th

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2NHZ11

Facility ID: VAICEMR11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	RYCLIA (X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		49G026	B. WING	talija in turi	0.0	10412042
	PROVIDER OR SUPPLIER KY AVENUE RESIDEN	CE		STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452		5/01/2018
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	(X5) COMPLETION DATE
	employees' on-duty hospice's care duri on-duty employees relocated during the must document the the receiving facility. *[For CMHCs at §4 procedures. (2) Sat which includes contreatment needs of responsibilities; transpossibilities; transpossibi	ck the location of hospice y and sheltered patients in the ing an emergency. If the sor sheltered patients are elemengency, the hospice elemengency the hospice elemengency the hospice and felemengency the control of the c	E 018		policy ocation ergency s clients each's or ation, ime, cuation e ICF MO tact well as a tion. Tying uses in om	7/15/18
	the Program Manage	er and the Intellectual Director, they were asked for	Total and the second se	, 3 , 3		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID 2NHZ11

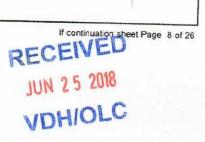
Facility ID: VAICEMR11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G026	B. WING _	and the same of th		6/04/0040
	PROVIDER OR SUPPLIER KY AVENUE RESIDENCE	CE		STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452		6/01/2018
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 022	preparedness track Individuals and staff emergency. The staff failt during an emergency Policies/Procedures CFR(s): 483.475(b): [(b) Policies and procedures and procedures and procedures and procedures and procedures and the communication of the policies and procedures and the communication of the policies and procedures and the communication of the policies and procedures and update minimum, the policies address the following: (4) A means to shelt and volunteers who (2),(3),(5),(6)] A mean and procedures. (6) The following are hospice-operated inpolicies and procedures. (6) The following are hospice-operated inpolicies and procedures. (i) A means to shelt hospice employees we have the procedures and procedur	ne facility's emergency ling system in the event if are relocated during an aff stated, they did not have a ed to have a tracking system by. If or Sheltering in Place (4) Indeedures. The [facilities] must lent emergency preparedness lares, based on the emergency largraph (a) of this section, risk largraph (a) of this section, lation plan at paragraph (c) of licies and procedures must be led at least annually. At a less and procedures must get] er in place for patients, staff, laremain in the [facility]. [(4) or lars to shelter in place for colunteers who remain in the lices at §418.113(b):] Policies additional requirements for latient care facilities only, ledures must address the liter in place for patients, who remain in the hospice	E 0	18	dness policy nteers during ce", a trained with only reviously beer pany staff and vacuation is no have not each's vetting in an extreme xtreme rovide any any only assisuch as help unds, or g 911 and ees to the gency has ed for their policy of the gone through ceived lient care."	7/15/18
	Triis STANDARD is r Based on record revi	not met as evidenced by: ew and staff interview the				



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G026	B. WING _		06/04/0045
KENTUC	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	06/01/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
E 022	The findings included: The findings included: During an interview or the Program Manager Residential Service Didocumentation of the procedures for the use emergency. The facilit developed policy and who remain in the facility accuration cannot be the the facility staff failed.	ave policies and procedures ers during an emergency. In 5/31/18 at 2:03 P.M. with a rand the Intellectual irector, they were asked for facility's policy and er of volunteers during an any staff stated, they had not procedures for volunteers lity in the event that an executed.	E 0	22	
	develop and implement policies and procedure plan set forth in paragra assessment at paragra and the communication this section. The policies reviewed and updated minimum, the policies address the following: *[For Hospices at §418. §441.184,(b) Hospitals Facilities at §483.73(b): (7) [or (5)] The development of the facilities and other facilities] [and] other policies and policies and policies at §483.73(b):	dures. The [facilities] must t emergency preparedness s, based on the emergency aph (a) of this section, risk ph (a)(1) of this section, n plan at paragraph (c) of es and procedures must be at least annually. At a and procedures must 113(b), PRFTs at at §482.15(b), and LTC] Policies and procedures. ment of arrangements with	E 02	5	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G026	B. WING _		
	PROVIDER OR SUPPLIER KY AVENUE RESIDENCE	E		STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	06/01/2018
(X4) ID - PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
- 1	operations to maintal to facility patients. *[For PACE at §460.8 §483.475(b), CAHs at §485.920(b) and ESI Policies and procedudevelopment of arrar [facilities] [or] other prince of the event of limitation operations to maintain to facility patients. *[For RNHCIs at §403 procedures. (7) The carrangements with other providers to receive provid	in the continuity of services 84(b), ICF/IIDs at at §486.625(b), CMHCs at RD Facilities at §494.62(b):] ares. (7) [or (6), (8)] The agements with other aroviders to receive patients alons or cessation of an the continuity of services 8.748(b):] Policies and development of her RNHCls and other actients in the event of an of operations to maintain amedical services to RNHCl and met as evidenced by: iew and staff interview, the ave documentation of the s and services for facilities.	EO	The facility will identify the individual se host ICF will provide to surged individual. The facility will update the Surge Capacisection of the Emergency Preparednes to include a list of services that will be provide a list of services that will be provide a list of services that will be provided individuals. The facility will update the Surge Capacisection of the Emergency Preparednes to the in the services the facility will prowhen receiving an individual from anoth facility: "The host ICF will only accept sindividuals from another City of Virginia ICF. The host ICF will provide needed such as protective undergarments, bath facilities, available hygiene products and available adaptive equipment. The host provide a space for medication storage as basic nutrition. The host ICF will proindividual with a personal space as outlifthe Surge Capacity Assessment. The him will ensure privacy as much as possible. Services will be provided as available." All staff will be trained on the updated Emergency Preparedness Policy and anthereafter.	city s policy 7/15/18 city s policy s policy vided ner 7/15/18 surge Beach supplies ning d st ICF will as well vide the ned in lost ICF . Nursing
	documentation that the Individuals from other they did not have docu arrangements and sen other facilities.	e facility had for receiving facilities. The staff stated.	C St. Martin Company of the Company		THE CHARGE STREET COMMISSION OF THE COMMISSION O

Facility ID: VAICEMR11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SUI COMPLET	RVEY
NAME OF S		49G026	B. WING	06/01/	2018
	PROVIDER OR SUPPLIER KY AVENUE RESIDENC	E	STREET ADDRESS, CITY, STATE, Z 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	PCODE	2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) OMPLETION DATE
E 025	Continued From pagother facilities.	ge 10	E 025		
E 026		er Declared by Secretary 8)	E 026		
	develop and implem policies and procedu plan set forth in para assessment at paragand the communication this section. The police reviewed and update	cedures. The [facilities] must ent emergency preparedness ures, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, cion plan at paragraph (c) of cices and procedures must be end at least annually. At a section and procedures must be estimated as and procedures must be estimated as and procedures must graph (c) of cices and cices			
	[facility] under a waiv in accordance with si provision of care and care site identified by officials.), or (9)] The role of the rer declared by the Secretary, ection 1135 of the Act, in the treatment at an alternate remergency management 3.748(b):] Policies and role of the RNHCI under a	The facility will update the section of the Emergency to include the services that surged individual at another only surge individuals to an Beach ICF. The guest ICF staff to support the surged specialized nutrition, if appicare staff's responsibilities policyThe DSP will provi	Preparedness policy t will be provided to a er facility: "The ICF will nother City of Virginia will supply direct care individual and licable. The direct will be outlined in the de assistance with all	5/18
	waiver declared by the with section 1135 of A at an alternative care management officials. This STANDARD is represented to be a section of the section of th	e Secretary, in accordance Act, in the provision of care site identified by emergency anot met as evidenced by: ew and staff interview the ave documentation that stole in providing care and	Activities of Daily Living inc medication administration, Management and Active To will assist the individual with needs and will provide bas scope of their training. Num provided as available. This list."	cluding hygiene, Physical reatment. The DSP h all of their nutritional ic First Aid within the rsing services will be s is not an all-inclusive	
	treatment at alternate The findings included:		Emergency Preparedness	policy. 7/15/	/18
- 1		1 5/31/18 at 2:24 P.M. with			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		49G026	B. WING _	The second secon	0	6/01/201B	
	ROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452		0/01/2018	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
E 026	for documentation to providing care and tre sites during emergend facility did not have po	e 11 Director, the staff were asked describe the facilities role in eatment at alternate care cies. The staff stated the policies and procedures that role in providing care at	ΕO	26	31.		
E 033	The facility staff failed policies and procedure facility's role in providi sites during an emerginethods for Sharing literature.	to develop and implement es that describes the ng care at alternate care ency.	E 03	33			
	emergency preparedn that complies with Fed and must be reviewed	develop and maintain an ess communication plan leral, State and local laws	***************************************				
	documentation for pati	ng information and medical ents under the [facility's] th other health providers to of care.		To continuous and con			
	(5) A means, in the ever release patient informa CFR 164.510(b)(1)(ii). required for HHAs under under §485.68(c), and ii §491.12(c).]	er §484.22(c), CORFs	000 to 000 man 1				
1	about the general cond	ity's] care as permitted	E				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second	(X2) MULTIPLE CONSTRUCTION (X3) I		
		49G026	B. WING	***	06/01/2018	
KENTU	PROVIDER OR SUPPLIER CKY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	0000112010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETIO	
E 033	Continued From page	12	E 03	3	***************************************	
	sharing information ar patients under the RN with care providers to	a.748(c):] (4) A method for and care documentation for HCI's care, as necessary, maintain the continuity of litten election statement in his or her legal		The facility will update the Emergency Preparedness policy to include obtaining general authorization for release of inform in an emergency from the Legal Guardial Authorized Representative during admission annually thereafter.	nation 7/15/18	
	*[For RHCs/FQHCs at of providing information condition and location facility's care as permit 164.510(b)(4). This STANDARD is not a Based on record reviet facility staff failed to hat facility have means to regarding the general of residents. The findings included: During an interview on the Program Manager.	of patients under the tted under 45 CFR of met as evidenced by: we and staff interview, the live documentation that the release patient information condition and location of		All individuals will have a to-go bag which include their Emergency Medical Information Physical Management Plan and a picture individual. A copy of the Physical Management plan individuals will also be kept in the Emerge Preparedness binder as a backup. The It Electronic Health Record is a web-based operating system and can be accessed rein case of emergency. A laptop with a howill accompany the ICF during an evacua access medical information if needed. The Virginia Beach's Emergency Manager Office will have contact with the ICF's Reconstruction Supervisory staff who will have remote act the EHR as another backup to be able to information.	for all ency CF's emotely t spot tion to ee City ment covery cess to	
	information and medical individuals under the fall not able to provide documentation necessary that been developed. The facility staff failed to patient information during the comments of t	o provide individual care to have a means to release		All staff will be trained on the updated Emergency Preparedness policy.	7/15/18	
E 035	maintain continuity of ca LTC and ICF/IID Sharin CFR(s): 483.475(c)(8)		E 035			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G026	B. WING	Windows are a second se	06	104/2040	
KENTUC	PROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	E	/01/2018	
PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 035	Continued From page	e 13	E 03	5			
	and maintain an emer communication plan to State and local laws a updated at least annu- plan must include all of (8) A method for shart emergency plan, that is appropriate, with re- families or representa This STANDARD is in Based on record revief facility staff failed to pre-	hat complies with Federal, and must be reviewed and ally.] The communication of the following: ing information from the the facility has determined sidents [or clients] and their tives. tot met as evidenced by: we and staff interview, the rovide family's of the did their representative with ness Plans.		The facility will provide a copy of Preparedness plan to all Legal Authorized Representatives. The review of the Emergency P be documented by the Legal Gual Authorized Representative's signatural Disaster/Weather Emery/Authorization Regarding Possit Client Form. This form will be kindividual's record. The Emerge Preparedness policy will be reviadmission and annually thereafted.	Preparedness will uardian's and gnature on the gency Directions ble Evacuation of tept in the ency	7/15/18 7/15/18	
W 000	the Program Manager Service Director, the fidocumentation that restheir representative has Emergency Preparedr "No", the families nor motified of the emerger The facility staff failed representatives with the Preparedness Plan. INITIAL COMMENTS An unannounced annu Medicaid Certification is 05/30/18 through 06/01	to provide family's or their e facility's Emergency	W 000				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 100 100 100 100 100 100 100 100 100	LE CONSTRUCTION		E SURVEY PLETED
		49G026	B. WING	The second secon	06	10412049
	ROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREETADDRESS, CITY, STATE, ZIP CODI 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452		/01/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 000	for Intermediate Carwith Intellectual Disa Safety Code survey/ complaints were inve The census in this 8 survey was 6. The si current Individual red #3) and one closed r CLIENT RECORDS	e Facilities for Individuals bilities (ICF/IID). The Life report will follow. No estigated during the survey. bed facility at the time of the urvey sample consisted of 3 cords (Individual #1 through ecord (Individual #4).	W 00			
	health care, active tread and protection of the This STANDARD is a Based on record revifacility staff failed to e (Individual #3) clinica complete in the surve	elop and maintain a methat documents the client's patment, social information, client's rights. not met as evidenced by: ew and staff interviews the ensure one individual's I record was accurate and by sample of four individuals.		Facility Nurse conducted quality review on Individual #3's medical specifically focusing on accuracy consistency of records related to lit was determined that Individual a dentist on 7/3/17. Also, record Individual #3 received appropriate medication according to physicial to the 7/3/17 appointment. Facility Nurse will conduct quality reviews of dental records for all the last completed visit as well a date for the next follow up appoint review will be conducted now an thereafter.	al chart y and o dental services. Il #3 was seen by is show that ite pre-dental an's order prior y assurance Residents noting is the anticipated intment. This	7/15/18
	Intellectual disability, palsy, spastic quadrip	ses which included Profound thyroid disease, cerebral legia, seizure disorder and the clinical record and an 04/03/17 indicated a	9 0000	A Dental Service Tracking Form developed for nurses to use in o schedule dental services recommindividuals' dentists. Document with monthly by the Nurse Manager in services are due and when servicempleted.	rder to track and mended by the will be monitored noting when	7/15/18
	cleanings to ensure a	essed being tactile s valium for routine dental dequate and thorough oral Treatment Plan dated		The nurses will be trained by the on the use of the Dental Service	Nurse Manager Tracking Form.	7/15/18



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		MEDICAID SERVICES			OME	NO. 0938-0391
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		49G026	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	06/01/2018
KENTUC	CY AVENUE RESIDENCE			145 KENTUCKY AVENUE	2002	
112711007				VIRGINIA BEACH, VA 23452		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 111	Continued From pag	e 15	W 1	111		
		Diazepam -prior to dental				
	dated 04/03/17 indice physician's order for 10 (mg) milligrams 1 procedures. The indice dental appointment of reviewed the orders. PRN for dental was recontacted the pharm pre-medication. The facility. However, on nursing staff noted the ordered was still in the documentation it is did not get the medical on March 31, 2017 was substance count was diazepam was still in Practical Nurse #3 (Li was aware that the in sedation in the past. Since March 30 she called the order for pre-sedation	vidual was scheduled for a in 3/31/17. Nursing staff on 3/28/17 and noted that the not available. Nursing staff acy and requested the medication was sent to the the overnight shift on 4/2/17 at the pre-medication e med cart. Upon review of appears that the individual ation as originally ordered.	The company of the co			
	She indicated she did Care Physician) office Thursday "I knew I wa in time and he was on	not call the PCP's (Primary She stated, at 4:00 on a s not going to get an order vacation." LPN #3 reported	X 51			The state of the s
	medication. She repor in December and furth him to be harmed by a	aff member not to give the ted it was a one-time order er stated, "I did not want medication he did not d with the original order				THE STATE OF THE S

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		49G026	B. WING		06	/01/2018	
KENTUC	PROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	CODE	10112010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	OTHE APPROPRIATE	(X5) COMPLETION DATE	
W 111	one-time order. LPN #3 verified her administration record the diazepam order. with the order that has he indicated she changed by her after and after the order with the order that the changed by her after and after the order with the order of the order	signature on the medication of for January that contained When she was presented ad (X 1) added to the bottom, anged the order to read (X 1) not it was supposed to say, the telephone order was to the was signed by the PCP has sent to the pharmacy on the set, "was X 1 order for dental the indicated, "she was not could not be changed after a secondar." Findings: LPN #3 order after it was signed functed a staff member to medication. In 5/30/18 at 1:30 P.M. with the stated, LPN #3 is order and Individual #3 did dation medication.					
W 149	The facility staff failed record that document care and treatment.		W 14	9			

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STATEMENT	OF DEFICIENCIES	(V1) PROMESSIONER			OMB NO. 0938-039
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G026	B. WING	THE STREET HAVE BEEN AS A STREET HAVE BEEN AS	05/04/0040
	PROVIDER OR SUPPLIER KY AVENUE RESIDENC	E		STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	06/01/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
W 149	policies and procedumistreatment, negle This STANDARD is Based on record revision facility staff failed to (Individual #3's) recedental treatment in the individuals. The findings included Individual #3 was add 04/01/02 with diagno	velop and implement written ures that prohibit ct or abuse of the client. not met as evidenced by: iew and staff interviews the ensure one individual eived medication prior to a ne survey sample of four dt: mitted to the facility on ses which included Profound	W 14	Facility Nurse conducted quality assurateview on Individual #3's medical chart specifically focusing on accuracy and consistency of records related to dental it was determined that Individual #3 was a dentist on 7/3/17. Also, records show Individual #3 received appropriate precedication according to physician's ord to the 7/3/17 appointment. Facility Nurse will conduct quality assurate in the individual records for all Resider the last completed visit as well as the arms.	service. s seen by 6/21/18 that dental der prior ance 7/15/18 hts noting
And the second Control of the second control	palsy, spastic quadrij scoliosis. A review of incident report dated Individual #3 experies	thyroid disease, cerebral olegia, seizure disorder and it the clinical record and an 04/03/17 indicated: need neglect as a result of medication for a dental		date for the next follow up appointment. review will be conducted now and quart thereafter. Staff will be retrained on Neglect and At Prevention policy which applies to all incorred.	ouse 7/15/18 dividuals
	cleanings to ensure a hygiene. A Restrictive	es valium for routine dental dequate and thorough oral Treatment Plan dated	State of the state	Nursing staff will be retrained on the revidental Services and Dental Services with Sedation policies that applies to all indiviserved.	h
Harry Market	10/24/16 indicated: "E appointments."	Diazepam -prior to dental ent Investigative report		Nurses will be trained on Board of Nursin Scope of Practice, Nurse Practice Act, specifically focusing on the record keepin section.	
	dated 04/03/17 indical physician's order for p 10 (mg) milligrams 1 h procedures. The individental appointment or reviewed the orders or	ted: "Individual #3 had a re-medication with Valium		A Dental Service Tracking Form will be developed for nurses to use in order to tr schedule dental services recommended individuals' dentists. Document will be monthly by the Nurse Manager noting when services are due and when services are completed.	by the onitored

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G026	B. WING		06/01/2018	
	PROVIDER OR SUPPLIER	CE	145	EETADDRESS, CITY, STATE, ZIP CODE KENTUCKY AVENUE GINIA BEACH, VA 23452	0000112018	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETION	
W 149	contacted the phar pre-medication. The facility. However, or nursing staff noted ordered was still in the documentation did not get the medication of the medication. She refund in the pass that on Friday March of Thursday "I knew I in time and he was that on Friday March on Friday March on Friday March on the medication of the medication. She refund to the medication of the medication. The medication of the medication. She refund the medication of the medication. She refund the medication of the medication. The medication of the medication. The medication or the medication. The medication of the medication. The medication or the medication or the medicated. The physician's order medicated.	macy and requested the remedication was sent to the on the overnight shift on 4/2/17 that the pre-medication the med cart. Upon review of it appears that the individual dication as originally ordered. When the controlled ras done it was noted that the in the medication cart. Licence (LPN#3) indicated that she individual did receive dental at the she reports on Thursday, and the dentist's office and that there was not a current ion. She indicated the office ghim in for the appointment. The did not call the PCP's (Primary fice. She stated, at 4:00 on a was not going to get an order on vacation." LPN #3 reported the distaff member not to give the ported it was a one-time order urther stated, "I did not want by a medication he did not documentation it appears that the get the medication as the ported in the medication as the difficult time and again that the individual be the ported in the ported dental as cheduled dental as cheduled dental.	W 149			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G026	B. WING		06/01/2018	
	PROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP COD 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION EAPPROPRIATE DATE	
W 149	documentation it app not receive the medic Per the dental health	eared that the individual did cation as originally ordered. consultation notes. The ndividual was not given the epam 10 mg), so	W 1	149		
	the Program Manage did not receive his me treatment and the der was difficult.	n 5/30/18 at 2:30 P.M. with er, she stated, Individual #3 edication prior to dental ntist noted the procedure				
	date 11/14/16 indicate agency to protect the from abuse, neglect, e injury. Any medication error evaluation/care by a preported as both an a serious injury. The following types of	ed: "It is the policy of the individuals who are served exploitation, crime and that requires further medical physician, PA, or NP is to be illegation of neglect and as f medication errors are to be ion of neglect: The lack of	5 050E (Common to 60) (p) 400			
W 331	The facility staff failed policies and procedure individuals. NURSING SERVICES	to implement it's written es that prohibit neglect of				
	CFR(s): 483.460(c) The facility must proviservices in accordance	de clients with nursing with their needs.	W 33	51		
***	This STANDARD is no	ot met as evidenced by:				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
	ROVIDER OR SUPPLIER	49G026	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	06	/01/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 331	Based on record review and staff interviews the facility staff failed to ensure one individual (Individual #3's) received medication prior to a dental treatment in the survey sample of four individuals. The findings included: Individual #3 was admitted to the facility on 04/01/02 with diagnoses which included Profound Intellectual disability, thyroid disease, cerebral palsy, spastic quadriplegia, seizure disorder and scoliosis. A review of the clinical record and an incident report dated 04/03/17 indicated:		W 33	Facility Nurse conducted quality as review on Individual #3's medical of specifically focusing on accuracy at consistency of records related to diffuse the determined that Individual #3 a dentist on 7/3/17. Also, records a Individual #3 received appropriate medication according to physician' to the 7/3/17 appointment.	chart nd ental service. 3 was seen by show that pre-dental	6/21/18
				Facility Nurse will conduct quality a reviews of dental records for all Re the last completed visit as well as t date for the next follow up appoint review will be conducted now and othereafter.	sidents noting he anticipated ment. This	7/15/18
	for a dental treatment Individual #3 was ass defensive and require	receive his pre-medication It per nursing care plan. Sessed being tactile es valium for routine dental adequate and thorough oral		All Individuals treatment plan will in section about oral hygiene/oral car the frequency of dental checkups. Nursing Staff will be retrained on D Services and Dental Services with	e indicating ental Sedation	7/15/18
α	hygiene. A Restrictive 10/24/16 indicated: "I appointments." Individual #3's nursin Diazepam prior to de #3 requires sedation treatment.	e Treatment Plan dated Diazepam -prior to dental g care plan indicated: ntal appointments. Individual one hour prior to dental		policies which outline nursing response relation to pre-dental service medical. A Dental Service Tracking Form will developed for nurses to use in ordeschedule dental services recomme individuals' dentists. Document will monthly by the Nurse Manager not services are due and when service completed.	onsibilities in cation. If be or to track and inded by the be monitored ing when	
The second secon	dated 04/03/17 indical physician's order for procedures. The individental appointment or reviewed the orders of PRN for dental was no contacted the pharma	dent Investigative report ated: "Individual #3 had a core-medication with Valium hour before dental vidual was scheduled for a m 3/31/17. Nursing staff on 3/28/17 and noted that the ot available. Nursing staff acy and requested the medication was sent to the		RN supervisors will be trained by the Manager on the use of the Dental S Tracking Form. Nurse manager will monthly.	Service	7/15/18

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		49G026	B. WING		06	/01/2018
	ROVIDER OR SUPPLIER KY AVENUE RESIDEN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE /IRGINIA BEACH, VA 23452	1 00	101/2016
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	DBE	(X5) COMPLETION DATE
W 348	facility. However, or nursing staff noted ordered was still in the documentation did not get the med buring an interview the Program Mana did not receive his his dental appointm. The facility staff fail services in accorda DENTAL SERVICE CFR(s): 483.460(e). The facility must prefor comprehensive services for each of including licensed of including licensed of the desired or still staff and the services for each of including licensed of including licensed of the desired or staff and the services for each of including licensed of the desired or staff and the services for each of including licensed of the desired or staff and the services for each of including licensed of the services for each of including licensed or staff and the services for each of including licensed or services for each of the services for e	that the overnight shift on 4/2/17 that the pre-medication the med cart. Upon review of it appears that the individual dication as originally ordered. Yon 5/31/18 at 10:00 A.M. with ger, she stated, Individual #3 medication as ordered prior to nent. Ided to implement nursing since to Individuals needs. S ((1) ovide or make arrangements diagnostic and treatment ient from qualified personnel, lentists and dental hygienists nized dental services in-house	The second secon		t al service. as seen by v that dental	6/21/18
	Based on record re facility staff failed to (Individual #3's) rec treatment in the sur The findings include Individual #3 was at 04/01/02 with diagnintellectual disability palsy, spastic quadr	dmitted to the facility on coses which included Profound r, thyroid disease, cerebral iplegia, seizure disorder and #3 did not receive a physician		Facility Nurse will conduct quality assureviews of dental records for all Reside the last completed visit as well as the adate for the next follow up appointmen review will be conducted now and qualithereafter. Nursing Staff will be retrained on Denti Services and Dental Services with Secolicies which outline nursing responsional relation to pre-dental service medication. RN supervisors will be trained by the Nanager on the use of the Dental Services and Services and Services will review the Nanager on the use of the Dental Services and Services and Services and Services will review the Nanager on the use of the Dental Services and	ents noting anticipated t. This rterly al lation bilities in in.	7/15/18 7/15/18 7/15/18

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY IPLETED
		49G026	B. WING	THE THE PARTY OF T	04	01001001
	ROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	06	6/01/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 348	Individual #3 was ass defensive and require	sessed being tactile es valium for routine dental	W 348	Facility nurse will review all individuand note upcoming dental service according to the Dental Service Tra	due dates acking Form.	7/15/18
	cleanings to ensure adequate and thorough oral hygiene. A Restrictive Treatment Plan dated 10/24/16 indicated: "Diazepam -prior to dental appointments."			Reminders to schedule appointmer placed on Outlook group calendar l designee based on information coll Dental Service Tracking Form.	by RN or	7/15/18
Change of the Control	indicated: "Dentist did removed, Individual a diazepam and the pro past. Individual is refe for deep cleaning, and	sultation dated 12/19/16 I cleaning, heavy calculi Ilready received pre-dental ocedure was better than the erred to sedation dentistry d X-rays. Awaits scheduling dual #3 will be seen for - March 2017.		The nurses will be trained by the Non the use of the Dental Service Tr. Forms will be submitted to the Nursmonthly.	acking Form.	7/15/18
	A review of the clinical Individual #3 received cleaning and X-rays.	I record did not indicate the physician ordered deep	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	mercental and the second of th		
	During an interview on the Program Manager did not receive the phy services and treatmen	n 6/1/18 at 9:15 A.M. with r, she stated, Individual #3 ysician ordered dental tt.				
W 368	The facility staff failed treatment and services DRUGADMINISTRAT CFR(s): 483.460(k)(1)	s. ION	W 368			
1	The system for drug act that all drugs are admir the physician's orders.	dministration must assure nistered in compliance with				
	This STANDARD is no Based on record revie	ot met as evidenced by: w and staff interviews the	10 10 10 10 10 10 10 10 10 10 10 10 10 1		77.7	

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		& MEDICAID SERVICES			OMB	NO. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G026	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	6/01/2018	
KENTUC	KY AVENUE RESIDENC	CE .		145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE	
W 368	(Individual #3's) reaccordance to physical sample of four individual #3 was at 04/01/02 with diagnintellectual disability palsy, spastic quadracciliosis. Individual medications in according the clinical review of the clinical	o ensure one individual's ceived medications in cician orders in the survey iduals. ed: dmitted to the facility on coses which included Profound of the	W 36	Facility Nurse conducted quality assure review on Individual #3's medical char specifically focusing on accuracy and consistency of records related to dent It was determined that Individual #3 was dentist on 7/3/17. Also, records should individual #3 received appropriate premedication according to physician's out to the 7/3/17 appointment. Facility RN will conduct quality assurate reviews of dental records for each residently, specifically noting accuracy intranscription of orders for medications pre-dental treatment sedation. Nurses will be retrained on the process receiving physicians' orders and the next assured the section of the process receiving physicians' orders and the next assured the section of the process receiving physicians' orders and the next assured the section of the process receiving physicians' orders and the next assured the section of the process receiving physicians' orders and the next assured the process are section.	ral service. ras seen b w that -dental rder prior nnce ident n used for	7/15/18	
	Individual #3 was as defensive and require cleanings to ensure hygiene. A Restrictiv 10/24/16 indicated: "appointments." An Incident and Accidated 04/03/17 indicated 04/03/17 indicated of the	res valium for routine dental adequate and thorough oral are Treatment Plan dated Diazepam -prior to dental dent Investigative report ated: "Individual #3 had a pre-medication with Valium hour before dental vidual was scheduled for a on 3/31/17. Nursing staff on 3/28/17 and noted that the not available. Nursing staff acy and requested the medication was sent to the the overnight shift on 4/2/17		Nursing Staff will be retrained on Dent Services and Dental Services with Secondicies which outline nursing responsions relation to pre-dental service medication. A Dental Service Tracking Form will be developed for nurses to use in order to schedule dental services recommended individuals' dentists. Document will be monthly by the Nurse Manager noting services are due and when services are completed. RN supervisors will be trained by the N Manager on the use of the Dental Services and the services manager will revision. Nurse manager will revision to the services are described by the N Manager on the use of the Dental Services and the services manager will revision.	s. al dation ibilities in on. e o track and ed by the monitored when re		



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		49G026	B. WING _	-		06/01/2018	
NAME OF PROVIDER OR SUPPLIER KENTUCKY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
The state of the s	On March 31, 2017 v substance count was diazepam was still in Practical Nurse #3 (L was aware that the in sedation in the past. March 30 she called informed the office the order for pre-sedation told her to still bring his She indicated she did Care Physician) office Thursday "I knew I was in time and he was on that on Friday March medication certified simedication. She repoin December and furth him to be harmed by a need." When presente LPN #3 indicated it recone-time order. LPN #3 verified her signadministration record the diazepam order. Which the order that had she indicated she chabecause that was what She indicated that the changed by her after it and after the order was March 28th. LPN #3 further indicates appt with dentist. She is easy that was the physician's order shee appt with dentist. She is	when the controlled done it was noted that the the medication cart. Licence PN#3) indicated that she dividual did receive dental She reports on Thursday, the dentist's office and at there was not a current in She indicated the office im in for the appointment. In not call the PCP's (Primary is She stated, at 4:00 on a cas not going to get an order in vacation." LPN #3 reported its was a one-time order interest the test of	W 3	68			

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		49G026	B. WING	****	06/01/2018
	ROVIDER OR SUPPLIER KY AVENUE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
W 368	doctor had signed the	e order." Findings: LPN #3 an's order after it was signed ructed a staff member to	w3	868	
Tentre describir anno companya (1974) — Films o Milandi Anno Milandi A	the Program Manage was not administered treatment as ordered	d to administer medication in			
			(M) 100(A) 1 (A) 100 (

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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