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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/30/18 through 06/01/18. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No complaints were investigated during the survey.	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power	E 006		

RECEIVED
JUN 25 2018
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tim Capaldo | TITLE: DS Director | (X6) DATE: 6/25/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 1 failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's risk assessment and associated strategies. The findings included: During an Emergency Preparedness review on 5/31/18 at 1:30 P.M. the Program Manager and Intellectual Residential Service Director was asked for documentation for the facility based risk assessment and strategies for addressing emergency events identified by the risk assessment. The Intellectual Residential Service Director stated, the facility had not conducted nor identified any strategies. The facility staff failed document strategies for addressing emergency events identified by the risk assessment.	E 006	The facility will conduct an individual risk assessment to identify the individual's potential risk factor related to emergency situations and emergency evacuations. The facility will conduct individual risk assessment to identify all individuals' potential risk level. The Comprehensive Functional Assessment will be updated with an Emergency Preparedness section. Based on the Individual's risk assessment, strategies will be listed to assist staff to know how to provide supports during emergency situations. If any change in an individual's condition warrants an update to the risk assessment, and the related strategies, the QIDP will make the needed changes and forward the updated information to the designate staff responsible for maintaining the Emergency Preparedness binder. All staff will be trained on the updated Emergency Preparedness policy and the QIDP will update all Comprehensive Functional Assessments.	7/15/18 7/15/18 7/15/18 7/15/18
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 007	Continued From page 2 *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation of the facility's patient population that would be at risk during an emergency and the strategies the facility have in place to address their needs. Also, the facility failed to have written delegation of authority and how the facility plan to continue to operate during an emergency. The findings included: During an interview on 5/31/18 at 1:40 P.M. with the Program Manager and the Intellectual Residential Service Director, they were asked for documentation that Individuals in the facility had been identified who were at risk and the types of services needed. The facility staff stated, they had not identified individuals based on their risk nor had services been identified. The Program Manager and the Intellectual Residential Service Director were asked for documentation for delegation of authority during an emergency and how the facility plan to continue to operate during an emergency. The staff stated, they had not identified which staff would assume specific roles in another's absence. The staff also stated, they did not have a continuity of operations plan during an emergency. The facility staff failed to identify at risk individual's during an emergency, have delegation of authority and continuity of operation during an	E 007	The facility will create a list of strategies to provide supports during emergency events based on the individuals' risk assessments and the level of supports needed. The Chain of Communication section of the Emergency Preparedness policy will be updated to denote the delegation of authority during an emergency: "During an unforeseen emergency, the on-site Shift Leader/Direct Support Staff has the authority to manage the emergency situation including making emergency decisions; maintaining communication with emergency contacts; initiating purchases and use of contracts; directing staff, EMS and other resources necessary to manage the emergency, and maintain the safety of the individuals served. Once the imminent danger has subsided, the on-site Shift Leader/Direct Support Staff will notify the ICF Supervisor or designee for support and directions." The Emergency Preparedness policy, including the delegation of authority, will be reviewed at least annually. All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 7/15/18 7/15/18 7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 007	Continued From page 3 emergency.	E 007		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they	E 015		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 4 evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have a Fire Watch Process and a written sewage and waste disposal agreement. The findings included: During an interview on 5/31/18 at 1:45 P.M. with the Program Manager and the Intellectual Residential Service Director, they were asked for documentation that the facility had a fire detection process. The Program Manager and the Intellectual Residential Service Director stated they were working on a "Fire Watch Process." The staff was asked if the facility had an agreement for waste and sewage disposal. The staff stated, the facility did not have a written agreement for sewage and waste disposal. The facility staff failed to have a Fire Watch Process and written agreement for waste and sewage disposal.	E 015	The facility will update the Facility Based Hazard Procedure section of the Emergency Preparedness policy to include the Fire Watch procedure. The Fire Watch form will be added to the Emergency Preparedness binder. The facility has contracts through the City of Virginia Beach with Elite Seats and Servpro. In the event of loss of sewage and waste disposal, Elite Seats will provide handicap accessible portable toilets, wash stations and sewage holding tanks within 4 hours of the order, 24 hours a day. Servpro will provide emergency restoration services due to fire, water and sewage damage. The policy and the emergency contact list will be updated to include these contract and emergency contact numbers. All staff will be trained on the updated Emergency Preparedness policy and contact list	7/15/18 7/15/18 7/15/18 7/15/18 7/15/18
E 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2)	E 018		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 5	E 018		

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 6 assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of an Emergency Preparedness tracking system. The findings included: During an interview on 5/31/18 at 1:54 P.M. with the Program Manager and the Intellectual Residential Service Director, they were asked for	E 018	The facility will update the Tracking Clients section of the Emergency Preparedness policy with the following: In order to track the location of on-duty staff and clients during an emergency, the facility will submit a list of the facility's clients and on-duty staff to the City of Virginia Beach's Emergency Management Office (EMO) for tracking purposes. In the event of evacuation, the facility will also submit the specific name, location, and contact numbers of the evacuation site.	7/15/18
			If there is a change in evacuation site, the ICF Supervisor or designee will provide the EMO with the specific name, location, and contact numbers of the new evacuation site, as well as a list of the clients and staff at the new location.	7/15/18
			Facility will research ID bands with identifying and contact information for tracking purposes in case the individual becomes separated from staff during emergency evacuation.	7/15/18
			All staff will be trained on the updated Emergency Preparedness policy.	7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 7 documentation of the facility's emergency preparedness tracking system in the event Individuals and staff are relocated during an emergency. The staff stated, they did not have a tracking system. The facility staff failed to have a tracking system during an emergency.	E 018		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and staff interview the	E 022	The facility will update the Shortage of Staff section of the Emergency Preparedness policy to outline the limited duties of volunteers during an emergency: "If sheltering in place", a trained volunteer may provide assistance with only those duties for which they have previously been trained; volunteers may not accompany staff and residents to the evacuation site if evacuation is deemed necessary. Volunteers who have not gone through the City of Virginia Beach's vetting process will not be utilized except in an extreme emergency situation. During the extreme emergency, the volunteer will not provide any direct client care. The volunteer may only assist with non-client care related tasks, such as help securing the area, cleaning the grounds, or clearing access to the facility, calling 911 and directing arriving Emergency Services to the location. Once the immediate emergency has passed, the volunteer will be thanked for their assistance and dismissed. It is the policy of the ICF that only volunteers who have gone through a criminal background check and received training may assist with any direct client care." All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 022	Continued From page 8 facility staff failed to have policies and procedures for the use of volunteers during an emergency. The findings included: During an interview on 5/31/18 at 2:03 P.M. with the Program Manager and the Intellectual Residential Service Director, they were asked for documentation of the facility's policy and procedures for the use of volunteers during an emergency. The facility staff stated, they had not developed policy and procedures for volunteers who remain in the facility in the event that an evacuation cannot be executed. The facility staff failed to have policies and procedures for the use of volunteers during an emergency.	E 022		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of	E 025		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 025	Continued From page 9 operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on Record review and staff interview, the facility staff failed to have documentation of the facility's arrangements and services for Individuals from other facilities. The findings included: During an interview on 5/31/18 at 2:12 P.M. with the Program Manger and Intellectual Residential Service Director, they were asked for documentation that the facility had for receiving Individuals from other facilities. The staff stated, they did not have documentation of the arrangements and services for Individuals from other facilities. The facility staff failed to have documentation for arrangements and services for Individuals from	E 025	The facility will identify the individual services the host ICF will provide to surged individual. The facility will update the Surge Capacity section of the Emergency Preparedness policy to include a list of services that will be provided to all received surged individuals. The facility will update the Surge Capacity section of the Emergency Preparedness policy to the in the services the facility will provided when receiving an individual from another facility: "The host ICF will only accept surge individuals from another City of Virginia Beach ICF. The host ICF will provide needed supplies such as protective undergarments, bathing facilities, available hygiene products and available adaptive equipment. The host ICF will provide a space for medication storage as well as basic nutrition. The host ICF will provide the individual with a personal space as outlined in the Surge Capacity Assessment. The host ICF will ensure privacy as much as possible. Nursing Services will be provided as available." All staff will be trained on the updated Emergency Preparedness Policy and annually, thereafter.	7/15/18 7/15/18 7/15/18 7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 025	Continued From page 10 other facilities.	E 025		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation that describes the facilities role in providing care and treatment at alternate care sites. The findings included: During an interview on 5/31/18 at 2:24 P.M. with the Program Manager and the Intellectual	E 026	The facility will update the Surge Capacity section of the Emergency Preparedness policy to include the services that will be provided to a surged individual at another facility: "The ICF will only surge individuals to another City of Virginia Beach ICF. The guest ICF will supply direct care staff to support the surged individual and specialized nutrition, if applicable. The direct care staff's responsibilities will be outlined in the policy. -The DSP will provide assistance with all Activities of Daily Living including hygiene, medication administration, Physical Management and Active Treatment. The DSP will assist the individual with all of their nutritional needs and will provide basic First Aid within the scope of their training. Nursing services will be provided as available. This is not an all-inclusive list." All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 11 Residential Service Director, the staff were asked for documentation to describe the facilities role in providing care and treatment at alternate care sites during emergencies. The staff stated the facility did not have policies and procedures that address the facility's role in providing care at alternate care sites during emergencies. The facility staff failed to develop and implement policies and procedures that describes the facility's role in providing care at alternate care sites during an emergency.	E 026		
E 033	Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).	E 033		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 033	Continued From page 12 *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the facility have means to release patient information regarding the general condition and location of residents. The findings included: During an interview on 5/31/18 at 2:32 P.M. with the Program Manager and the Intellectual Residential Services Director they were asked for documentation for providing a method for sharing information and medical documentation for the individuals under the facility's care. The staff were not able to provide documentation that information necessary to provide individual care had been developed. The facility staff failed to have a means to release patient information during an emergency to maintain continuity of care.	E 033	The facility will update the Emergency Preparedness policy to include obtaining a general authorization for release of information in an emergency from the Legal Guardian or Authorized Representative during admission and annually thereafter. All individuals will have a to-go bag which will include their Emergency Medical Information, Physical Management Plan and a picture of the individual. A copy of the Physical Management plan for all individuals will also be kept in the Emergency Preparedness binder as a backup. The ICF's Electronic Health Record is a web-based operating system and can be accessed remotely in case of emergency. A laptop with a hot spot will accompany the ICF during an evacuation to access medical information if needed. The City the Virginia Beach's Emergency Management Office will have contact with the ICF's Recovery Supervisory staff who will have remote access to the EHR as another backup to be able to share information. All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 11/15/17 7/15/18 7/15/18
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8)	E 035		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 035	Continued From page 13 [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide family's of the facility's individuals and their representative with Emergency Preparedness Plans. The findings included: During an interview on 5/31/18 at 2:42 P.M. with the Program Manager and Intellectual Residential Service Director, the facility staff were asked for documentation that residents and families or their representative had been informed of the Emergency Preparedness Plan. The staff stated, "No", the families nor representatives had been notified of the emergency plan. The facility staff failed to provide family's or their representatives with the facility's Emergency Preparedness Plan.	E 035	The facility will provide a copy of the Emergency Preparedness plan to all Legal Guardians and Authorized Representatives. The review of the Emergency Preparedness will be documented by the Legal Guardian's and Authorized Representative's signature on the Natural Disaster/Weather Emergency Directions /Authorization Regarding Possible Evacuation of Client Form. This form will be kept in the individual's record. The Emergency Preparedness policy will be reviewed at admission and annually thereafter.	7/15/18 7/15/18
W 000	INITIAL COMMENTS An unannounced annual 55 Fundamental Medicaid Certification survey was conducted 05/30/18 through 06/01/18. The facility was not in compliance with 42 CFR Part 483 Requirements	W 000		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	Continued From page 14 for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 8 bed facility at the time of the survey was 6. The survey sample consisted of 3 current Individual records (Individual #1 through #3) and one closed record (Individual #4).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews the facility staff failed to ensure one individual's (Individual #3) clinical record was accurate and complete 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 a physician's order had been altered. Individual #3 was assessed being tactile defensive and requires valium for routine dental cleanings to ensure adequate and thorough oral hygiene. A Restrictive Treatment Plan dated	W 111	Facility Nurse conducted quality assurance review on Individual #3's medical chart specifically focusing on accuracy and consistency of records related to dental services. It was determined that Individual #3 was seen by a dentist on 7/3/17. Also, records show that Individual #3 received appropriate pre-dental medication according to physician's order prior to the 7/3/17 appointment.	6/21/18
			Facility Nurse will conduct quality assurance reviews of dental records for all Residents noting the last completed visit as well as the anticipated date for the next follow up appointment. This review will be conducted now and quarterly thereafter.	7/15/18
			A Dental Service Tracking Form will be developed for nurses to use in order to track and schedule dental services recommended by the individuals' dentists. Document will be monitored monthly by the Nurse Manager noting when services are due and when services are completed.	7/15/18
			The nurses will be trained by the Nurse Manager on the use of the Dental Service Tracking Form.	7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 15	W 111		

10/24/16 indicated: "Diazepam -prior to dental appointments."

An Incident and Accident Investigative report dated 04/03/17 indicated: "Individual #3 had a physician's order for pre-medication with Valium 10 (mg) milligrams 1 hour before dental procedures. The individual was scheduled for a dental appointment on 3/31/17. Nursing staff reviewed the orders on 3/28/17 and noted that the PRN for dental was not available. Nursing staff contacted the pharmacy and requested the pre-medication. The medication was sent to the facility. However, on the overnight shift on 4/2/17 nursing staff noted that the pre-medication ordered was still in the med cart. Upon review of the documentation it appears that the individual did not get the medication as originally ordered.

On March 31, 2017 when the controlled substance count was done it was noted that the diazepam was still in the medication cart. Licence Practical Nurse #3 (LPN#3) indicated that she was aware that the individual did receive dental sedation in the past. She reports on Thursday, March 30 she called the dentist's office and informed the office that there was not a current order for pre-sedation. She indicated the office told her to still bring him in for the appointment. She indicated she did not call the PCP's (Primary Care Physician) office. She stated, at 4:00 on a Thursday "I knew I was not going to get an order in time and he was on vacation." LPN #3 reported that on Friday March 31 she directed the medication certified staff member not to give the medication. She reported it was a one-time order in December and further stated, "I did not want him to be harmed by a medication he did not need." When presented with the original order

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 16 LPN #3 indicated it read to her that it was a one-time order. LPN #3 verified her signature on the medication administration record for January that contained the diazepam order. When she was presented with the order that had (X 1) added to the bottom, she indicated she changed the order to read (X 1) because that was what it was supposed to say. She indicated that the telephone order was changed by her after it was signed by the PCP and after the order was sent to the pharmacy on March 28th. LPN #3 further indicated that she wrote on the physician's order sheet, "was X 1 order for dental appt with dentist. She indicated, "she was not aware that an order could not be changed after a doctor had signed the order." Findings: LPN #3 changed the physician's order after it was signed by the PCP, and instructed a staff member to withhold a prescribed medication. During an interview on 5/30/18 at 1:30 P.M. with the Program Manager, she stated, LPN #3 altered the physician's order and Individual #3 did not receive his pre-sedation medication. A policy and procedure for accuracy of record keeping was requested. The facility did not provide the policy. The facility staff failed to maintain an accurate record that documented the individuals health care and treatment.	W 111		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)	W 149		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 17 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: 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: Individual #3 experienced neglect as a result of not receiving his pre-medication for a dental treatment. Individual #3 was assessed being tactile defensive and requires valium for routine dental cleanings to ensure adequate and thorough oral hygiene. A Restrictive Treatment Plan dated 10/24/16 indicated: "Diazepam -prior to dental appointments." An Incident and Accident Investigative report dated 04/03/17 indicated: "Individual #3 had a physician's order for pre-medication with Valium 10 (mg) milligrams 1 hour before dental procedures. The individual was scheduled for a dental appointment on 3/31/17. Nursing staff reviewed the orders on 3/28/17 and noted that the PRN for dental was not available. Nursing staff	W 149	Facility Nurse conducted quality assurance review on Individual #3's medical chart specifically focusing on accuracy and consistency of records related to dental service. It was determined that Individual #3 was seen by a dentist on 7/3/17. Also, records show that Individual #3 received appropriate pre-dental medication according to physician's order prior to the 7/3/17 appointment. Facility Nurse will conduct quality assurance reviews of dental records for all Residents noting the last completed visit as well as the anticipated date for the next follow up appointment. This review will be conducted now and quarterly thereafter. Staff will be retrained on Neglect and Abuse Prevention policy which applies to all individuals served. Nursing staff will be retrained on the revised Dental Services and Dental Services with Sedation policies that applies to all individuals served. Nurses will be trained on Board of Nursing Scope of Practice, Nurse Practice Act, specifically focusing on the record keeping section. A Dental Service Tracking Form will be developed for nurses to use in order to track and schedule dental services recommended by the individuals' dentists. Document will be monitored monthly by the Nurse Manager noting when services are due and when services are completed.	6/21/18 7/15/18 7/15/18 7/15/18 7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 18	W 149		

contacted the pharmacy and requested the pre-medication. The medication was sent to the facility. However, on the overnight shift on 4/2/17 nursing staff noted that the pre-medication ordered was still in the med cart. Upon review of the documentation it appears that the individual did not get the medication as originally ordered.

On March 31, 2017 when the controlled substance count was done it was noted that the diazepam was still in the medication cart. Licence Practical Nurse #3 (LPN#3) indicated that she was aware that the individual did receive dental sedation in the past. She reports on Thursday, March 30 she called the dentist's office and informed the office that there was not a current order for pre-sedation. She indicated the office told her to still bring him in for the appointment. She indicated she did not call the PCP's (Primary Care Physician) office. She stated, at 4:00 on a Thursday "I knew I was not going to get an order in time and he was on vacation." LPN #3 reported that on Friday March 31 she directed the medication certified staff member not to give the medication. She reported it was a one-time order in December and further stated, "I did not want him to be harmed by a medication he did not need."

Upon review of the documentation it appears that individual #3 did not get the medication as originally ordered. Per the MD and nurses notes of the visit. Individual #3 had a difficult time and the DDS requested again that the individual be pre medicated.

Per physician's order from the PCP (Primary Care Physician) the individual had a scheduled dental appointment and upon review of the

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 19 documentation it appeared that the individual did not receive the medication as originally ordered. Per the dental health consultation notes. The Dentist reported the individual was not given the pre-medication (diazepam 10 mg), so management of him was challenging to impossible. During an interview on 5/30/18 at 2:30 P.M. with the Program Manager, she stated, Individual #3 did not receive his medication prior to dental treatment and the dentist noted the procedure was difficult. A review of the facility's Abuse policy adoption date 11/14/16 indicated: "It is the policy of the agency to protect the individuals who are served from abuse, neglect, exploitation, crime and injury. Any medication error that requires further medical evaluation/care by a physician, PA, or NP is to be reported as both an allegation of neglect and as serious injury. The following types of medication errors are to be reported as an allegation of neglect: The lack of administrating a significant medication..." The facility staff failed to implement it's written policies and procedures that prohibit neglect of individuals.	W 149		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by:	W 331		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 20 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: Individual #3 did not receive his pre-medication for a dental treatment per nursing care plan. Individual #3 was assessed being tactile defensive and requires valium for routine dental cleanings to ensure adequate and thorough oral hygiene. A Restrictive Treatment Plan dated 10/24/16 indicated: "Diazepam -prior to dental appointments." Individual #3's nursing care plan indicated: Diazepam prior to dental appointments. Individual #3 requires sedation one hour prior to dental treatment. An Incident and Accident Investigative report dated 04/03/17 indicated: "Individual #3 had a physician's order for pre-medication with Valium 10 (mg) milligrams 1 hour before dental procedures. The individual was scheduled for a dental appointment on 3/31/17. Nursing staff reviewed the orders on 3/28/17 and noted that the PRN for dental was not available. Nursing staff contacted the pharmacy and requested the pre-medication. The medication was sent to the	W 331	Facility Nurse conducted quality assurance review on Individual #3's medical chart specifically focusing on accuracy and consistency of records related to dental service. It was determined that Individual #3 was seen by a dentist on 7/3/17. Also, records show that Individual #3 received appropriate pre-dental medication according to physician's order prior to the 7/3/17 appointment.	6/21/18
			Facility Nurse will conduct quality assurance reviews of dental records for all Residents noting the last completed visit as well as the anticipated date for the next follow up appointment. This review will be conducted now and quarterly thereafter.	7/15/18
			All Individuals treatment plan will include a section about oral hygiene/oral care indicating the frequency of dental checkups.	7/15/18
			Nursing Staff will be retrained on Dental Services and Dental Services with Sedation policies which outline nursing responsibilities in relation to pre-dental service medication.	7/15/18
			A Dental Service Tracking Form will be developed for nurses to use in order to track and schedule dental services recommended by the individuals' dentists. Document will be monitored monthly by the Nurse Manager noting when services are due and when services are completed.	7/15/18
			RN supervisors will be trained by the Nurse Manager on the use of the Dental Service Tracking Form. Nurse manager will review form monthly.	7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 21 facility. However, on the overnight shift on 4/2/17 nursing staff noted that the pre-medication ordered was still in the med cart. Upon review of the documentation it appears that the individual did not get the medication as originally ordered. During an interview on 5/31/18 at 10:00 A.M. with the Program Manager, she stated, Individual #3 did not receive his medication as ordered prior to his dental appointment. The facility staff failed to implement nursing services in accordance to Individuals needs.	W 331		
W 348	DENTAL SERVICES CFR(s): 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. This STANDARD is not met as evidenced by: Based on record review and staff interviews the facility staff failed to ensure one individual (Individual #3's) received dental services and 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. Individual #3 did not receive a physician ordered dental treatment.	W 348	Facility Nurse conducted quality assurance review on Individual #3's medical chart specifically focusing on accuracy and consistency of records related to dental service. It was determined that Individual #3 was seen by a dentist on 7/3/17. Also, records show that Individual #3 received appropriate pre-dental medication according to physician's order prior to the 7/3/17 appointment.	6/21/18
			Facility Nurse will conduct quality assurance reviews of dental records for all Residents noting the last completed visit as well as the anticipated date for the next follow up appointment. This review will be conducted now and quarterly thereafter.	7/15/18
			Nursing Staff will be retrained on Dental Services and Dental Services with Sedation policies which outline nursing responsibilities in relation to pre-dental service medication.	7/15/18
			RN supervisors will be trained by the Nurse Manager on the use of the Dental Service Tracking Form. Nurse manager will review form monthly.	7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 348	Continued From page 22 Individual #3 was assessed being tactile defensive and requires valium for routine dental cleanings to ensure adequate and thorough oral hygiene. A Restrictive Treatment Plan dated 10/24/16 indicated: "Diazepam -prior to dental appointments." A Dental Health Consultation dated 12/19/16 indicated: "Dentist did cleaning, heavy calculi removed, Individual already received pre-dental diazepam and the procedure was better than the past. Individual is referred to sedation dentistry for deep cleaning, and X-rays. Awaits scheduling for procedures. Individual #3 will be seen for sedation in 3 months - March 2017. A review of the clinical record did not indicate Individual #3 received the physician ordered deep cleaning and X-rays. During an interview on 6/1/18 at 9:15 A.M. with the Program Manager, she stated, Individual #3 did not receive the physician ordered dental services and treatment. The facility staff failed to provide for dental treatment and services.	W 348	Facility nurse will review all individuals' charts and note upcoming dental service due dates according to the Dental Service Tracking Form. Reminders to schedule appointments will be placed on Outlook group calendar by RN or designee based on information collected on the Dental Service Tracking Form. The nurses will be trained by the Nurse Manager on the use of the Dental Service Tracking Form. Forms will be submitted to the Nurse Manager monthly.	7/15/18 7/15/18 7/15/18
W 368	DRUGADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interviews the	W 368		

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 23 facility staff failed to ensure one individual's (Individual #3's) received medications in accordance to physician orders 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. Individual #3 did not receive medications in accordance to physician orders. A review of the clinical record and an incident report dated 04/03/17 indicated a physician's order had been altered. Individual #3 was assessed being tactile defensive and requires valium for routine dental cleanings to ensure adequate and thorough oral hygiene. A Restrictive Treatment Plan dated 10/24/16 indicated: "Diazepam -prior to dental appointments." An Incident and Accident Investigative report dated 04/03/17 indicated: "Individual #3 had a physician's order for pre-medication with Valium 10 (mg) milligrams 1 hour before dental procedures. The individual was scheduled for a dental appointment on 3/31/17. Nursing staff reviewed the orders on 3/28/17 and noted that the PRN for dental was not available. Nursing staff contacted the pharmacy and requested the pre-medication. The medication was sent to the facility. However, on the overnight shift on 4/2/17 nursing staff noted that the pre-medication ordered was still in the med cart. Upon review of the documentation it appears that the individual did not get the medication as originally ordered.	W 368	Facility Nurse conducted quality assurance review on Individual #3's medical chart specifically focusing on accuracy and consistency of records related to dental service. It was determined that Individual #3 was seen by a dentist on 7/3/17. Also, records show that Individual #3 received appropriate pre-dental medication according to physician's order prior to the 7/3/17 appointment. Facility RN will conduct quality assurance reviews of dental records for each resident monthly, specifically noting accuracy in transcription of orders for medications used for pre-dental treatment sedation. Nurses will be retrained on the process of receiving physicians' orders and the nursing tasks that must follow for all individuals. Nursing Staff will be retrained on Dental Services and Dental Services with Sedation policies which outline nursing responsibilities in relation to pre-dental service medication. A Dental Service Tracking Form will be developed for nurses to use in order to track and schedule dental services recommended by the individuals' dentists. Document will be monitored monthly by the Nurse Manager noting when services are due and when services are completed. RN supervisors will be trained by the Nurse Manager on the use of the Dental Service Tracking Form. Nurse manager will review form monthly.	6/21/18 7/15/18 7/15/18 7/15/18 7/15/18

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 24	W 368		

On March 31, 2017 when the controlled substance count was done it was noted that the diazepam was still in the medication cart. Licence Practical Nurse #3 (LPN#3) indicated that she was aware that the individual did receive dental sedation in the past. She reports on Thursday, March 30 she called the dentist's office and informed the office that there was not a current order for pre-sedation. She indicated the office told her to still bring him in for the appointment. She indicated she did not call the PCP's (Primary Care Physician) office. She stated, at 4:00 on a Thursday "I knew I was not going to get an order in time and he was on vacation." LPN #3 reported that on Friday March 31 she directed the medication certified staff member not to give the medication. She reported it was a one-time order in December and further stated, "I did not want him to be harmed by a medication he did not need." When presented with the original order LPN #3 indicated it read to her that it was a one-time order.

LPN #3 verified her signature on the medication administration record for January that contained the diazepam order. When she was presented with the order that had (X 1) added to the bottom, she indicated she changed the order to read (X 1) because that was what it was supposed to say. She indicated that the telephone order was changed by her after it was signed by the PCP and after the order was sent to the pharmacy on March 28th.

LPN #3 further indicated that she wrote on the physician's order sheet, "was X 1 order for dental appt with dentist. She indicated, "she was not aware that an order could not be changed after a

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

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G026	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKY AVENUE RESIDENCE	145 KENTUCKY AVENUE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 25 doctor had signed the order." Findings: LPN #3 changed the physician's order after it was signed by the PCP, and instructed a staff member to withhold a prescribed medication. During an interview on 5/31/18 at 2:45 P.M. with the Program Manager, she stated, Individual #3 was not administered his medication for dental treatment as ordered by the physician. The facility staff failed to administer medication in compliance with physician's orders.	W 368		