STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G069	A. BUILDING _____ B. WING _____	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWYER ICF	529 RIVERVIEW ROAD MADISON HEIGHTS, VA 24572

(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 08/27/19 through 08/28/19. The facility was in substantial 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		
W 000	INITIAL COMMENTS An unannounced Focused Fundamental Medicaid re-certification survey was conducted 08/27/19 through 08/28/19. The facility was not in compliance with 42 CFR Part 483 Requirements 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 4 certified bed facility was 3 at the time of the survey. The survey sample consisted of 2 Individual reviews (Individuals #1 through 2).	W 000		
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure the off site day program services met the nutritional supplementation needs of Individual #2.	W 120	1) Address the corrective action taken for the problem. a. The timing of the Ensure Enlive and Magic Cup was changed so that Individual # 2 receives these while at home and not at day support. b. We will implement a documentation system for day support programs that requires day program staff to initial that the supplement was given and the percentage consumed.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Ferguson — TITLE: Residential Manager — (X6) DATE: 9/10/19

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

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Findings include:

Individual #2 was admitted to the facility on 08/26/14. Diagnoses for Individual #2 included, but were not limited to profound mental intellectual disability, limb deformity with contractures, dysphagia (difficulty swallowing), scoliosis, hernia, and communication deficit (non-verbal).

Individual #2 was observed on 08/27/19 from approximately 10:45 AM to 12:00 PM. Individual #2 was observed in an off site day program setting. Individual #2 was receiving lunch during the observation. DSP (direct staff person) #1 was feeding Individual #2 and explained that due to the individual's difficulty swallowing, it takes a long time for meal consumption. DSP #1 stated that it may take up to an hour to achieve 100% of the meal. DSP #1 stated that Individual #2 comes to day program with a meal prepared, along with benefiber which is mixed in the food, just prior to feeding. DSP #1 was asked if Individual #2 received snacks or anything else to eat while at the program. DSP #1 stated, "No." DSP #1 stated that Individual #2 was eating pureed pot roast, potatoes, mixed vegetables with thickened kool-aid to drink for today's meal. Individual #2 attends the off site day program five days a week, Monday through Friday from 9:00 AM to 1:30 PM. DSP #1 stated that if Individual #2 eats less than 50% of a meal, that give her a supplement drink. DSP #1 stated that Individual #2 will almost always eat 100%, it just takes time.

Individual #2's physician's orders were reviewed and revealed that Individual #2 had a physician's order for a magic cup twice daily, ensure enlive chocolate (give one bottle) by mouth twice daily.

W 120 2) Address how the facility will identify similar occurrences of the problem

a. We will implement a documentation system for day support programs that requires day program staff to initial that the supplement was given and the percentage consumed.

3) Identify measures/systemic changes to ensure deficient practices will not recur.

a. The flow sheets will be reviewed daily upon return from day program by Residential Manager, Instructor Counselor or designee.

b. If there is an issue with the flow sheets during the daily review and it is found that the day program did not follow the physician's order, we will reach out to the day program for explanation.

4) Indicate how facility will monitor its performance.

a. The flow sheets will be reviewed daily upon return from day program by Residential Manager, Instructor Counselor or designee.

b. If there is an issue with the flow sheets during the daily review and it is found that the day program did not follow the physician's order, we will reach out to the day program for explanation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 120 Continued From page 2

and an order to give extra fluids (4 ounces every 2 hours while awake-as tolerated).

Individual #2's flow sheets were then reviewed. The ensure enlive was listed for Individual #2 to receive one bottle at 10:00 AM and was signed off as administered for the whole month of August. The magic cup was listed for the individual to receive one cup at 12:00 PM and was documented as administered with initials, several days only had the letter "D" listed in the space. The extra fluids was listed on the MARS (medication administration records) and documented as administered, with 20 times listed as not administered. The back of the MAR documented that the fluids were offered at the day program and signed off by facility staff, not day program staff.

The administrator was asked to explain the above information. The administrator stated that the she did not know why her facility staff were signing off on the ensure enlive as administered at 10:00 AM, as Individual #2 was at the day program site during that time. The administrator then stated that they (the facility) didn't know for sure if the individual received the magic cup at noon as ordered because the day program does not fill anything out to verify that it was administered, refused, etc. The administrator stated that they send magic cup with her to the day program, but don't know if she is actually getting it. The administrator stated that the "D" was for day program and that facility staff put that in. The administrator stated that the extra fluids should be offered at the day program, but again stated that there isn't documentation to evidence that Individual #2 is receiving it.

W 120 c. The QIDPs will monitor for supplement administration through direct observation and/or record review at day programs during their visits which take place every 60 days.

Completion date: 9/30/19

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W 120	Continued From page 3 On 08/28/19 at approximately 10:45 AM, in a meeting with the survey team, the administrator, the supervisor and assistant administrator were made aware of concerns with Individual #2 being ordered supplements and no evidence of coordination of care between the day program and the facility for nutritional supplementation. No further information and/or documentation was presented prior to the exit conference on 08/28/19 at 11:30 AM to evidence Individual #2's day program provided consistent implementation of the individual's physician ordered supplements and the individual's active treatment plan.	W 120		
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: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure nursing services for gastrostomy tube (peg tube) care for Individual #1. Findings include: Individual #1 was admitted to the facility on 11/05/14. Diagnoses for Individual #1 included, but were not limited to profound mental intellectual disability, seizure disorder, chronic constipation, severe dysphagia, and chronic peg tube placement. Individual #1 was observed during a medication	W 331	1) Address the corrective action taken for the problem. a. The policy for enteral feeding was updated on 8/29/19 to reflect best practice. Checking placement prior to each medication, nutrition or fluid administration was modified. See attached policy. b. All LPNs will be individually inserviced on the updated policy. 2) Address how the facility will identify similar occurrences of the problem. a. The updated policy applies to all individuals who receive medications, nutrition, or fluids through gastrostomy tubes.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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pass and pour observation on 08/27/19 at 2:50 PM. LPN (Licensed Practical Nurse) #5 prepared medications for Individual # 1. LPN #5 took a 50 cc (cubic centimeter) syringe attached it to the peg tube and attempted to aspirate gastric fluid into the syringe. No gastric fluids were seen and the peg tube collapsed. LPN #5 then released the peg tube and took the medications ordered and administered them through the peg tube. LPN #5 did not check and or confirm placement of the peg tube prior to administering medications through the peg tube.

During clinical record review on 08/27/19 and 08/28/19 it was documented throughout Individual #1's record that the individual had a history of pulling out the peg tube or causing peg tube dislodgement, which had required on multiple occasions, the need for further medical treatment to replace the peg tube.

A policy was requested on peg/gastrostomy tube care.

The policy titled, "Enteral Feeding Policy and Procedures" documented, ".. Gastrostomy feeding...equipment...irrigating syringe...stethoscope...wash hands...remove plug of gastrostomy tube, check patency and position. Use syringe to inject 5-10 cc of air through the tube while AUSCULTATING the individual's stomach with the stethoscope. LISTEN for a swooshing sound. ASPIRATE for stomach contents to confirm the tube is patent and properly positioned..."

On 08/28/19 at approximately 10:45 AM, the administrator, supervisor and assistant administrator were made aware in a meeting of

W 331 3) Identify measures/systemic changes to ensure deficient practices will not recur.

a. All LPNs will be observed by an RN within one month following inservice on the updated policy.

b. All LPNs will be observed by an RN every six months thereafter.

4) Indicate how facility will monitor its performance.

a. All LPNs will be observed by an RN within one month following inservice on the updated policy.

b. All LPNs will be observed by an RN every six months thereafter.

Completion date: 9/30/19

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the above concerns.

No further information and/or documentation was presented prior to the exit conference on 08/28/19 at 11:30 AM.

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

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

This STANDARD is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff to ensure proper infection control practices for hand washing during a medication pass and pour observation.

Findings include:

On 08/27/19 at 2:50 PM, LPN (Licensed Practical Nurse) #5 prepared medications for Individual #3. This individual had a gastrostomy (peg) tube. LPN #5 donned gloves and began to prepare the medication for Individual #3. LPN #5 took a 50 cc syringe, administered the medication via the peg tube then removed the gloves and proceeded to the next individual. LPN #5 did not use hand sanitizer or wash his hands before or after medication administration.

LPN #5 donned gloves and prepared medications for Individual #1. Individual #1 had a gastrostomy (peg) tube. LPN #5 pulled up the individual's shirt exposing the peg tube and removed a saturated dressing from around the peg tube site, removed the gloves with the soiled dressing inside and

W 331

W 454 1) Address the corrective action taken for the problem.

a. LPN #5 will receive progressive discipline related to his performance.

b. All staff will be inserviced on proper handwashing/sanitization.

2) Address how the facility will identify similar occurrences of the problem.

a. RNs will observe LPNs during medication administration for proper handwashing/sanitization practices at least every 6 months.

b. RNs/LPNs will observe RTs during medication administration for proper handwashing/sanitization practices at least every 6 months.

3) Identify measures/systemic changes to ensure deficient practices will not recur.

a. RNs will observe LPNs during medication administration for proper handwashing/sanitization practices at least every 6 months.

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discarded the dressing and gloves in the trash. LPN #5 immediately donned another pair of gloves and administered the medications via peg tube to the individual. LPN #5 did not wash or sanitize his hands at any time during this observation.

LPN #5 was interviewed after completion of the observation. LPN #5 was made aware that he did not wash or sanitize his hands during the medication observations. LPN #5 stated, "You are right." LPN #5 stated that he was nervous.

A policy was requested on infection control/handwashing expectations.

A policy was presented titled, "Infection Control in ICF [intermediate care facilities]." The policy documented, "...clean, neat and sanitary environment...Staff will use universal precautions at all times...Staff will wash hands after using restroom, during meal preparation, before providing any direct care services, between providing direct care services to different individuals, before medication administration...and at other critical times to prevent or control the spread of infection..."

A policy was also presented on peg/gastrostomy tube care.

The policy titled, "Enteral Feeding Policy and Procedures" documented, "...Gastrostomy...equipment...wash hands..."

Concerns were shared with the administrator, supervisor and assistant administrator in a meeting with the survey team on 08/28/19 at approximately 10:45 AM.

b. RNs/LPNs will observe RTs during medication administration for proper handwashing/sanitization practices at least every 6 months.

4) Indicate how facility will monitor its performance.

a. RNs will observe LPNs during medication administration for proper handwashing/sanitization practices at least every 6 months.

b. RNs/LPNs will observe RTs during medication administration for proper handwashing/sanitization practices at least every 6 months.

Completion date: 9/30/19

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W 454	Continued From page 7 No further information and/or documentation was presented prior to the exit conference on 08/28/19 at 11:30 AM.	W 454		

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