CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					OMB NO.	0938-	039
STATEMENT OF DET CIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER	97 5300	A. BUILDING			(X3) DATE SURVE COMPLETED		
		49G069	B. WING	7.00 7. 00			09/2	8/201	0
NAME OF BOWYE	PROVIDER OR SUPPLIER			529 (RIVER	DRESS CITY STATE, ZIP CODE	08/2	0/201	9
				MAC	DISON	NHEIGHTS, VA 24572			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRFFIX IAG			PROVIDER'S PLAN OF CORRECTI ACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS COMPLE DAT	HON
E 000	Initial Comments		E 00	00					
W 000	survey was conduct 08/28/19. The facilities with 42 Condition of Partici Facilities for Individ	Emergency Preparedness ted 08/27/19 through lity was in substantia! CFR Part 483.73, 483.475, pation for Intermediate Care uals with Intellectual inplaints were investigated	W oc	00					
	Medicaid re-certification 08/27/19 through 01 compliance with 42 for Intermediate Calwith Intellectual Dis Safety Code survey	ocused Fundamental ation survey was conducted 8/28/19. The facility was not in CFR Part 483 Requirements re Facilities for Individuals abilities (ICF/IID). The Life freport will follow. No restigated during the survey.							
W 120	the time of the survi consisted of 2 Indivi through 2).	Certified bed facility was 3 at ey. The survey sample dual reviews (Individuals #1 DED WITH OUTSIDE	W 12	1)	pro	dress the corrective action ta blem. The timing of the Ensure Er		e	
	The facility must as: meet the needs of e	sure that outside services ach client.				Magic Cup was changed so Individual # 2 receives thes home and not at day suppo	e while at	D	SEE - 3
	Based on observati record review, the fa	on, staff interview and clinical acility staff failed to ensure the			b.	We will implement a docum system for day support pro requires day program staff	grams that	STC.	2013

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

supplementation needs of Individual #2.

off site day program services met the nutritional

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

percentage consumed.

that the supplement was given and the

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

comes to day program with a meal prepared,

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 meat, 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.

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.'

along with benefiber which is mixed in the food,

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		(X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER	93 23	(X2) MULT PLE CONSTRUCTION A BUILDING		
		49G069	B WING		08/28/2019	
NAME OF PROVIDER OR SUPPLIER BOWYER ICF			529	LET ADDRESS CITY STATE ZIP CODE RIVERVIEW ROAD DISON HEIGHTS, VA 24572	=	
(X4) ID PREF X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION	
W 120	Continued From p	age 1	W 120 ²⁾	Address how the facility will occurrences of the problem		
	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			 We will implement a do system for day support requires day program si that the supplement was percentage consumed. 	programs that taff to initial	
			3)	ensure deficient practices was a. The flow sheets will be in	rill not recur. reviewed daily	
				upon return from day p Residential Manager, In Counselor or designee. b. If there is an issue with	structor	
	that it may take up	to an hour to achieve 100% of stated that Individual #2		during the daily review	and it is found	

4) Indicate how facility will monitor its performance.

the day program for explanation.

that the day program did not follow the

physician's order, we will reach out to

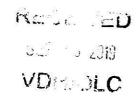
- The flow sheets will be reviewed daily upon return from day program by Residential Manager, Instructor Counselor or designee.
- b. If there is an issue with the flow sheets during the daily review and it is found that the day program did not follow the physician's order, we will reach out to the day program for explanation.

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Event ID, V39B11

Facility ID: VAICEID75

If continuation sheet Page 2 of 8



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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		10 mm to 10	(3) DATE SURVEY COMPLETED	
		49G069	B WING.	(e.e. (see.ex))	08	/28/2019	
BOWYER	IOVIDER OR SUPPLIE	н		STREET ADDRESS CITY, STATE ZIP COD 529 RIVERVIEW ROAD MADISON HEIGHTS, VA 24572			
(X4) ID PREFIX TAG	FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL B LSC IDENTIFYING INFORMATION:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) GÖMPLET:ON DATE	

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 entive 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 wi

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.

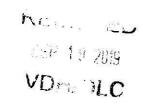
Completion date: 9/30/19

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Event -D: V39B11

Facility D: VAICFID75

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			IX1) PROVIDER/SUPPLIER/CLIA DENT-FICATION NUMBER	(X2) MULTI A BUILDIN	_	DNSTRUCTION		(X3) DATE SURVEY COMPLETED
			49G069	B. WING _	300000			08/28/2019
	NAME OF F	PROVIDER OR SUPPLIER			529 R	ET AUDHESS, CITY STATE ZIP C RIVERVIEW ROAD ISON HEIGHTS, VA 24572		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCHDENTIFYING INFORMATION:	D PREF X TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CHOSS-REFERENCED TO THE DEFICIENCY)	V SHOULD	DIBE COMPLETION
	W 120	meeting with the su the supervisor and made aware of con ordered supplement coordination of care and the facility for in No further informati presented prior to the 08/28/19 at 11:30 A day program provide of the individual's p	ge 3 roximately 10:45 AM, in a livey team, the administrator, assistant administrator were cerns with Individual #2 being its and no evidence of a between the day program putritional supplementation was the exit conference on IM to evidence Individual #2's ed consistent implementation hysician ordered supplements active treatment plan.	W 12	0			
	W 331	This STANDARD is Based on observat record review, and facility staff failed to	PER CONTROL	W 33	1 1)	 Address the corrective ad problem. a. The policy for enteral updated on 8/29/19 practice. Checking pleach medication, nutradministration was nattached policy. b. All LPNs will be indivion the updated policy. 	il feedin to reflect lacemen trition o modified	g was ct best it prior to ir fluid I. See
		11/05/14. Diagnose but were not limited intellectual disability constipation, severe tube placement.	dmitted to the facility on es for Individual #1 included, to profound mental r, seizure disorder, chronic e dysphagia, and chronic peg		2)	Address how the facility occurrences of the problem. The updated policindividuals who renutrition, or gastrostomy tubes.	lem. cy app	lies to all

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
		49G069	B. WING	2022.226	08/28/2019
NAME OF PROVIDER OR SUPPLIER BOWYER ICF			529 F	ET ADDRESS, CITY, STATE, ZIP COD IVERVIEW ROAD ISON HEIGHTS, VA 24572	
(X4) ID PHEHX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFOHMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
	PM. LPN (Licens medications for Incc (cubic centime peg tube and atteinto the syringe. If the peg tube and and administered LPN #5 did not choof the peg tube professions the peg tube professions the peg tube professions. The policy was required and administered LPN #5 did not choof the peg tube professions the peg tube professions the peg dislodgement, who coasions, the neto replace the peg A policy was required are. The policy titled, "Procedures" docu feedingequipme syringestethoso of gastrostomy tube while AUSCU stomach with the swooshing sound contents to confirm properly positione.	servation on 08/27/19 at 2:50 ed Practical Nurse) #5 prepared idividual # 1. LPN #5 took a 50 ter) syringe attached it to the impted to aspirate gastric fluid No gastric fluids were seen and ipsed. LPN #5 then released took the medications ordered them through the peg tube. eck and or confirm placement for to administering medications ube. Ford review on 08/27/19 and occumented throughout Individual individual had a history of gitube or causing peg tube in had required on multiple ed for further medical treatment gitube. Enteral Feeding Policy and mented, " Gastrostomy intirrigating opewash handsremove plug ope, check patency and position. ect 5-10 cc of air through the JLTATING the individual's stethoscope. LISTEN for a ASPIRATE for stomach in the tube is patent and	W 331 3)	 performance. a. All LPNs will be observed within one month for on the updated policy. b. All LPNs will be observed within one months there 	vill not recur. erved by an RN lowing inservice erved by an RN eafter. vill monitor its erved by an RN llowing inservice erved by an RN

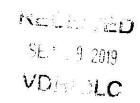
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administrator were made aware in a meeting of

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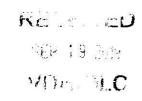
STATEMENT OF DEFICIENCES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT PLE I A BUILDING	(X3) DATE SURVEY COMPLETED		
		49G069	8 WING		08/28/2019
NAME OF PROVIDER OR SUPPLIER BOWYER ICF			529	REET ADDRESS CITY, STATE, ZIP CODE RIVERVIEW ROAD DISON HEIGHTS, VA 24572	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION:	D PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRO DEF CIENCY:	LD BE COVPLETION
W 331		ion and/or documentation was	W 331		
W 454	presented prior to t 08/28/19 at 11:30 A INFECTION CONT CFR(s): 483.470(I)	ROL	W 454 1	Address the corrective action to problem.	aken for the
		ovide a sanitary environment and transmission of infections.		a. LPN #5 will receive progres discipline related to his pe	
	Based on observa document review, t proper infection col washing during a m	s not met as evidenced by: tion, staff interview and facility he facility staff to ensure ntrol practices for hand nedication pass and pour	Ž	 b. All staff will be inserviced handwashing/sanitization. c) Address how the facility will in occurrences of the problem. 	
	observation. Findings include:	O DM 1 DN // increased December		medication administration handwashing/sanitization	
	Nurse) #5 prepared This individual had LPN #5 donned glo medication for Indivisyringe, administer tube then removed the next individual.	O PM, LPN (Licensed Practical dimedications for Individual #3. a gastrostomy (peg) tube. Eves and began to prepare the vidual #3. LPN #5 took a 50 cc ed the medication via the pegithe gloves and proceeded to LPN #5 did not use hand is hands before or after		least every 6 months. b. RNs/LPNs will observe medication administration handwashing/sanitization least every 6 months. 3) Identify measures/systemic ensure deficient practices will	on for proper n practices at changes to
	LPN #5 donned glo for Individual #1. In (peg) tube. LPN #5 exposing the peg to dressing from arou	eves and prepared medications individual #1 had a gastrostomy pulled up the individual's shirt ube and removed a saturated and the peg tube site, removed soiled dressing inside and		companies and described the second control of the second control o	LPNs during on for proper

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OCH L	15 TOTT MEDIONITE	A MEDICAID SERVICES	-,			· · · · · · · · · · · · · · · · · · ·	716 140. 0838-038 I
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	18 18			RUCTION	(X3) DATE SURVEY COMPLETED
		49G069	8 MING				08/28/2019
NAME OF I	PROVIDER OF SUPPLIER			STHEF	T At)	ORESS CITY, STATE, ZIP CODE	
BOWYER	RICF					IVIEW ROAD NHEIGHTS, VA 24572	
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION:	D PREFI TAG	×		PROVIDER'S PLAN OF CORRECTI FACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	LPN #5 immediately gloves and administ tube to the individual sanitize his hands a observation. LPN #5 was intervious observation. LPN #5 was intervious observation. LPN #5 was intervious observation. LPN #6 was intervious observation. LPN #6 was intervious observation. LPN #5 was intervious observation. A policy was request control/handwashin. A policy was present ICF [intermediate of documented, "clear environment Staff was all times Staff we restroom, during me providing any direct care individuals, before a administration and prevent or control the A policy was also prevent or control the A policy was also prevent or control the Concerns was also prevent or control the Concerns were shared	sing and gloves in the trash. y donned another pair of tered the medications via peg al. LPN #5 did not wash or at any time during this ewed after completion of the f5 was made aware that he itize his hands during the tions. LPN #5 stated, "You stated that he was nervous. sted on infection g expectations. ated titled, "Infection Control in are facilities]." The policy an, neat and sanitary will use universal precautions ill wash hands after using eal preparation, before care services, between a services to different nedication at other critical times to be spread of infection" esented on peg/gastrostomy hteral Feeding Policy and ented, uipmentwash hands"	W 4	4)	Inc pe a.	medication administration handwashing/sanitization least every 6 months. RNs/LPNs will observe medication administration handwashing/sanitization least every 6 months.	n for proper practices at monitor its PNs during in for proper practices at RTs during on for proper
	Concerns were shar supervisor and assis						

approximately 10:45 AM.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICA	HE & MEDICAID SERVICES		1900 10 - 12 - 12	OMB NO	0. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER/	:X2: MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		49G069	B. W.NG		DE	3/28/2019		
NAME OF P	ROVIDER OR SUPPLIE	ER		STREET ADDRESS, CITY, STATE ZIP				
BOWYER	BOWYER ICF			529 RIVERVIEW ROAD				
				MADISON HEIGHTS, VA 24572	2			
(X4) 'D PREFIX TAG	HEACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL RILSC (DENTIFYING INFORMATION)	:D PREFIX TAG	PROVIDER'S PLAN OF CO LEACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEF CIENCY)	N SHOULD BE E APPROPRIATE	X5" COVP. FT DN DATE		
W 454	Continued From	page 7	W 45	1		950 (17 t)		

VV 454

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

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