STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G040	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLBY WAY RESIDENCE	6316 COLBY WAY VIRGINIA BEACH, VA 23464

(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 11/12/19 through 11/14/19. 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 emergency preparedness complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 11/12/19 through 11/14/19. 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 5 certified bed facility was 4 at the time of the survey. The survey sample consisted of 2 Individual reviews.	W 000		
W 251	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, the facility staff failed to implement the	W 251		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	DS Director	12/4/19

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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W 251	Continued From page 1	W 251		

Individual Program Plan (IPP) for one (Individual #2) of 4 Individuals in the survey sample, to encourage use of the right hand to increase range of motion.

The findings included;

Individual #2 was originally admitted to the residence 7/15/2008. The current diagnoses included: Severe Intellectual Disability, cerebral palsy and partial right side paralysis. Individual #2 walked independently with a limp, required supervision with transfers, and cueing with task and meal consumption after set-up.

On 11/13/19 at approximately 10:45 a.m., Individual #2 was observed seated in the activity room of the day support program. The Individual had a plastic container with a lid on it which had an opening on the top for the resident to insert coins. The plastic container and the coins were set-up on the individual's left side. The individual used the left hand only to pick up the coins and put them in the container until he had used most of the coins. Day support staff #1 removed the coins from the container and again placed them to his left and Individual #2 resumed putting the coins in the container one at a time. At no time while the Individual was completing the activity did staff move the container or coins to his right side and neither was the individual encouraged to utilize his right hand.

Also on 11/13/19 at approximately 4:05 p.m., Individual #2 was observed at the dining table of the residence consuming a pre-dinner snack. The individual was consuming an item which required no utensils; he used only the left hand to hold his food and consume the snack. At no point did the

Facility staff and day support staff will be re-trained on individual #2's Program Plan (IPP). 12/27/19

Facility staff will be re-trained on all residents' IPP. Day support staff will be re-trained on all attending residents' IPP. 12/27/19

The QIDP will complete monthly unannounced visits to the day support program. The QIDP will complete random observations at the facility monthly. The QIDP will address all treatment plan discrepancies. 12/27/19

The QIDP will document observations in monthly case coordination note. 12/27/19

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W 251	Continued From page 2 staff encourage him to use his right hand during self-feeding. Review of Individual #2 Active Treatment Plan dated 5/1/19, revealed the staff would encourage the individual to use his right hand as much as possible throughout the day. Staff will provide hand over hand assistance as needed to encourage use. On 11/13/18 at approximately 12:25 p.m., the above findings were shared with the Residential Manager, Administrator, the Quality Improvement Manager, and the ICF Supervisor. The Residential Manager stated "I understand the items weren't positioned to encourage use of the right hand."	W 251		
W 368	DRUG ADMINISTRATION 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 clinical record review, staff interview, and facility documentation review, the facility's staff failed to administer one of 4 Individual's in the survey sample, Individual #1, 8:00 p.m. medications on 3/26/19. The findings included; Individual #1 was originally admitted to the residence on 12/1/16. The current diagnoses included; severe intellectual disability, Down's Syndrome, Alzheimer's dementia and a seizure	W 368		

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W 368	Continued From page 3	W 368		

disorder.

A nurse's note dated 3/27/19, revealed on 3/26/19 at 8:00 p.m., Individual #1 didn't receive scheduled medications: Lamictal, Simvastatin and Docusate sodium. Facility staff were notified of the medications not administered as well as the physician and the individual's responsible party.

The physician's order included four medications scheduled with start dates; 9/29/17, Lamictal 200 milligrams tablet - administer one tablet by mouth two times each day for seizures; 11/22/16, Simvastatin 20 milligrams tablet - administer one tablet at bedtime and 2/28/17, Docusate sodium 100 milligram capsule - administer one capsule at bedtime. There was also an order dated 1/3/17, for Systane ultra eye drops - administer one drop into both eyes three times each day.

Further facility documentation dated 3/28/19; revealed the staff member who was responsible for medication administration on 3/26/29, at 8:00 p.m., signed out the medications to be administer to Individual #1 but the medications were still in the packages on 3/27/19. The individual responsible for administering the medications stated on 3/28/19, that Individual #1 "is the last to receive medications and I overlooked giving his medications."

On 11/13/18 at approximately 12:25 p.m., the above findings were shared with the Residential Manager, Administrator, the Quality Improvement Manager, and the ICF Supervisor. The facility's staff stated there had been no medication omissions since the above event.

Staff involved in the medication administration error will receive disciplinary action in the form of counseling statement. 12/27/19

All medication trained staff will complete the annual medication recertification training. 10/3/19

All medication scheduled to be administered will be counted by two medication administration trained staff at the end of each shift to ensure all medications have been administered. Any discrepancies will be reported to nursing staff. 7/1/19

Nursing staff will conduct and document random medication pass observations for direct care staff at the following intervals: weekly for eight weeks and monthly thereafter. 12/27/19

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W 473	Continued From page 4	W 473		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii)	W 473		

Food must be served at appropriate temperature.

This STANDARD is not met as evidenced by:
Based on observation, staff interviews, clinical record review, and facility documentation review, the facility staff failed to serve hot foods during the 11/12/19, dinner meal at safe temperature for 1 of 2 Individuals (Individual #1), in the survey sample.

The findings included;

Individual #1 was originally admitted to the residence 12/1/16. The current diagnoses included; severe intellectual disability, Down's Syndrome, Alzheimer's dementia and a seizure disorder.

Individual #1's diet orders signed 9/12/19, read: low cholesterol, low fat, no added salt, moist mechanical soft/ground consistency diet Thick-it to be added to all thin liquids to make a nectar consistency.

On 11/12/19, at approximately 5:45 p.m., during the dinner meal Direct Support Personnel (DSP) #2 plated Individual #1's meal which consisted of baked ziti, a squeezable fruit/vegetable mixture, yogurt and a red drink in a red topped cup.

DSP #2 was asked for the recorded temperatures for the meal currently being served. DSP #2 stated there was no temperature log and no temperatures had been obtained for the dinner meal being served at the time. DSP obtained a

Staff will test all food thermometers for accuracy and discard any defective equipment. 11/15/19

The facility will purchase new food thermometers. 11/29/19

All staff will be in-serviced on proper food handling and servicing temperatures. 12/27/19

To ensure proper food handling procedures are being followed, effective immediately, the QIDP, House Manager, and/or the Behavioral Specialist will regularly monitor mealtimes. The observations will take place across shifts and with varying staff. 12/27/19

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W 473	Continued From page 5	W 473		

thermometer from the drawer and obtain a temperature of the meal on Individual #1's plate prior to feeding it to him. The thermometer reading was 83 degrees Fahrenheit. DSP #2 stated the thermometer's beginning temperature was 70 and would not register at zero even after submersion in cold water. The same thermometer was used to obtain another temperature of the baked ziti, it recorded 80 degrees. DSP served and fed the plated baked ziti to Individual #1.

During the 11/12/19, interview with DSP #2 at approximately 6:30 p.m., she stated she would find out what temperatures hot and cold foods needed to be prior to serving for at that time she couldn't state the acceptable ranges.

On 11/14/19 at approximately 10:50 a.m., an interview was conducted with the Residential Manager. The Residential Manager stated a hot food temperature should be 140 degrees in order to be served and if it wasn't at the time of service the staff should have heated the food to reach the 140 degree temperature. The Residential Manager looked in the drawer when the thermometers were located and removed four thermometers, she never stated if they were reading accurately or if they were not functioning properly. The Residential Manager was unable to state when the staff had last been in-serviced on safe food temperatures and/or recording food temperatures.

On 11/13/18 at approximately 12:25 p.m., the above findings were shared with the Residential Manager, Administrator, the Quality Improvement Manager, and the ICF Supervisor. The facility staff offered no additional information on safe

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W 473	Continued From page 6 serving temperatures for foods.	W 473		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to serve 1 of 4 Individuals, Individual #1's, drink on 11/13/19, during the midday meal at a nectar thick consistency. The findings included; Individual #1 was originally admitted to the residence 12/1/16. The current diagnoses included; severe intellectual disability, Down's Syndrome, Alzheimer's dementia and a seizure disorder. Individual #1's diet orders signed 9/12/19, read: low cholesterol, low fat, no added salt, moist mechanical soft/ground consistency diet Thick-it to be added to all thin liquids to make a nectar consistency. Review of the 11/4/19, Nutrition Assessment revealed the Individual is a high aspiration risk and is to continue the diet as ordered. On 11/13/19, at approximately 12:45 p.m., during the midday meal, Direct Support Personnel (DSP) #3 plated Individual #1 meal which consisted of a peanut butter and jelly sandwich, a squeezable fruit/vegetable mixture, and a red drink in a red	W 474	All drinks will be prepared individually to proper consistency as stated in physician orders. Drinks will not be prepared in bulk. 12/27/19 The QIDP or dietician will train all facility staff on everyone's special prescribed diet orders and consistencies. 12/27/19 All staff will be in-serviced on proper food handling and servicing temperatures. 12/27/19 To ensure proper food handling procedures are being followed, effective immediately, the QIDP, House Manager, and/or the Behavioral Specialist will regularly monitor mealtimes. The observations will take place across shifts and with varying staff. 12/27/19	

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W 474	Continued From page 7	W 474		

topped cup.

At the end of the midday meal the fluid in Individual's #1 cup was observed and it was thinner than a nectar consistency therefore, an interview was conducted with DSP #3. DSP #3 stated the staff makes a 64 ounce pitcher of nectar thick Crystal Light at a time and to obtain the nectar thick consistency they add 12 pumps of the Thick-it.

Review of the Thick-it container read; to obtain a nectar thick consistency add 2 pumps to each eight ounce of liquid.

Licensed Practical Nurse (LPN) #1 calculated how many pumps of Thick-it was required to convert 64 ounces of a thin liquid to a nectar thick consistency. LPN #1 stated 16 pumps was necessary to obtain a nectar thick consistency of 64 ounces of fluid. LPN #1 stated the question had not be asked by the DSP staff therefore there had not been a discussion about the formula necessary to achieve the desired consistency.

On 11/13/18 at approximately 12:25 p.m., the above findings were shared with the Residential Manager, Administrator, the Quality Improvement Manager, and the ICF Supervisor. The Residential Manager stated the necessary information is posted in the kitchen and it is on the Thick-it container and the concerned will be addressed with the DSP staff.