| 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 | 11/22/2019 |

| 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 |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 11/21/19 through 11/22/19. 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.<br><br>No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| E 031 | Emergency Officials Contact Information<br>CFR(s): 483.475(c)(2)<br><br>[(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:<br><br>(2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br><br>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, or local emergency preparedness staff.<br>(ii) The State Licensing and Certification Agency.<br>(iii) The Office of the State Long-Term Care Ombudsman.<br>(iv) Other sources of assistance.<br><br>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff. | E 031 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Tim Capdeo | DS Director | 12/10/19 |

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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| E 031 | Continued From page 1<br>(ii) Other sources of assistance.<br>(iii) The State Licensing and Certification Agency.<br>(iv) The State Protection and Advocacy Agency.<br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the facility staff failed to have all required contact information in the communication plan.<br><br>The findings included:<br><br>During an interview on 11/21/19 at 3:43p.m. with the Residential Coordinator and Supervisor II, they were asked for names and contact information for all facility staff, as well as entities providing services under agreement during an emergency. A review of the communications plan did not include the Emergency Officials contact information. The Residential Coordinator did not provide contact information of Federal, State and Regional Emergency Preparedness staff. | E 031 | The Emergency Contact List will be updated.<br><br>The Emergency Contact List will be updated when changes occur, reviewed for needed updates when the Emergency Preparedness Plan is modified and/or annually. | 12/13/19<br><br>12/13/19 |
| W000 | INITIAL COMMENTS<br><br>An unannounced Fundamental Medicaid re-certification survey was conducted 11/21/19 through 11/22/19. 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.<br><br>The census in this 8 certified bed facility was 6 at the time of the survey. The survey sample consisted of 3 current Individual reviews (Individuals #1 through #3). | W000 | | |
| W368 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(1) | W368 | | |

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| | 49G026 | A. BUILDING — — — — — — B. WING | 11/22/2019 |

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| W 368 | Continued From page 2<br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to ensure medications were administered in accordance with physician's orders for two Individuals (Individual#1 and #3) in the survey sample of three Individuals.<br><br>The findings included:<br><br>Individual #1 was admitted to the facilty on 04/01/02 with diagnoses which included Profound Intellectual Disability, seizures, bowel obstruction, hypothyroidism, chronic pedal edema, scoliosis, and Kyphosis. The facility staff failed to administer physician ordered (Zonisamide) medication for seizures.<br><br>A facility incident and accident report dated 09/15/19 indicated: "During the medication administration on the morning of 09/16/19, staff LPN (Licensed Practical Nurse) discovered that one Zonisamide 100 mg (milligram) cap was left from the previous day. The individual is to take (2) capsules each morning for seizure activity, but only one was administered. Wrong dose administered. Staff LPN assessed individual and noted no increased seizure activity. Staff notified on call physician, and AR (authorized representative). Staff LPN waiting for physician response.<br><br>CQI (sic) opened an investigation, interviewed DSP #1 and DSP #2 (Direct support staff) and reviewed individual's Medication Administration | W 368 | Staff involved in the medication administration error will receive disciplinary action in the form of counseling statement.<br><br>All medication trained staff will complete the annual medication recertification training.<br><br>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.<br><br>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. | 1/6/2020<br><br>1/6/2020<br><br>7/1/2019<br><br>1/6/2020 |

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| W 368 | Continued From page 3 | W368 | | |

Record (MAR), count sheets and staffs schedules. Information obtained from the CQI investigation indicated that DSP #1 stated she should have slowed down and taken her time when she administered meds the morning of 9/15. DSP #2 stated, she did not follow procedures for ensuring medications were accounted for. DSP indicated she was focused on writing a number on the count sheets and not focused on whether the count was correct.

Both DSP #1 and DSP #2 admitted to rushing through the administration of the individual's medication administration on the morning of 09/15/19 which caused the error."

Physician order dated 09/03/19 indicated "Zonisamide 100 mg cap take 2 capsules by mouth every morning for seizure management at (0700)."

During an interview on 11/21/19 at 2:30P.M. with the Supervisor II, she stated both staff members were amenable to extra training for administering incorrect medications.

2. Individual #3 was admitted to the facility on 04/01/02 with diagnoses which included Profound Intellectual Disability, seizures, failure to thrive, scoliosis, cerebral palsy and thyroid. The facility staff failed to administer medications in accordance with physician orders.

A Facility Incident and Accident Report dated 10/06/19 indicated: "It was noted during the evening look-behind that Individual #3 medication (Zonegran) Zonisamide count was off by 2 additional pills. Upon review of the med count

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| W 368 | Continued From page 4 | W368 | | |

sheets, it was noted that the count was off only 3 caps were given instead of 5. During medication administration on the morning of 10/06/19, staff LPN discovered that Individual #3's Zonegran count was off by 2 additional pills. Upon review of the med count sheets, it was noticed that the count became off after administration the evening of 10/03/19. The order is for individual to take (5) 100 mg capsules each evening for seizure activity, but only three had been administered. The wrong dose was administered.

The look-behind process includes staff documenting how many pills are remaining on the card following administration, however, there is no indication that the previous balance is noted so staff would be unable to determine if an error had occurred until a later audit can be conducted."

A physician order dated 11/20/19 indicated: "Zonisamide 100 mg cap, open 5 capsules, dissolve in water and administer via G-tube seizure management.

During an interview on 11/22/19 at 3:30P.M. with the Supervisor II, she stated staff members were amenable to extra training for administering incorrect medications.

A Physician Policy indicated: All medications will be administered as ordered by the physician.