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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G004	A. BUILDING ______ B. WING ______	C 06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S HOME FOR DISABLED CH	6171 KEMPSVILLE CIRCLE NORFOLK, VA 23502

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/29/19 through 05/31/19 and 06/03/19 through 06/05/19. 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. No emergency preparedness complaints were investigated during the survey.	E 000		
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.** *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 identified population at risk during an emergency. The findings included: During an interview on 05/30/19 at 2:00 P.M. with the Administrator and Director of Operations	E 007	A more complete risk assessment will be completed for each individual to ensure that they have access to items necessary for their health and safety, either while sheltering in place or evacuating to another facility. Individual templates will be expanded and available to accompany the individuals if needed. Medical Records will maintain a spreadsheet by unit with all equipment, medical supplies and personal items, like communication devices, identified. Prioritization will occur should evacuation become necessary.	7/19/19 7/19/19 7/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
H. Wayne Jones [signature]	CEO	6/28/19 7/1/19

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 007	Continued From page 1 Support, they were asked for documentation of the facility's identified population at risk and strategies that the facility has put in place during an emergency. The Administrator stated the facility had not conducted a full risk assessment and developed strategies for all of it's resident population at risk during an emergency.	E 007	The Risk Assessment Policy has been revised and added to the emergency Preparedness and Continuing Operations Plan. The information will be reviewed by the Emergency Preparedness Committee.	7/19/19 7/19/19
W 000	INITIAL COMMENTS An unannounced Medicaid fundamental survey for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) was conducted 5/29/19 through 5/31/19. An extended survey was conducted from 6/3/19 through 6/5/19. The facility was not compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled.Four complaints were investigated during the survey. The Life Safety Code survey report will follow. The census in this 100 bed facility was 98 at the time of the survey. The survey sample consisted of 14 Individual reviews (Individuals #1 through #14).	W 000		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to ensure privacy was maintained for 1 of 14 individuals (Individual #9),	W 130		

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W 130	Continued From page 2 in the survey sample. The facility staff failed to ensure Individual #9's abdomen wasn't exposed when administering medications via a G-Tube 5/30/19. The findings included; Individual #9 was originally admitted to the facility 2/27/2002. The current diagnoses were profound intellectual disabilities, shaken infant syndrome, spastic quadriplegia, cerebral palsy, encephalopathy and dysphagia. On 5/30/19, at approximately 11:00 a.m., Licensed Practical Nurse (LPN) #1 entered class #7 with a 60 milliliter syringe containing a liquid and 2 vials of ophthalmologic drops. Approximately 8 peers were in the classroom and 5 employees. LPN #1 stooped beside Individual #9 lifted his clothing exposing the right side of the his abdomen. LPN #1 grasped the G-tube and proceeded to instill the liquid from the syringe into the the G-tube. LPN #1 left the G-tube hanging to Individual #9's side, walked over to the sink to obtain water to flush the G-tube and returned to instill the water into the G-tube. An interview was conducted with LPN #1 on 5/30/19, at approximately 2:40 p.m. LPN #1 stated the normal procedure is not to provide privacy when they enter the classroom to administer medications via a G-tube but they are careful not to expose the individual's body. The facility's policy titled "Medication Administration" dated 4/18 read at Procedure Bb., read always greet the individual by name and introduce yourself. Inform the individual about	W 130	Privacy for Individual #9's G-tube administration in a public space will be achieved by using a privacy drape. When in his room, the curtain will be pulled around his bed space. Privacy during G-tube administration for all other identified individuals will follow the same process. All nurses who administer G-tube feeding will receive instruction about where to find the drapes, both in the classrooms and on the living units. Compliance will be monitored via the implementation of a med Pass/Tube feeding audit. Results of the audits has been added to the agenda for the Quality Improvement (QI) monthly meeting, and will be brought by the Director of Nursing (DON)	6/28/19 7/19/19 7/2/19 7/19/19 7/19/19

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W 130	Continued From page 3 medications and/or treatments they are receiving. On 5/31/19 at approximately 4:00 p.m., the above findings were shared with the Chief Compliance Officer and the Director of Nursing. The Director of Nursing stated LPN #1 had talked to her about the above events and he was just nervous. The Chief Compliance Officer stated usually the privacy screens are not utilized in the classroom unless an individuals body parts will be exposed during care.	W 130		
W 170	PROFESSIONAL PROGRAM SERVICES CFR(s): 483.430(b)(5) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. This STANDARD is not met as evidenced by: Based on record review, staff interviews and facility document reviews, the facility staff failed to ensure three professional program staff were licensed and or eligible to provide professional services in accordance with the requirements of the state of Virginia. 1. The facility staff failed to verify the continued status of an Registered Nurse (RN) applicant, allowing her to provide care to the individuals without a valid license, placing all individuals at risk and facility liable for lack of care based on standards of practice. Upon the survey team's investigation, interview with the Presumed RN applicant and inquiry with the Director of Nursing (DON) and Department of Health Professions (DHP), it was discovered the presumed RN	W 170	Of the three staff found to not meet state licensing regulations, the Presumed RN Applicant resigned, the presumed LPN#1 was terminated and RN #1 did not produce her Eligibility to Test/Authorization to Practice letter prior to hire. RN #1 has since provided the letter	6/7/19

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W 170	Continued From page 4 applicant was no longer eligible to practice in any nursing capacity as of 3/21/19. 2. The facility staff failed to ensure all Licensed Practical Nurses (LPN) employed by thefacility were eligible to practice nursing. 3. The facility staff failed to ensure all Registered Nurses (RN) practicing nursing in the facility were eligible to practice nursing. The findings included: 1. According to the employee records of Presumed RN applicant; she was hired as an RN applicant on 3/12/19, and the eligibility to test/authorization letter was issued to the applicant. The applicant presented this letter to the facility at the time of hire on 3/12/19. An RN applicant status allows the applicant to practice in the state of Virginia for a period of 90 days from completion of their nursing education and the receipt of the results of the first licensing examination. Once the 90 days have lapsed or the results of the first licensing examination, the applicant is no longer authorized to practice nursing without a valid license and the practice of nursing must immediately stop. The 90 days for the Presumed RN Applicant started on 3/12/19, per her authorization to practice letter in her employee file. Her authorization to practice would cease on 6/10/19. However, if the applicant took the NCLEX-RN exam and failed it within that 90 day timeframe, she would not be able to practice nursing which was also information within the authorization to practice letter. On 5/31/19 at approximately 12:00 p.m., the survey team conducted an interview with the	W 170	All other professional staff licenses have been checked. One other was found to be out of compliance, but has produced her Eligibility to Test/Authorization to Practice letter. All others were current. The Hiring Policy has been changed to ensure that completed applications are received, and licenses checked with the Department of Health Professions by the Human Resources (HR) Department prior to the interview. Prior to requesting that a job offer be made, the DON or designee will also check that the license is current. The HR Department will initiate a third check while completing the on-boarding paperwork. Nursing applicants without a license will need to provide an Eligibility to Test/Authorization to practice letter during this process. Employee badges for nurses waiting to take the NCLEX-RN/LPN test will denote whether RN or LPN Applicant and thus inform preceptors and other nurses of their status. New badges will be issued once a copy of their license is provided within the 90 days allowed by the Board of Nursing.	6/12/19 6/21/19 6/21/19 6/21/19 6/28/19

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W 170	Continued From page 5 Director of Human Resources (DHR) and the Director of Nursing (DON), they stated the applicant relayed to them that the testing company set up a wrong test on 3/21/19, which was a Licensed Practical Nurse (LPN) exam and that she could not re-test for the NCLEX until 45 days later and was set up to take the correct test NCLEX-RN on 5/30/19. The DON supported the explanation from the Presumed RN Applicant that the test kept "glitching" but that she completed 85 questions of an LPN test. The DON stated, "What more was I to do. We are checking daily and she has until 6/10/19 anyway, so there is time left and she is rescheduled for her test on 5/30/19." The DHR reaffirmed what the DON stated to the survey team. Both accepted the explanation from the applicant that the test administered was an incorrect one, not the NCLEX-RN with no further investigation on their part. They provided information that a verification check for the Presumed RN Applicant's test results were conducted on 4/16/19, 4/22/19, 5/15/19 and 5/23/19 with no results and they would continue to check on a weekly basis but she had until 6/10/19 to work as as RN Applicant. They stated Presumed RN Applicant was scheduled to work again on Monday 6/3/19 for the 2:30 p.m. to 11:00 shift. During further interview with the DON, DHR and Chief Compliance Officer (CCO) on 5/31/19 at 4:00 p.m., they could not explain why they did not insist on having the Presumed RN Applicant provide information about the testing company making a mistake in setting her up for the "wrong test," or that no red flags went up for further inquiry when the Presumed RN Applicant stated the test was "glitchy" as well as evidence that she would be set up for the "correct test." It was	W 170	The HR Department will maintain a spreadsheet to ensure all licenses are current, as well as the status of those waiting to take their test. This will be shared with the Chief Executive Officer monthly.	6/28/19

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shared with them that this has not been the practice for (name of national testing company) to make those types of mistakes.

On 6/3/19 at 11:00 a.m., the DON and DHR stated after several attempts and voicemail messages left throughout the day on 5/31/19, Presumed RN Applicant responded with a return call on 5/31/19 at 5:45 p.m. and stated she was sleeping and missed their calls. The DON stated she asked the Presumed RN Applicant, and she agreed, to provide any materials from the testing company that would reflect her testing status and send any communication sent to her via a call or email. The DON spoke to the Presumed RN Applicant again at 7:00 p.m. and requested she get confirmation from the testing company as soon as possible. It was at this time the DON stated the Presumed RN Applicant told her she was thinking about resigning because she was not confident she could get the requested information. The DON stated she asked the Presumed RN Applicant did she fail the NCLEX-RN test to which she stated she had not. The Presumed RN Applicant and DON confirmed they would talk again on 6/1/19.

The DON spoke to the Presumed RN Applicant on 6/1/19 and stated she was not successful in reaching (gave a female name) at the location where she went to sit for the test. She also shared with them that she overslept and missed the rescheduled test date of 5/30/19 and had another the rescheduled test date for the NCLEX-RN of 6/21/19. The DON stated she reached out to the Presumed RN Applicant again on 6/3/19 and she responded she was not able to get in contact with the person she referenced at the testing center and inquired about the status of

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her employment and suggested she resign and return 6/21/19 after the rescheduled NCLEX-RN test. Additionally, she told them she was unable to get information about what test she sat for from the Board of Nursing. The DON said she requested that the Presumed RN Applicant come to the facility to discuss her testing and any other problems she was experiencing.

As of 6/3/19 at 12:35 p.m., the DON and DHR had not heard back from the Presumed RN Applicant. The DHR stated Presumed RN Applicant said she was going to take her test 6/21/19 and would check to see if she could take it after her 90 days on 6/21/19. They stated they were unable to get any further info from the DHP (Department of Health Professions). The DON stated they should be given consideration due to the fact that they could not get the information from DHP on 6/3/19 about whether the Presumed RN Applicant was set up for the LPN test instead of the NCLEX-RN on 3/21/19, and whether she passed the LPN test she claimed she was administered or in actuality took the NCLEX-RN and failed it. They did not give clear indication during this part of the interview on what decisions they were going to make about Presumed RN Applicant's current employment status. They mentioned that consideration could be given to change her status to a Disability Support Professional (DSP) or a Certified Nursing Assistant (CNA).

During the above interview, after the aforementioned explanations from the DON and DHR, the survey team shared the information obtained from the Virginia State DHP by the their supervisor on 6/3/19 which indicated "As of 3/21/19, (name of the Presumed RN Applicant)

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was no longer eligible to practice as as RN Applicant." It was at this time the DON stated they had already taken the Presumed RN Applicant off the schedule based on her inability to meet with them to provide evidence of what test she claimed she sat for by the mistake and why if that was the case what took so long to reschedule for the correct test. All of this inquiry was prompted by requested information for review by the survey team and not initiated by the DON or DHP. They stated, "Going forward we are going to do many things differently so this will never happen again." It was also brought to their attention that Resumed RN Applicant had made medication errors on at least two separate occasions involving two separate individuals.

According to documents presented by the scheduler on 6/3/19 at 11:35 a.m., the Presumed RN Applicant was released to practice as an RN as of April 30, 2019 and care for all the children on Unit 4, which were the most vulnerable children in the facility with tracheostomies and other complicated nursing procedures. Upon review of the schedules, on 5/4/19 and 5/19/19, Presumed RN Applicant was the only supposed on site "RN" for all four units for the children to include the one unit for the adult population. The scheduler stated, "I scheduled (Presumed RN Applicant's name) as a full fledged RN after 5/1/19 because that is what I was told by the DON. I only schedule how I am told by nursing." In reality, Presumed RN Applicant was eligible to practice nursing for only nine days, from 3/12/19 through 3/21/19, but was scheduled to continue practice nursing from 3/21/19 to 6/3/19.

On 6/3/19 at 2:40 p.m., an interview was conducted with LPN #6 and LPN #7. They stated

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W 170	Continued From page 9 they expected the Presumed RN Applicant would be at work for the evening shift, but thought maybe she was late. When asked if she was an RN or RN applicant, they stated she was an RN and she took on a full assignment without anyone and had been doing so for "awhile." LPN #7 stated, "I was pulled from Unit 1 to Unit 4 (current unit) and that must have been because (Presumed RN Applicant) is not going to be here." LPN #6 stated, "She is doing better, she is working on some things, but will be a good RN in time." On 6/3/19 at 4:45 p.m., a telephone interview was conducted with Presumed RN Applicant. She stated on 3/21/19 she was given the wrong NCLEX test by the testing company which was an LPN test. She said the testing company told her she could not sit for the next one until 45 days later and she would not have to pay due to their mistake but was unable to provide information regarding the testing company's mistake. She stated she called (female name) at the testing company site and asked for evidence of their mistake and that she actually sat for the NCLEX-LPN test, but they did not get back with her. She also said she called the Department of Health Professions for information and they would no not give it to her. Presumed RN Applicant stated, "The DON asked me to come in and talk to her in that I was scheduled to come to work at 2:30 today, but I have decided I should resign due to personal problems." On 6/3/19 at 5:05 p.m., a return call to the Presumed RN Applicant to ask if she could give the survey team the contact information for the person at the testing company to which she said, "No one is able to speak to (female name) at (company name) anymore."	W 170		

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The Presumed RN Applicant's previous preceptor, LPN #4 stated she precepted her and signed her off as able to provide care for the children on one side of the unit, rooms 20, 21 and 22. She stated she often precepted RN's because had tenure, experience and was very familiar with treatments, medication management and all procedures on the unit. She stated Unit 4 housed the most vulnerable children and required more skills to care for them because they had tracheostomies, ostomy changes, wound care, feeding tubes and respiratory treatments. She stated she had to slow Presumed RN Applicant down a lot and re-focus her from the computer to be more centered on the children. She stated she sent emails to the DON and RN supervisor and the scheduler on 4/8/19 that the Presumed RN Applicant appeared rushed and she had to assume some of her assignment because she focused on the medication pass for two days in a row. She told them that on the second day Presumed RN Applicant left without documenting several treatments and follow-ups to those treatments. LPN #4 passed on to them that she felt pressed to get people trained, but felt that it was as equally important that new staff were trained adequately. The nurses who trained Presumed RN Applicant on rooms 18 and 19 was not available for interview, but the Presumed RN Applicant was signed off as fully trained on 5/10/19 to care for all 20 children on Unit 4. LPN #4 stated she thought Presumed RN Applicant was an RN because that is what she was told.

The schedule revealed on 4/22/19, 4/26/19 (worked a double shift-2:30 p.m. to 11:00 p.m. and 10:30 p.m. to 7:00 a.m.-no preceptor with a full assignment), 5/1/19 there was no preceptor with the Presumed RN Applicant and was

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scheduled to work independently. In addition the facility improperly scheduled her without a preceptor as well as assigning her a full assignment prior to completing her floor training and scheduling her as the only supposed "RN" in the facility on two separate occasions, 5/4/19 and 5/19/19. It was determined from the survey team's investigation that Presumed RN Applicant was no longer eligible to practice nursing as an RN Applicant or any nursing care as of 3/21/19 and the facility staff failed to validate the obtain documentation regarding the outcome of the scheduled NCLEX-RN exam on 3/21/19, which placed all children and adults in harms way. The Presumed RN Applicant signed all official records to include client medical records as "RN".

The job description titled Director of Nursing (DON) dated 9/2017 indicated the DON is responsible for the day-to-day operational processed, staffing, and organization of the Nursing Department. Incumbent in role supervises all RNs and LPNs, and insures their compliance with the nursing policies and standards of practice expected from our nurses. Responsible for 24/7 staffing, interviewing and hiring, coordinating training needs based on performance and experience, and maintaining compliance with federal and state regulations governing clinical programs provided by an ICF/IID. Maintains up-to-date knowledge of the Federal and State regulations that apply to the Home's operations and the nursing department specifically. This job description was signed by the DON on 1/2/19.

The job description titled Director of Human Resources dated 6/2018 indicated this position is responsible for planning, developing, and

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W 170	Continued From page 12 implementing Human Resources (HR) policies and practices that are compliant with federal, state and ICF licensing regulations regarding employment process. Incumbent in the role is also responsibility for developing and implementing creative HR, wellness activities, and other staff activities/celebrations. Advises management on policies, employee performance, and staff needs, making or recommending appropriate decisions. Directs the preparation of information requested or required for compliance with laws. This job description was signed by the HR director on 7/28/18. The Presumed RN Applicant signed an RN job description on 3/22/19 that indicated the following: Provides specialized nursing care and treatments for critically fragile individuals with special medical and physical needs at (Facility name). Incumbents may e required to work a variety of shifts and fill the charge nurse role when scheduled. All services will be provided under a person centered model of care in support of each individual's support plan (ISP). Conducts physical assessments, administers medications, treatments and tube feedings, receive, transcribe and implement physician's orders, manage and provide care to tracheostomy-dependent and ventilator-dependent individuals after completed the required training, documents activities related to nursing and medical care, direct and supervise the delivery of nursing care, delegate task allowed by the nursing license, act as charge nurse, precept new nurse. Qualifications must be a graduate of an accredited school of musing, provide a current license issued by the State, provide references that reflect a good attitude, dependability, good judgement and ability to	W 170		

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function independently.

The Regulations Governing the Practice of Nursing for the Virginia Board of Nursing dated as revised on 3/22/19 indicated under VAC90-19-110 Licensure by examination F. Practice of nursing pending receipt of examination results:
1. A graduate who has filed a completed application for licensure in Virginia and has received as authorization letter issued by the board may practice nursing in Virginia from the date of the authorization letter. The period of practice shall not exceed 90 days between the date of successful completion of the nursing education program, as documented on the applicant's transcript, and the publication of the results of the candidate's first licensing examination.

2. Candidates who practice nursing as provided in subdivision 1 of this subsection shall use the designation "R.N. Applicant" and L.P.N. Applicant" on a nametag or when signingofficial records.

3. The designations "RN Applicant" and L.P.N. Applicant shall not be used by applicants beyond the 90-day period of authorized practice or by applicants who have failed the examination.

G. Applicants who fail the examination:

1. An applicant who fails the licensing examination shall not be licensed or be authorized to practice nursing in Virginia.

2. An applicant for licensure by reexamination shall file the required board application and reapplication fee in order to establish eligibility for

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W 170	Continued From page 14 reexamination. 2. Review of personnel records revealed Presumed LPN #1 was offered a position as an LPN 6/27/18 and started orientation in the facility 7/10/18. Presumed LPN #1 work experience completed by the applicant, stated she was educated at a local school of nursing from 6/2016 through 3/2017. The applicant's work experience as an LPN was listed as home care private duty nursing beginning 4/2017 through 5/2018. This private duty nursing position as an LPN included tracheotomy care, gastrostomy tube care, medication administration, activities of daily living and wound care. A note written at the top of a document titled "Nurse's Pre-interview Information" read; "she has been an LPN for 1 year. Please hire for 11 p.m..-7 a.m." Further review of the personnel record revealed Presumed LPN #1 didn't complete an official application for employment until 7/18/18, and on the application the Presumed LPN #1 stated she had beenconvicted of welfare fraud in 1997, passing a worthless check in 2008 and attempted identity theft in 2018. A copy of a license to practice as a Licensed Practical Nurse issued by the Department of Health Professions was not included in the personnel records. An interview was conducted with The Professional Development Director who stated they were unable to obtain a license for Presumed LPN #1 to practice as an LPN and the information had been shared multiple times with the administrative staff as well as information	W 170		

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about Presumed LPN #1 pending court case.

An interview was conducted with the Nursing Support Specialist on 6/5/19 at approximately 10:45 a.m. The Nursing Support Specialist stated Presumed LPN #1 was in general classroom orientation and demonstrated a lacked of fundamental nursing skills but on 7/20/18, Presumed LPN #1 provided hands of care under the supervision of the Respiratory Therapist for multiple children.

An interview was conducted with the Respiratory Therapist on 6/5/19 at approximately 11:30 a.m. The Respiratory Therapist stated Presumed LPN #1 performed suctioning for 3 children, administered nebulizer treatments to 3 children, provided tracheostomy care to 1 child, application of the vest treatment to 3 children and use of the VitalCough system for 2 children.

Further review of the personnel record was an email stating Presumed LPN #1 was terminated effective 7/27/18, for inability to verify a license to practice as a LPN.

3. Review of graduate Registered Nurse #1's personnel records revealed she was hired 5/14/19, and began general orientation 5/28/19. Further review of the personnel records didn't reveal a license to practice as a registered Nurse nor a letter from the Department of Health Professions authorizing graduate Registered Nurse #1 to practice for 90 days or until results were received from the first licensing examination.

An interview was conducted with the Human

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Resource Director on 5/31/19 at approximately 12:40 p.m. The Human Resource Director stated graduate RN #1 didn't have a license to practice as a RN because she had recently graduated from a local School of Nursing. The Human Resource Director further stated graduate RN #1 didn't have a letter from the Department of Health Professions authorizing her to practice as a RN Applicant but she would consult the Director of Nursing to determine if she had the document.

On 5/31/19, at approximately 3:30 p.m., a letter was presented which had been obtained from graduate RN #1 faxed to the facility 5/31/19 at 2:36 p.m. The letter dated 5/22/19 stated graduate RN #1 was authorized to take the National Council Licensure Examination (NCLEX) for Registered Nurses and provided instructions for scheduling the exam, acceptable types of identification, and etc. It didn't authorize graduate RN #1 to practice nursing.

On 6/3/19 at approximately 4:45 p.m. a letter from the Department of Health Professions dated 5/22/19 was presented. It stated as of 5/22/19, you have been declared eligible by the Board of Nursing to take the NCLEX- Registered Nurse... and, you may practice as a RN Applicant for 90 days or until results were received from the first licensing examination.

Another interview with the Human Resources Director on 6/3/19 at approximately 5:00 p.m., they hadn't ensured all necessary documents were in personnel records but since a concern has been identified the procedure would be changing.

On 5/14/19, graduate RN #1 was ineligible to

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W 170	Continued From page 17 accept a Registered Nurse or RN Applicant position. On 6/5/19 at approximately 4:00 p.m., the above findings were shared with the Chief Compliance Officer, Human Resource Director and the Director of Nursing. No additional information was provided.	W 170		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide two Individual's (Individual #2 and #3) with supervision in accordance with their Individual Program Plans (IPP) in the survey sample of 14 individuals. The findings included: 1. Individual #2 was admitted to the facility with diagnoses that included CHARGE Syndrome, Reflux, Heart defects, hearing impairment, G tube, and Unspecified diagnosis. Individual #2 was not provided supervision in accordance with his (IPP). Individual #2 was assessed as requiring constant supervision. An Individual Support Plan dated	W 186	An IDT meeting will be held to review the Functional Assessment and discuss levels of supervision required to maintain Individual #2's safety. His ISP will be revised to reflect supervision levels that the team decides are appropriate.	7/19/19

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9/8/17 indicated: "I need supervision from adults to ensure my safety due to my age and my current walking skills. I am provided constant supervision during waking hours and am often provided specifically assign staff member to assist me in safely and appropriately moving around my environment independently.

AFacility Incident Report dated 4/23/18 Indicated: "Individual #2 was observed by staff walking in the hallway without direct care staff accompanying him. The staff who found him walked him back to Unit II." A review of the investigation indicated: 'Individual #2 left the Unit II approximately 6:30 A.M. after receiving a bath. Staff that were on the unit had been assigned to other individuals and were busy getting the individuals ready for the school bus. The report indicated a Licensed Practical Nurse (LPN) and a Respiratory Therapist (RT) were in the LPN office around 6:45 A.M. when they heard the Unit II door open and observe Individual #2 walking. Individual #2 was observed to open a office door next to LPN office and go inside. LPN realized the individual was alone. The RT stated, once back on the unit, she asked who had Individual #2. The RT stated the staff replied "No one, we are short staffed." There were reportedly at least 5 DSP's (Direct Support Professionals) sitting at the table or leaning against the wall. RT informed the staff that Individual #2 got off the unit and got into a closet."

A review of the incident report indicated: "There were two individuals who had 1:1's. Individual #2 did not have 1:1 because the additional staff was working on doing baths."

A review of the April 23, 2018 staff schedule

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W 186	Continued From page 19 indicated: " Unit II had four DSP's and one trainee. Two staff persons names were noted to be marked through the schedule. Individual #2 left the unit unattended. An April 1, 2018 at 9:15 A.M. Incident Report indicated: " Staff heard the door to Unit II close looked around for Individual #2 and could not find him. Went into hallway outside of Unit II. Found Individual #2's Big Wheel in hallway between classrooms 7 & 8 and 4 & 5. Individual #2 was not there. Immediately began searching building /doors, ran to Unit II to alert DSP's/staff. other staff began to search for him. He was found in activities office (alone). Facility's Program Manager made aware. Spoke of concerns regarding Individuals leaving Unit with staffing . Discussed staffing issues (short staffed). Assigned DSP's were all present and actively participating in feeding/care of individuals at the time of event." A review of the Unit II Staffing for April 1, 2018 indicated: " Three DSP's were assigned for the morning shift of 6:30 A.M.-3:00 P.M." Individual #2 was found by staff in the activities closet corner playing in the room. 2. Individual #3 was not provided supervision in accordance with his (IPP). Individual #3 was assessed as having a history of elopement from the family home environment and wears a personal monitoring device to track location. Individual #3 was admitted to the facility on 12/19/17. Individual #3 had diagnoses which included seizures, developmental delay of	W 186	An IDT meeting will be held to review the Functional Assessment and discuss levels of supervision required to maintain Individual #3's safety. His ISP will be revised to reflect supervision levels that the team decides is appropriate.	7/19/19

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W 186	Continued From page 20 unknown etiology, and Autism. The Individual Service Plan indicated Individual #3 was to be monitored overnight by a 1:1 staff. Protective Device/s-The benefit of the GPS tracking anklet is that Individual #3 could be located if he leaves school building or his family's home while on weekend outings. An Incident Report dated March 30, 2018 Indicated: "Individual #3 was reported to be found at the front desk on March 30, 2018 at 2:55 PM. The front desk paged Unit II nurse on duty and informed her that Individual #3 was at the front desk alone. DSP statement indicated: Individual #3 was assigned to her and she passed him of to another DSP while cleaning isolation room to prepare to move Individual #3 back to the living unit. Three DSP's were in the isolation room with two individuals. The individuals were to be returned back to there living units. The DSP's were transferring the individuals and there beds back to the unit. During the transfer Individual #3 became unattached from the group and was found at the front desk." An IPP service plan dated 12/15/18 started- end date 12/10/19 indicated: "Please record when Individual #3 attempts to leave or leaves the unit unannounced." Program notes dated 3/15/19 indicated: "There were 3 recorded episodes of Individual #3 leaving the unit unannounced which accounts for 1 episode in each month. A review of the staff assignments dated 3/30/18 indicated: Individual #3 was assigned to be one on one. During an interview on 5/31/19 at 11:30 AM with	W 186	Ten other individuals have the potential to be affected by the type of supervision available; and they will also have team meetings to reassess their current needs and ensure that their ISPs are written to reflect correct supervision levels. The Facility is actively seeking to fill a maximum of 6 additional positions to assist in preventing other occurrences. Meanwhile building security has been a high priority, ensuring that no individual can access outside doors without staff. During early morning hours, security personnel will be available upon the request of supervisors to sit outside the doors of the unit where Individuals 2 and 3 reside. Staffing schedules are checked regularly, and supervisory staff move staff to units where additional supervision is required. Every effort is made to ensure that the level of supervision required for certain activities is available, i.e in-sight supervision or one on one staff while walking from the unit to a group activity. Data will be kept to establish the number of times an individual has attempted to leave the unit and been re-directed vs. any reports submitted showing an actual event. Management staff will carefully monitor events and make the necessary adjustments to staffing, making sure that the Qualified Intellectual Disability Professionals are aware of changes that might affect the ISP.	7/19/19 7/19/19 7/19/19 7/19/19

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W 186	Continued From page 21 the Unit II Support Coordinator / Qualified Intellectual Disability Professional (QIDP) she stated, staff failed to provide 1:1 staff supervision to Individuals #2 and #3. A Direct Care Supervision of Individuals and Groups indicated: Purpose- To ensure the availability and supervision of sufficient numbers of competent, direct care professionals to provide active treatment, assist with activities of daily living and to protect the health and safety of each individual. One to One Supervision: Constant, uninterrupted focused, visual observation of an individual by at least one staff member who is not performing any other duties and has no other assignments.	W 186		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on staff interviews, clinical record review, and review of the facility's policy the facility staff failed to implement the Individual Program Plan (IPP) for 3 of 14 residents (Resident #9, #2 and #3), in the survey sample.	W 242		

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W 242 — Summary Statement of Deficiencies

1. The facility staff failed to assure Resident #9's assistive device (seat belt) was in place; resulting in a fall from the wheel chair with the resident sustaining a large gash over the left eye, and requiring an emergency room visit where eight nylon sutures were placed.

2. The facility failed to provide Individuals #2with supervision in accordance with their Individual Program Plans (IPP).

3. The facility failed to provide Individuals #3with supervision in accordance with their Individual Program Plans (IPP).

The findings included;

1. Individual #9 was originally admitted to the facility 2/27/2002. The current diagnoses were profound intellectual disabilities, shaken infant syndrome, spastic quadriplegia, cerebral palsy, encephalopathy and dysphagia.

Individual #9's Individual Support Plan dated 3/1/19, read under Adaptive Equipment/Assistive Technology: wheelchair with planar seating system with lateral supports, seat belt, chest harness, head rest and tray.

Review of an Event Form dated 5/20/19 at 3:00 p.m., revealed Individual #9 had a fall from his wheelchair. It read: "(Individual #9) was being checked, I put his straps on and tilted him and then I heard a pop and the buckle was loose and (Individual #9) fell. I called for help."

Another note dated 5/20/19 at 3:40 p.m. read: I was leaving the room, I turned around and noticed (Individual #9) was on the floor, so I

W 242 — Provider's Plan of Correction

Corrective action	Completion date
An Interdisciplinary team (IDT) was held for Individual #2, Individual #3 and Individual #9 to ensure their needs were correctly identified in their ISPs.	7/19/19
Supervision levels for the 3 individuals were reassessed to ensure that their ISPs reflected the level of supervision needed.	7/19/19
Program Managers will create a list for each unit stating which individual should receive what type of supervision, keeping this updated as individual needs change	7/19/19
Staff working with the 3 identified individuals were re-trained on the plan for each individual, and shown where to find the supervision guidelines.	7/19/19
Following review, many individuals living at the home have the potential to be affected by the deficient practice.	6/28/19
Unit staff meetings will re-educate staff about where to find the ISPs.	7/19/19
Staff Development will continue to provide general training about supervision levels, providing the Facility Guidelines document to all new employees.	7/19/19
Safety Care Training will emphasize that a seatbelt should always be put on first and taken off last.	7/19/19

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W 242	Continued From page 23 immediately grabbed (name of person) then I noticed when she tilted him up he was not strapped in the wheel chair. The Qualified Intellectual Disabilities Professional (QIDP) note dated 5/20/19 and without a time read: "about 3:40 p.m., I heard someone calling for help from Living Unit #16 so I went over to see what was going on. Staff was on the floor with (name of individual) holding his head and his feet were still in the foot bucket of the wheel chair. I assisted with moving his legs so that they were straight and then moved his wheel chair back so nursing could attend to him. The Direct Support Professional (DSP) tilted his wheel chair up and he fell hitting his head. The DSP stated his seatbelt must not have been on. Nursing was in the room working on getting oxygen saturation and cleaning the head wound above his left eye and (Individual #9) has a seizure... 911 was called and the individual left by ambulance. A nurses note dated 5/21/19 at 1:10 a.m., read: (Individual #9) returned from (name of the hospital). Resident received stitches to the laceration above the left eye and the side of his face was swollen. No new medications were ordered. A follow-up evaluation by the primary physician is necessary. The follow-up assessment by the primary physician was conducted 5/21/19 at 1:16 p.m. included "fell forward from the wheel chair sustaining a gash over the left eyebrow. He was taken to the emergency room where approximately 8 sutures were inserted... Removal of sutures in about 6 days." An interview was conducted with the	W 242	Preceptors will also be responsible for training, including demonstrations of wheelchair safety, for individuals on the unit and the check off sheet has been enhanced to reflect this requirement. Management team will receive a list of all staff re-trained on the plans for the 3 individuals identified. The preceptor form will be updated to include more information, and this will be shared with the management team. At the daily review of event reports, the management team will request to see all training sheets for any staff involved in similar events to determine need for further changes.	7/19/19 7/19/19 7/19/19 7/19/19

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Occupational Therapist (OT) on 6/4/19 at approximately 2:00 p.m. The OT stated "On 5/21/19 Individual's #9's wheel chair was assessed for function and integrity which could have caused the fall on 5/20/19; all components were found to be in good working order."

The above information was shared with the Chief Compliance Officer, Director of Nursing and Social Worker #3 on 6/5/19 at approximately 4:00 p.m. The Chief Compliance Officer stated the fall was determined to be neglect and accidental because the staff failed to ensure the seatbelt and chest harness were fastened prior to tilting the wheel chair.

The facility's policy titled Program Implementation dated 9/2012. Procedure #4 read; The Qualified Intellectual Disability Professional will develop a unique active treatment schedule that outlines the current active treatment program, allowing flexibility and reflecting normal daily routines... All staff will be expected to work with the Individual Support Plan.

2. Individual #2 was admitted to the facility with diagnoses that included CHARGE Syndrome, Reflux, Heart defects, hearing impairment, G tube, and Unspecified diagnosis. Individual #2 was not provided supervision in accordance with his (IPP). The facility staff failed to implement Individual #2's 1:1 supervision program.

Individual #2 was assessed as requiring constant supervision. An Individual Support Plan dated 9/8/17 indicated: I need supervision from adults to ensure my safety due to my age and my current walking skills. I am provided constant supervision during waking hours and am often provided

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specifically assign staff member to assist me in safely and appropriately moving around my environment independently.

A Facility Incident Report dated 4/23/18 indicated: Individual #2 was observed by staff walking in the hallway without direct care staff accompanying him. The staff who found him walked him back to Unit II. A review of the investigation indicated: Individual #2 left the Unit II approximately 6:30 A.M. after receiving a bath. Staff that were on the unit had been assigned to other individuals and were busy getting the individuals ready for the school bus. The report indicated a Licensed Practical Nurse (LPN) and a Respiratory Therapist (RT) were in the LPN office around 6:45 A.M. when they heard the Unit II door open and observe Individual #2 walking. Individual #2 was observed to open a office door next to LPN office and go inside. LPN realized individual was alone. The RT stated, once back on the unit, she asked who had Individual #2. The RT stated the staff replied "No one, we are short staffed." There were reportedly at least 5 DSP's (Direct Support Professionals) sitting at the table or leaning against the wall. RT informed the staff that Individual #2 got off the unit and got into a closet."

A review of the incident report indicated: There were two individuals who had 1:1's. Individual #2 did not have 1:1 because the additional staff was working on doing baths.

A review of the April 23, 2018 staff schedule indicated: "Unit II had four DSP's and one trainee. Two staff persons names were noted to be marked through the schedule."

Individual #2 left the unit unattended.

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An April 1, 2018 at 9:15 A.M. Incident Report indicated: "Staff heard the door to Unit II close looked around for Individual #2 and could not find him. Went into hallway outside of Unit II. Found (Individual #2's) Big Wheel in hallway between classrooms 7 & 8 and 4 & 5. Individual #2 was not there. Immediately began searching building /doors, ran to Unit II to alert DSP's /staff. other staff began to search for him. He was found in activities office (alone). Facility's Program Manager made aware. Spoke of concerns regarding Individuals leaving Unit with staffing Discussed staffing issues (short staffed). Assigned DSP's were all present and actively participating in feeding/care of individuals at the time of event."

A review of the Unit II Staffing for April 1, 2018 indicated: "Three DSP's were assigned for the morning shift of 6:30 A.M.-3:00 P.M."

Individual #2 was found by staff in the activities closet corner playing in the room.

3. Individual #3 was not provided 1:1 supervision in accordance with his (IPP).

Individual #3 was assessed as having a history of elopement from the family home environment and wears a personal monitoring device to track location. Individual #3 was admitted to the facility on 12/19/17. Individual #3 had diagnoses which included seizures, developmental delay of unknown etiology, and Autism.

Individual Service Plan indicated Individual #3 was to be monitored overnight by a 1:1 staff. Protective Device/s- The benefit of the GPS

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tracking anklet is that Individual #3 could be located if he leaves school building or his family's home while on weekend outings.

An Incident Report dated March 30, 2018 Indicated: "Individual #3 was reported to be found at the front desk on March 30, 2018 at 2:55 PM. The front desk paged Unit II nurse on duty and informed her that Individual #3 was at the front desk alone. DSP statement indicated: Individual #3 was assigned to her and she passed him of to another DSP while cleaning isolation room to prepare to move Individual #3 back to the living unit. Three DSP's were in the isolation room with two individuals. The individuals were to be returned back to there living units. The DSP's were transferring the individuals and there beds back to the unit. During the transfer Individual #3 became unattached from the group and was found at the front desk."

An IPP service plan dated 12/15/18 started- end date 12/10/19 indicated: "Please record when Individual #3 attempts to leave or leaves the unit unannounced." Program notes dated 3/15/19 indicated: "There were 3 recorded episodes of Individual #3 leaving the unit unannounced which accounts for 1 episode in each month.

A review of the staff assignments dated 3/30/18 indicated: Individual #3 was assigned to be one on one.

During an interview on 5/31/19 at 11:30 AM with the Unit II Support Coordinator / Qualified Intellectual Disability Professional (QIDP) she stated, staff failed to provide 1:1 staff supervision to Individuals #2 and #3 in accordance to their IPP.

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W 242	Continued From page 28 A Direct Care Supervision of Individuals and Groups indicated: Purpose-To ensure the availability and supervision of sufficient numbers of competent, direct care professionals to provide active treatment, assist with activities of daily living and to protect the health and safety of each individual. One to One Supervision: Constant, uninterrupted focused, visual observation of an individual by at least one staff member who is not performing any other duties and has no other assignments.	W 242		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on clinical record review, staff interviews, and review of the facility's policy, the facility staff failed to ensure intrusive techniques were approved prior to implementation for 1 of 14 residents (Individual #6), in the survey sample. The facility's staff failed to ensure use of Morphine for brain injury "storming" incidents was reviewed and approved by Specially Constituted Committee (SCC) for Individual #6. The findings included; Individual #6 was admitted to the facility 5/6/14.	W 262		

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W 262	Continued From page 29 The current diagnoses included profound intellectual disabilities, spastic quadriplegia, shaken infant syndrome, a seizure disorder, cerebral palsy and a panic disorder. Brain injury "storming" is a state of agitation, extreme posturing/dystonia, tachycardia, tachypnea, hypertension, diffuse diaphoresis, and hyperthermia within seconds. Signs and symptoms vary from episode to episode and from individual to individual. (http://ccn.aacnjournals.org/content/27/1/30.full) Review of Individual #6 Physician's Order Summary revealed an order for Morphine concentrate 100 milligrams/5 milliliters; give 0.5 milliliters (5 milligrams) sublingual route every 3 hours as necessary for dyspnea or respiratory distress not relieved by usual pulmonary interventions. The Physician's Order Summary also revealed order for Lorazepam 0.5 milligram tablet-give 1 tablet (0.5 milligrams) by g-tube route every 6 hours for 365 days as needed for dystonic storm that continues for more than 5 minutes, and an order for Clonazepam 1 milligram tablet - give 1 tablet (1 milligram) by g-tube route 3 times per day. Every day at 6:00 a.m., 2:00 p.m., and 10:00 p.m., for panic disorder without agoraphobia. Review of nurse's documentation for 1/22/19 at 2100 (9:00 p.m.) revealed Individual #6 was administered Morphine concentrate fordyspnea and an elevated heart rate (142 beats per minute). Another nurse's note dated 1/25/19 at 18:05 (6:05 p.m.) read: Individual continueswith "storming" and dyspnea, as needed Morphine concentrate given at this time.	W 262	An Interdisciplinary team (IDT) meeting was held for Individual #6. It was agreed that the use of morphine should be for end of life/comfort care.	6/18/19
			The order will remain, but be changed from liquid to suppositories, and his medical plan of care will clearly state the reason and parameters for the use of morphine.	6/28/19
			Only one other individual had morphine available for end of life/comfort care, but as this had not been used, it was destroyed.	6/18/19
			The order will remain and her medical plan of care will clearly state the reason and parameters for use of morphine.	6/28/19
			The facility conferred with the Specially Constituted Committee (SCC) members, and received permission to exempt the use of morphine for individual #6 from their approval and monitoring, as the condition being treated was medical not behavioral.	6/21/19
			Any future orders for the use of morphine will be presented to the SCC for their determination as to whether approval is required, and approval will be sought if deemed necessary.	6/21/19
			An agenda item has been added to the monthly QI committee, to ensure that requests for morphine use has been noted and investigated thoroughly.	6/26/19

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W 262	Continued From page 30 Review of Individual #6's Health Related Protection Plan dated 10/4/18, revealed: (Name of Individual) has a history of panic disorder. With this disorder may come episodes of fear and anxiety defined as; crying, elevated blood pressure, increased heart rate, decreased oxygen saturations, flushed face, sweating, increased mucous secretions and foaming with potential risk of aspiration. The protective devices needed were pharmacological: Clonazepam for panic disorder and Lorazepam following any storming incident that last 5 minutes or more. Consent was obtained for both from the guardian on 3/27/19 and both medications were approved by the SCC on 4/25/19 but the guardian neither the SCC consented to use of the Morphine concentrate. The above information was shared with the Chief Compliance Officer, Director of Nursing and Social Worker #3 on 6/5/19 at approximately 4:00 p.m. The Chief Compliance Officer stated the she thought the Morphine Concentrate was for end of life care and therefore it wasn't necessary to go before the SCC but after further review she realized the staff was using the Morphine Concentrate for "storming" and it should have been presented to the SCC for approval. She stated it would be presented to the SCC.	W 262		
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 clinical record reviews, staff interviews and facility documentation, the facility staff failed	W 331		

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W 331	Continued From page 31 to ensure nursing services were provided in accordance with the needs of 2 of 14 individuals (Individuals #8 and #11) in the survey sample.	W 331	The Medication Administration Record was verified to ensure that the tube feeding orders were correctly entered into the electronic record for Individual #8 and Individual #11.	6/5/19
	1. Licensed Practical Nurse (LPN) #9 administered Individual #8 another individual's tube feeding in error.		All other individuals who receive fluids/feeding via G-tube were identified and orders checked.	6/28/19
	2. LPN #9 administered Individual #11 another individual's tube feeding in error.			
	The findings include:		Audits of tube feeding administration will be implemented, to include correct formula, rate and volume, checking the container for expiration date, labeling of the container, validation of pump settings, correct equipment being used, privacy, positioning, and route verifications.	7/19/19
	1. Individual #8 was admitted to the facility on 4/5/18 with diagnoses that included developmental delay, atrial defect, gastro-esophageal reflux disease and gastrostomy tube (g-tube). Individual #8 resided on Unit 1.		Results of these audits will be an agenda item for the monthly QI meeting.	6/28/19
	Individual #8 had physician orders dated 4/15/19 for tube feeding: 110 milliliters (ml) Elecare (for infants) mixed to 24 kcal/ounce (oz) run over 1 hours with 10 ml of water flush x 5 every day, at 2:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m. and 10:00 p.m.		The kitchen staff will ensure that labels are placed at the top of the bag and the Kitchen Manager will complete spontaneous audits on the placement of labels and report to the Safety Committee.	6/27/19
	On 4/18/19 at 7:00 a.m. another nurse noted that LPN #9 had another individual's tube feeding bag connected to Individual #8's g-tube. The entire feeding had been administered with the wrong formula.			
	On 5/30/19 at 2:30 p.m. an interview was conducted with the Director of Nursing (DON) and the Chief Compliance Officer (CCO). The DON stated she was aware of the problem and that it was stated by the nurses that sometimes the label comes off of the bag that is prepared by the			

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kitchen when the formula is warmed. She stated the solution was to have the kitchen put the labels on the top of the prepared bags to avoid them coming off during the warming process because all feedings are warmed due to them placed in the refrigerator.

During observations of tube feedings on 5/31/19 at 9:00 a.m. that were stored in the refrigerator on unit 1, no labels were on the top of the client's prepared tube feedings of the 9 bags of individual client's enteral feedings. Licensed Practical Nurse (LPN) #2 stated that they had to be careful to make sure the labels did not come off when they warm the tube feedings from the refrigerator. Based on the observation of the tube feeding bags and interviews with the nurses, the facility did not implement changes to prevent future mix up of feedings for any of the individuals.

The facility's policy and procedure titled gastrostomy feedings dated last revised 11/2008 indicated the purpose of the feedings was to supply enteral feedings. hydration for the child who is unable to take nourishments by mouth. Ensue to verify gastrostomy feeding time, amount and type of feeding.

2. LPN #9 administered Individual #11 another individual's tube feeding in error. Individual # 11 was admitted to the facility on 4/15/13 with diagnoses that included severe intellectual disability, spastic quadriplegic cerebral palsy swallowing problems and scoliosis.

Individual #11 had physician orders dated 4/15/13 for tube feeding: 155 milliliters (ml) Pediasure with fiber with 135 ml water flush (plus additional automatic 25 ml water flush after each feeding) x

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W 331	Continued From page 33 5 infused over 2 hours via g-tube x 5 every day, at 2:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m. and 10:00 p.m. Documentation revealed: on 4/18/19 at 7:00 a.m. the nursing supervisor noted that LPN #9 had another clients tube feeding bag connected to Individual #11's g-tube. The feeding had not been fully administered, thus the nursing supervisor discarded the remaining feeding. On 5/30/19 at 2:30 p.m. an interview was conducted with the Director of Nursing and the Chief Compliance Officer (CCO). The DON stated she was aware of the problem and that it was stated by the nurses that sometimes the label comes off of the bag that is prepared by the kitchen when the formula is warmed. She stated the solution was to have the kitchen put the labels on the top of the prepared bags to avoid them coming off during the warming process because all feedings are warmed due to them placed in the refrigerator. During observations of tube feedings on 5/31/19 at 9:00 a.m. that were stored in the refrigerator on unit 1, no labels were on the top of the client's prepared tube feedings of the 9 bags of individual client's enteral feedings. Licensed Practical Nurse (LPN) #2 stated that they had to be careful to make sure the labels did not come off when they warm the tube feedings from the refrigerator. Based on the observation of the tube feeding bags and interviews with the nurses, the facility did not implement changes to prevent future mix up of feedings for any of the individuals.	W 331		
W 333	NURSING SERVICES CFR(s): 483.460(c)(2)	W 333		

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W 333	Continued From page 34	W 333		
	Nursing services must include the development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.		An IDT meeting was held and it was agreed to request that the physician change the morphine order from liquid to suppositories.	6/2/8/19
	This STANDARD is not met as evidenced by: Based on clinical record review, staff interviews, and review of the facility's policy the facility staff failed to ensure medical care plan of treatment included all medical conditions for 1 of 14 residents (Individual #6), in the survey sample.		The order for morphine will remain and his medical care plan will clearly state the reason and parameters for use of morphine as part of his plan for the treatment of dyspnea related to comfort care. The medical plan of care will clearly delineate the indications for treatment of "storming".	6/28/19
	The facility's staff failed to integrate the use of Morphine into Individual #6's Medical care plan of treatment for brain injury storming.		Only one other individual had morphine available for end of life/comfort care, but as it had not been used, it was destroyed.	6/18/19
	Brain injury "storming" is a state of agitation, extreme posturing/dystonia, tachycardia, tachypnea, hypertension, diffuse diaphoresis, and hyperthermia within seconds. Signs and symptoms vary from episode to episode and from individual to individual. (http://ccn.aacnjournals.org/content/27/1/30.full)		The order will remain, and her medical care plan will clearly state the reason and the parameters for use of the morphine when re-ordered.	6/18/19
	The findings included;		If other individuals, who wish to receive end of life/comfort care, have morphine added to their physician orders, it will be included in their medical care plan; discussed with the SCC and the QI Committee.	7/19/19
	Individual #6 was admitted to the facility 5/6/14. The current diagnoses included profound intellectual disabilities, spastic quadriplegia, shaken infant syndrome, a seizure disorder, cerebral palsy and a panic disorder.		Any use of morphine will be reported to the quarterly Medical Review Committee with the medical directors.	7/11/19
	Review of Individual #6 Physician's Order Summary revealed an order for Morphine concentrate 100 milligrams/5 milliliters; give 0.5 milliliters (5 milligrams) sublingual route every 3			

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W 333	Continued From page 35 hours as necessary for dyspnea or respiratory distress not relieved by usual pulmonary interventions. The Physician's Order Summary also revealed order for Lorazepam 0.5 milligram tablet-give 1 tablet (0.5 milligrams) by g-tube route every 6 hours for 365 days as needed for dystonic storm that continues for more than 5 minutes, and an order for Clonazepam 1 milligram tablet-give 1 tablet (1 milligram) by g-tube route 3 times per day. Every day at 6:00 a.m., 2:00 p.m., and 10:00 p.m., for panic disorder without agoraphobia. Review of nurse's documentation for 1/22/19 at 2100 revealed Individual #6 was administered Morphine concentrate for dyspnea (difficulty breathing) and an elevated heart rate (142 beats per minute). Another nurse's note dated 1/25/19 at 18:05 read: Individual continues with "storming" and dyspnea, as needed Morphine concentrate given at this time. Review of Individual #6's Health Related Protection Plan dated 10/4/18, revealed: (Name of Individual) has a history of panic disorder. With this disorder may come episodes of fear and anxiety defined as; crying, elevated blood pressure, increased heart rate, decreased oxygen saturations, flushed face, sweating, increased mucous secretions and foaming with potential risk of aspiration. The protective devices needed were pharmacological: Clonazepam for panic disorder and Lorazepam following any storming incident that last 5 minutes or more. Consent was obtained for both from the guardian on 3/27/19 and both medications were approved by the SCC on 4/25/19 but the guardian neither the SCC consented to use of the Morphine concentrate.	W 333		

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W 333	Continued From page 36 The above information was shared with the Chief Compliance Officer, Director of Nursing and Social Worker #3 on 6/5/19 at approximately 4:00 p.m. The Chief Compliance Officer stated the she thought the Morphine Concentrate was for end of life care and therefore it wasn't included in the Health Related Protection Plan but it should have been included.	W 333		
W 343	NURSING STAFF CFR(s): 483.460(d)(1) Nurses providing services in the facility must have a current license to practice in the State. This STANDARD is not met as evidenced by: Based on record reviews, staff interviews and facility document reviews, the facility staff failed to ensure three nurses providing services in the facility held a current license to practice in the State. 1. The facility staff failed to validate an RN applicant's status to be able to legally provide nursing services to the individuals in the facility. This Presumed RN Applicant, hired on 3/12/19, was not authorized to continue to provide nursing services as of 3/21/19, but was scheduled to provide these services until brought to the facility's attention by the survey team. 2. The facility staff failed to have a procedure in place to ensure that Presumed Licensed Practical Nurse #1 had a license to practice in the state prior to hiring, starting orientation and rendering care to individuals. 3. The facility staff failed to have a procedure in	W 343	Of the three staff found not to meet state licensing regulations, the Presumed RN Applicant resigned, Presumed LPN #1 was terminated and RN #1 did not produce her Eligibility to Test/Authorization to Practice letter prior to hire. She has since done this. All other professional staff licenses have been checked and one other was found to be out of compliance but has produced her Eligibility to Test/Authorization to Practice letter. All others were current.	6/7/19 6/12/19

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W 343	Continued From page 37 place to ensure that Graduate Registered Nurse #1 had a license or authorization to practice in the state prior to hiring. The findings included: 1. The facility staff failed to verify the continued status of an Registered Nurse (RN) applicant, allowing her to provide care to the individuals without a valid license, placing all individuals at risk and facility liable for lack of care based on standards of practice. Upon the survey team's investigation, interview with the Presumed RN applicant on 6/3/19 at 4:45 p.m. and inquiry with the Director of Nursing (DON), the Director of Human Resources on 5/31/19 at 12:00 p.m. and Department of Health Professions (DHP), it was discovered the Presumed RN applicant was no longer eligible to practice in any nursing capacity as of 3/21/19. Upon review of the Administration Audit Detail Report, Presumed RN Applicant, per her schedule, had the opportunity to have provided nursing care for all 20 residents on the unit for scheduled shifts from 4/29/19 through 5/30/19. This report included administration of medications and tube feedings as well as respiratory treatments. According to documents presented by the scheduler on 6/3/19 at 11:35 a.m., the Presumed RN Applicant was released to practice as an RN as of April 30, 2019 and care for all the children on Unit 4, which were the most vulnerable children in the facility with tracheostomies and other complicated nursing procedures. Upon review of the schedules, on 5/4/19 and 5/19/19, Presumed RN Applicant was the only on site "RN"	W 343	The hiring policy will be changed to ensure that completed applications are received, and licenses checked by the HR Department prior to the interview. Prior to requesting a job offer, the DON or designee will check the license status with the Department of Health Professions a second time. The HR Department will initiate a third check while completing the on-boarding paperwork. Nursing applicants without a license will need to provide an Eligibility to Test/Authorization to Practice letter when completing the on-boarding paperwork. Employee badges for nurses waiting to take the NCLEX-RN/LPN test will denote whether RN or LPN Applicant and thus inform preceptors and other nurses of their status. New badges will be issues once a copy of the license is provided.within the 90 days allowed by the Board of Nursing. The HR Department will maintain a spreadsheet to ensure all licenses are current, as well as the status of those waiting to take their test. This will be shared with the Chief Executive Officer monthly	6/21/19 6/28/19 6/28/19

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for all four units for the children to include the one unit for the adult population. The scheduler stated, "I scheduled (Presumed RN Applicant's name) as a full fledged RN after 5/1/19 because that is what I was told by the DON. I only schedule how I am told by nursing." Presumed RN Applicant was only eligible to practice nursing for only nine days, from 3/12/19 through 3/21/19, but was scheduled to continue practice nursing from 3/21/19 to 6/3/19.

On 6/3/19 at 2:40 p.m., an interview was conducted with LPN #6 and LPN #7. They stated they expected the Presumed RN Applicant would be at work for the evening shift, but thought maybe she was late. When asked if she was an RN or RN applicant, they stated she was an RN and she took on a full assignment without anyone and had been doing so for "awhile." LPN #7 stated, "I was pulled from Unit 1 to Unit 4 (current unit) and that must have been because (Presumed RN Applicant) is not going to be here." LPN #6 stated, "She is doing better, she is working on some things, but will be a good RN in time."

The Presumed RN Applicant signed an RN job description on 3/22/19 that indicated the following:
Provides specialized nursing care and treatments for critically fragile individuals with special medical and physical needs at (Facility name).
Incumbents may e required to work a variety of shifts and fill the charge nurse role when scheduled. All services will be provided under a person centered model of care in support of each individual's support plan (ISP). Conducts physical assessments, administers medications, treatments and tube feedings, receive, transcribe

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and implement physician's orders, manage and provide care to tracheostomy-dependent and ventilator-dependent individuals after completed the required training, documents activities related to nursing and medical care, direct and supervise the delivery of nursing care, delegate task allowed by the nursing license, act as charge nurse, precept new nurse. Qualifications must be a graduate of an accredited school of musing, provide a current license issued by the State, provide references that reflect a good attitude, dependability, good judgement and ability to function independently.

The Regulations Governing the Practice of Nursing for the Virginia Board of Nursing dated as revised on 3/22/19 indicated under VAC90-19-110 Licensure by examination F. Practice of nursing pending receipt of examination results:

1. A graduate who has filed a completed application for licensure in Virginia and has received as authorization letter issued by the board may practice nursing in Virginia from the date of the authorization letter. The period of practice shall not exceed 90 days between the date of successful completion of the nursing education program, as documented on the applicant's transcript, and the publication of the results of the candidate's first licensing examination.

2. Candidates who practice nursing as provided in subdivision 1 of this subsection shall use the designation "R.N. Applicant" and L.P.N. Applicant" on a nametag or when signing official records.

3. The designations "RN Applicant" and L.P.N.

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Applicant shall not be used by applicants beyond the 90-day period of authorized practice or by applicants who have failed the examination.

G. Applicants who fail the examination:

1. An applicant who fails the licensing examination shall not be licensed or be authorized to practice nursing in Virginia.

2. An applicant for licensure by reexamination shall file the required board application and reapplication fee in order to establish eligibility for reexamination.

2. Review of personnel records revealed Presumed LPN #1 was offered a position as an LPN 6/27/18 and started orientation in the facility 7/10/18. Presumed LPN #1 work experience completed by the applicant stated she was educated at a local school of nursing from 6/2016 through 3/2017. The applicant's work experience as an LPN was listed as home care private duty nursing beginning 4/2017 through 5/2018. This private duty nursing position as an LPN included tracheotomy care, gastrostomy tube care, medication administration, activities of daily living and wound care.

A note written at the top of a document titled "Nurse's Pre-interview Information" read; "she has been an LPN for 1 year. Please hire for 11p.m.-7 a.m." Further review of the personnel record revealed Presumed LPN #1 didn't complete an official application for employment until 7/18/18, and on the application the Presumed LPN #1 stated she had been convicted of welfare fraud in 1997, passing a worthless check in 2008 and attempted identity theft in

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2018.

A copy of a license to practice as a Licensed Practical Nurse issued by the Department of Health Professions was not included in the personnel records.

An interview was conducted with The Professional Development Director who stated they were unable to obtain a license for Presumed LPN #1 to practice as an LPN and the information had been shared multiple times with the administrative staff as well as information about Presumed LPN #1 pending court case.

An interview was conducted with the Nursing Support Specialist on 6/5/19 at approximately 10:45 a.m. The Nursing Support Specialist stated Presumed LPN #1 was in general classroom orientation and demonstrated a lacked of fundamental nursing skills but on 7/20/18, Presumed LPN #1 provided hands of care under the supervision and assistance of the Respiratory Therapist for multiple children.

An interview was conducted with the Respiratory Therapist on 6/5/19 at approximately 11:30 a.m. The Respiratory Therapist stated Presumed LPN #1 performed suctioning for 3 children, administered nebulizer treatments to 3 children, provided tracheostomy care to 1 child, application of the vest treatment to 3 children and use of the VitalCough system for 2 children.

Further review of the personnel record was an email stating Presumed LPN #1 was terminated effective 7/27/18, for inability to verify a license to practice as a LPN.

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3. Review of graduate Registered Nurse #1 personnel records revealed she was hired 5/14/19, and began general orientation 5/28/19. Further review of the personnel records didn't reveal a license to practice as a registered Nurse nor a letter from the Department of Health Professions authorizing graduate Registered Nurse #1 to practice for 90 days or until results were received from the first licensing examination.

An interview was conducted with the Human Resource Director on 5/31/19 at approximately 12:40 p.m. The Human Resource Director stated graduate RN #1 didn't have a license to practice as a RN because she had recently graduated from a local School of Nursing. The Human Resource Director further stated graduate RN #1 didn't have a letter from the Department of Health Professions authorizing her to practice as a RN Applicant but she would consult the Director of Nursing to determine if she had the document.

On 5/31/19, at approximately 3:30 p.m., a letter was presented which had been obtained from graduate RN #1 faxed to the facility 5/31/19 at 2:36 p.m. The letter dated 5/22/19 stated graduate RN #1 was authorized to take the National Council Licensure Examination (NCLEX) for Registered Nurses and provided instructions for scheduling the exam, acceptable types of identification, and etc. It didn't authorize graduate RN #1 to practice nursing.

On 6/3/19 at approximately 4:45 p.m. a letter from the Department of Health Professions dated 5/22/19 was presented. It stated as of 5/22/19, you have been declared eligible by the Board of Nursing to take the NCLEX- Registered Nurse...

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W 343	Continued From page 43 and it read you may practice as a RN Applicant for 90 days or until results were received from the first licensing examination. Another interview with the Human Resources Director on 6/3/19 at approximately 5:00 p.m., they hadn't ensured all necessary documents were in personnel records but since a concern has been identified the procedure would be changing. On 5/14/19, graduate RN #1 was ineligible to accept a Registered Nurse or RN Applicant position. On 6/5/19 at approximately 4:00 p.m., the above findings were shared with the Chief Compliance Officer, Human Resource Director and the Director of Nursing. No additional information was provided.	W 343		
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 observation, clinical record review, facility documentation, staff interviews, and review of the facility's policy the facility staff failed to follow the physician order for 3 of 14 Individuals (Individuals #10, #13 & #14), in the survey sample. 1. The facility staff failed to administer Individual #10's noon dose of Diazepam as ordered on	W 368		

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W 368	Continued From page 44 5/5/19. 2. The facility staff failed to administeredthe medication diazepam 5 milligrams (mg) as ordered for Individual #13. 3. The medication, lorazepam, scheduled for 4/17/19 was not administered at 10:00 p.m. per physician's orders. The findings included; 1. Individual #10 was admitted to the facility 7/23/13. The current diagnoses included profound intellectual disability, spastic quadriplegia, cerebral palsy, a seizure disorder, other congenial malformations of the brain and muscle spasms. The current physician order summary revealed an order dated 2/13/19, for Diazepam 2 milligram tablet-give 1 milligram (0.5) tablet by g-tube route 4 times per day at 12:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m., for muscle spasms. A review of the facility's Event Form dated 5/5/19 revealed Individual #10 didn't receive the physician ordered Diazepam scheduled for 12:00 noon on 5/5/19. The Event report dated 5/5/19 read under "Investigative Summary:" It was discovered that on 5/5/19, Individual #10 did not receive his Diazepam 1 milligram which was due at 12:00 noon, this was evidenced by the controlled medication unitization record not signed by Licensed Practical Nurse (LPN) #1. LPN #1 written statement on 5/6/19 read" medication administration in the afternoon didn't see to give on the double check. Signing for medication on	W 368	An audit was completed on current medications ordered for Individual #10, Individual #13 and Individual #14 and all were found to be correct. All other residents have the potential to be affected. A Medication Administration Audit was implemented to ensure that all other individuals receive medications as prescribed. All nurses will be observed completing the med pass. Additional training will be provided to nurses as needed based on observations Number of audits and results have been added as an agenda item for the monthly QI Committee.	6/14/19 6/14/19 6/28/19 7/19/19 6/26/19

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the Medication Administration Record prior to administration. Medication signed 5/5/19 at 1:01 p.m. Failed to verify order on the Medication Administration Record and compare to the labels on the bingo card and controlled medication utilization.

A medication pass observation was conducted with LPN #1 on 5/30/19, from 1:05 p.m. through 2:10 p.m. Diazepam 4 milligrams was administer to Individual #9 via g-tube at approximately 1:55 p.m. The Diazepam 4 milligrams wasn't reconciled on the control medication medication utilization form at any time during the medication pass observation. LPN #1 stated the medication pass for the 12 p.m. to 2:00 p.m., time span was completed but the Diazepam wasn't reconciled during or after the observation of the medication pass.

An interview was conducted with LPN #1 on 5/30/19 at approximately 2:45 p.m., LPN #1 stated the he should have documented immediately after the medication administration the the Medication Administration Record and the controlled medication utilization.

On 5/30/19 at approximately 3:00 p.m., the above findings were shared with the Chief Compliance Officer and the Director of Nursing. The Director of Nursing stated LPN #1 had talked to her about the above events and he was just nervous.

The facility's policy titled Drug Administration and dated 9/2012 read under procedure #1: all medications will be administered per the physician's orders and documented in the electronic medical record.

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2. The facility staff failed to administered medications as ordered for Individual#13, diazepam 5 milligrams (mg).

Individual #13 was admitted to the facility on 10/5/15 with diagnoses that included profound intellectual disability, spastic quadriplegic cerebral palsy, tracheostomy and gastrostomy.

Individual #13 had physician's orders dated 10/5/15 and renewed on 4/22/19 for diazepam 5 mg every day at 10:00 p.m.

Review of the controlled medication utilization record revealed diazepam scheduled for 5/24/19 was not administered at 10:00 p.m. per physician's orders. The error was identified by the Registered Nurse (RN) supervisor 5/25/19 at 10:30 p.m. and an event form was filled out. The investigation summary of the event indicated that it was discovered on 5/25/19 that Individual #13's 10:00 p.m. dose was not administered the night before. The report noted the cause of the error was "not checking the Medication Administration Record (MAR) to ensure all medications were given." The event report also revealed the error was made by an un-licensed nurse, Presumed RN applicant, but the report indicated she was an "RN." The event report further noted the Presumed RN was spoken to and did not recall how she missed it, but that she understood the importance of checking the MARs. This employee was only authorized to practice nursing as an RN applicant from 3/12/19 to 3/21/19.

3. The facility staff failed to administered medications as ordered by the physician for Individual #14.

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W 368	Continued From page 47 Individual #14 was admitted on 3/14/17 with diagnoses that included profound intellectual disability, spastic quadriplegic cerebral palsy, seizures and gastrostomy. Individual #14 had physician's orders dated 3/14/18 and renewed on 3/26/19 for lorazepam 2 mg every day at 10:00 p.m. Review of the controlled medication utilization record revealed lorazepam scheduled for 4/17/19 was not administered at 10:00 p.m. per physician's orders. The error was identified by the Licensed Practical Nurse (LPN) #7 on 4/18/19 that the 4/17/19 10:00 p.m. was omitted as evidenced by absence of documentation on the controlled medication utilization record and an event form was filled out. The event report also revealed the error was made by an un-licensed nurse, Presumed RN applicant, but the report indicated she was an "RN." The investigation event report further noted that per the Presumed RN's statement she wrote, "I was doing too much at once. I will be more careful and prioritize better. I will pay close attention, do one thing at a time." The event report indicated the medication was signed prior to obtaining the medication from the bingo card which resulted in the omission. This employee was only authorized to practice nursing as an RN applicant from 3/12/19 to 3/21/19. The facility policy and procedure titled Medication Administration last revised on 4/2018 indicated medications were to be administered by a licensed nurse and the following 6 rights of medication administration would be followed at all times:	W 368		

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W 368	Continued From page 48 1. Right individual 2. Right medication 3. Right form 4. Right dose/strength 5. Right route 6. Right time The policy titled medication/Treatment Errors last revised 6/2018 indicated the licensed nurse or certified respiratory therapist is responsible for reviewing labels of medications/treatments he/she is administering to ensure accuracy.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369		
	This STANDARD is not met as evidenced by: Based on observations of a medication pass, the facility staff failed to ensure they were free of medication errors for 1 out of 14 individuals (Individual #12) in the survey sample.		All current orders for Individual #12 have been audited to ensure that all required elements – milligram dosing, concentration and volume – are present.	6/7/19
	During a medication pass observation on 5/31/19 at 8:30 a.m., Individual #12 was not administered the correct dose of Bromocriptine (anti-spasmodic medication).		All other individuals have the potential to be affected.	6/7/19
	The findings include: Individual #12 was admitted to the facility on 1/17/19 with diagnoses that included developmental delay, muscle spasms, retinal hemorrhage, gastrostomy tube, seizures fractured skull and gastro-esophageal reflux		An audit for all other individuals has been implemented, and will be carried out by the clinic nurse and/or the physician every 90 days to ensure that milligram dosing, concentration and volume is present.	6/5/19

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W 369	Continued From page 49 disease (GERD). Individual #12 had physician's orders dated 1/17/19 for Bromocriptine 0.125 milligrams (mg) in 1 milliliters (ml) scheduled for 8:00 a.m. and 8:00 p.m. On 5/31/19 at 8:30 a.m., during a medication pass observation, Licensed Practical Nurse (LPN) #2 pulled up 0.125 ml in a 1 ml syringe and administered 0.125 ml. The bottle clearly indicated that 0.125 mg was in 1 ml. The computerized MAR screen indicated to give 0.125 mg not 0.125 ml. When asked to check the order and the bottle, LPN #2 found it difficult to interpret that she should give 1 ml. She stated, "Obviously, I have been giving less than what was ordered for the resident since it had been ordered on 1/17/19." LPN #2 stated she was full time and had Individual #12 on a full time basis. Another nurse was summoned, LPN #3, who also looked at the MAR and the bottle and interpreted the order as did LPN #2. The Director of Nursing (DON) was shown the medication error and that two nurses could not do the math to accurately interpret medication orders. She stated, "That is an easy fix, I will just get the order clarified on the Medication Administration Record (MAR) so there is no confusion in the future." She did not address the need to review the central issue which was the nurse's failure to know the difference between milligrams and milliliters and the need for retraining and that the error in administration had been since the inception of the order from 1/17/19. The facility policy and procedure titled Medication	W 369	The medication Administration policy has been revised to require all nurses to ensure that the required elements are present when entering a new order on the electronic Medication Administration Record. The clinic nurse/physician will verify the correct entry of all new orders. The DON will receive a report monthly from the clinic nurse, and the audit of orders will be added to the QI agenda monthly.	6/28/19 6/28/19 7/19/19

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W 369	Continued From page 50 Administration last revised on 4/2018 indicated medications were to be administered by a licensed nurse and the following 6 rights of medication administration would be followed at all times: 1. Right individual 2. Right medication 3. Right form 4. Right dose/strength 5. Right route 6. Right time The policy titled medication/Treatment Errors last revised 6/2018 indicated the licensed nurse or certified respiratory therapist is responsible for reviewing labels of medications/treatment he/she is administering to ensure accuracy.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations made during the medication pass, staff interviews and review of the facility's policy the facility staff failed to ensure drugs and biological storage area remained locked when not in use for 1 of 1 medication carts on Unit 3. The facility staff failed to ensure the Unit 3 medication cart was locked when it was not attended and/or in use. The findings included;	W 382	The medication carts on Unit 3 were checked to ensure that the locking mechanism was functional and that nurses had access to the correct keys. Other medication carts in the building were also checked.	6/14/19 6/14/19

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W 382	Continued From page 51 A medication pass observation was conducted with Licensed Practical Nurse (LPN) #1 on 5/30/19, from 1:05 p.m. through 2:10 p.m. LPN #1 removed a Diazepam 4 milligrams from the back side of the medication cart at approximately 1:15 p.m. The two side closures to themedication drawers were not closed and the lock activated after LPN #1 obtained the Diazepam. LPN #1 proceeded to prepare the Diazepam for administration by crushing it and mixing it with water and drawing it up in a 60 milliliter syringe. The medication as well as an ophthalmologic ointment, was administered to Individual #9 in classroom #7. Medications were also administered to 2 other individuals in classroom #7, and at approximately 2:10 p.m., a medication was administered to an individual in classroom #10. Prior to administration of a water flush for another individual LPN #1 observed the lock to the back of the medication cart (the side of the cart controlled drugs were stored) was not activated, he activated the lock but the side closures remained open and the medications remained accessible to others. An interview was conducted with LPN #1 on 5/30/19 at approximately 2:45 p.m., regarding the medication pass and pour observation. LPN #1 stated that particular medication cart was the only one in the facility with 2 sides and he forgot to lock it after removing Individual #9's Diazepam. LPN #1 also acknowledged when he did activate the lock the side closures were not activated until it was brought to his attention. On 5/30/19 at approximately 3:00 p.m., the above	W 382	A reminder was sent out to all nurses reiterating the importance of securing all medications and informing them of "spot checks" being completed to ensure compliance. Further training will be completed at the next nurse staff meeting. Ensuring locked carts when stored or not being attended to will be included in the Medication administration audits. Results of MAR audits and the "spot checks" have been added to the agenda for the monthly QI Committee.	6/14/19 7/2/19 7/19/19 6/26/19

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W 382	Continued From page 52 findings were shared with the Chief Compliance Officer and the Director of Nursing. The Director of Nursing stated LPN #1 had talked to her about the above events and he was just nervous. The facility's policy titled "Medication Administration" with a revision date of 4/18 read under procedure; Ab., Medication carts, laptops including refrigerated medications, will be kept locked and stored in the medication room if not in use. Procedure Ac., read Medication carts must be within the nurse's sight at all times unless in a locked medication room.	W 382		
W 386	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(4) The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308). This STANDARD is not met as evidenced by: Based on a complaint investigation, facility document review, clinical record review, staff interviews, and review of the facility's policy, the facility staff failed to ensure controlled medications were accounted for for 1 of 14 individuals (Individual #6), in the survey sample. The facility's staff failed to reconcile a schedule II controlled drug (which had a great potential for abuse and had been involved in unaccounted for doses), at the change of each shift and document the count.	W 386	The liquid morphine has been destroyed and is no longer an active order.	6/7/19

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W 386	Continued From page 53 The findings included; Individual #6 was admitted to the facility 5/6/14. The current diagnoses include profound intellectual disabilities, spastic quadriplegia, shaken infant syndrome, a seizure disorder, cerebral palsy and a panic disorder. Review of Individual #6 Physician's Order Summary revealed an order for Morphine concentrate 100 milligrams/5 milliliters; give 0.5 milliliters (5 milligrams) sublingual route every 3 hours as necessary for dyspnea or respiratory distress not relieved by usual pulmonary interventions. Review of Individual #6's Controlled Medication Utilization Record revealed on 2/28/18, 30 milliliters of Morphine Concentrate 100 milligrams (mg)/5 milliliters (ml) was delivered to the facility and recorded. On 7/3/18 at 8:55 a.m., 0.25 ml was administered to Individual #6 and signed out leaving the count 29.75 ml. Another 0.25 ml dose was administered 7/17/18 at 7:54 p.m., leaving a total of 29.5 ml. An Abuse Allegation Report dated 8/24/18, revealed on 8/22/18, the 11:00 p.m.-7:00 a.m., nurse documented the actual Morphine Concentrate count was 17 ml and the p.m.-11:00 p.m., nurse on 8/23/18, actual count was documented as 9 ml. The actual count of 9 ml on 8/23/18, revealed 20.5 ml was unaccounted for. The nurse assessment of Individual #6 didn't indicate the unaccounted for medication had been administered to him. The Human Resource Department was notified of the unaccounted for Morphine Concentrate as well as the Director of Operational Support, law enforcement and the facility's attorney were also notified. All nurses	W 386	The morphine order for Individual #6 has been converted from a liquid to suppositories and it will be included in the shift count/change of personnel reconciliation count, and recorded on the Controlled Medication Utilization Record. The suppositories will be housed with the other controlled medications in the locked cart in a secondarily locked drawer. One other individual could have been affected by a failure to reconcile morphine at the change of shift. The morphine for this individual has been destroyed as it has not been used recently. All Schedule II – IV medications will be counted as per the Medication Administration policy. They will be recorded on the Controlled Utilization Record. There will be no exceptions to the storage and counting of morphine. The policy will be reviewed with all nurses. Controlled medication sheets and storage will be reviewed as part of the medication administration audit and a DON report has been added to the agenda for the monthly QI Committee meeting.	6/28/19 6/7/19 7/2/19 6/26/19

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W 386	Continued From page 54 who worked at the time of the discovery were interviewed and drug tested. All drug test came back negative. As a result of the unaccounted for Morphine Concentrate additional counting procedures and enhanced locking methods were put in place for this drug. During an interview with the Chief Compliance Officer and the Director of Nursing on 5/31/19 at approximately 12:30 p.m., the Chief Compliance Officer stated the new system put in place does not allow the nursing staff to actually count the Morphine Concentrate unless a dose is removed from the bottle. The Chief Compliance Officer stated this intervention was instituted because of the dark bottle the medication comes in prevents the nurses from making an accurate count. An observation was made of the enhanced locking method; the Morphine Concentrate was boxed and stored in the medication room in a a locked cabinet, inside a clear locked box with a numbered locked tab. The oncoming and offgoing nurses were verifying no one assessed the bottle inside the clear locked box but; they were still unable to verify what or how much Morphine Concentrate was in the bottle. The above information was shared with the Chief Compliance Officer and the Director of Nursing on 5/31/19, at approximately 4:00 p.m. The Chief Compliance Officer stated the Schedule II drug count system was developed in conjunction with the consulting pharmacist based on the previous discrepancies involving the Morphine Concentrate for lack of another method of accounting for the medication. At the time of the interview on 5/31/19, the facility	W 386		

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W 386	Continued From page 55 staff were unable to state what they knew to be in the bottle. They speculated because the affix number had not been removed since 1/25/19, at 6:05 p.m., and the balance at that time was 7.75 ml, that there was still 7.75 ml, in the bottle. An interview was conducted with Licensed Practical Nurse (LPN) #6, on 6/4/19 at approximately 11:30 a.m. LPN #6 stated at the change of each shift the nurses stand side by side and count each Schedule II-IV medication, confirm the count is accurate and sign. The facility's policy titled "Medication Management" Narcotic Count with a revised date of 8/18 read; the purpose of the policy is to ensure accurate count of controlled drugs (narcotics) specific to that of the individual and units; compliance with state and federal regulations; and to avoid potential drug abuse. Under Procedure; #3 read; the narcotic count will be done at the change of every shift or when the person responsible for the medication cart changes. under #4 read; Scheduled II drugs will be maintained on the Controlled Medication Utilization Record in declining inventory format. #5 read; Scheduled II drugs will be counted by the offgoing and oncoming nurse at the change of each shift and documented on a Controlled Drug Count Verification form. (Shift count sheet for narcotics).	W 386		