STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	A. BUILDING _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	2752 WEST NECK RD VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED SY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER's PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted D1/22/20 through 01/23/20. No 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.	E000		
W 000	INITIAL COMMENTS The unannounced Fundamental Medicaid re-certification survey was conducted 01/22/20 through 01/23/20. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Disabilities (ICF/110). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 24 bed facility at the time of the survey was 19. The survey sample consisted of 5 current Individual records (Individual #1 through #3, #5 and #6) and one closed record review (Individual #4).	W 000		
W 104	GOVERNING BODY CFR(s): 483.41O(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility staff failed to maintain a clean, safe and sanitary environment which could potentially affect the current residents in the survey sample.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lim Capoldo DS Director 2/10/2020

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

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W 104	Continued From page 1	W 104		

The findings included;

During the initial tour of the kitchen and dining area 1/22/20, at approximately 11:25 a.m., the porch used by the individuals was observed from the kitchen window and dining area. There were bed frames, mattresses, a defective cook top stove, paint cans/buckets, a wagon full of boxes and trash. Directly on the floor of the porch was also dirt, paper and other debris.

Except for the wagon items, same was observed with Supervisor II #2 on 1/23/20, at approximately 11:00 a.m. Supervisor II #2 stated all of the items on the porch were there to be discarded but it hadn't happened yet. Supervisor II #2 further stated a call would be made for a pick-up of the items.

On 1/23/20, at approximately 4:45 p.m., the above findings were shared with the two Residential Managers, Supervisor II, the Administrator, the Corporate Nurse and two Qualified Intellectual Disabilities Professionals. Supervision II #1, stated the call had been made and the items will be removed soon.

The debris will be removed from the back porch. 1/24/2020

The House Manager or designee will complete a monthly walk through of the residence to include a check of the facilities external and internal structures to ensure the environment is safe and free of debris. 3/6/2020

The Physical Environment policy will be reviewed and updated to include the new procedures. Staff will be trained on the revised policy. 3/6/2020

The ICF Supervisor will do random spot checks to ensure the facility is clean and free of debris. 3/6/2020

W 149 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

W 149

This STANDARD is not met as evidenced by:
Based on record review and staff interview the facility staff failed to ensure one Individual

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W 149	Continued From page 2 (Individual #3) in the survey sample of six individuals was protected from a burn during bathing. The findings included: Individual #3 was diagnosed with Profound Intellectual Disability, Cerebral Palsy and Calliopsis. The facility staff failed to protect Individual #3 from a burn during showering. An Abuse Allegation Investigation Report dated 06/05/2019 indicated: Supervisor II was notified by DSP (Direct Support Professional) that individual #3 leg was red and blistered after having the shower head running towards left. Individual taken to medical facility for evaluation. Staff was interviewed face to face after the incident. Staff indicated: she was alone while assisting Individual #3 in the shower room and indicated the individual was on the shower gurney while she assisted with hygiene prior to the shower. DSP #1 was asked if she requested assistance from co-workers to complete the Individual's shower? DSP #1 could not offer an explanation whey she did not request assistance. A shower temp log kept in the shower room specifically states that two staff must sign the log sheet to indicate they were present the entire time while assisting with the bath. Further review indicates there is only one set of initials present for all of the showers given between June 1 and June 5. During the interview, DSP #1 stated that during hygiene, the shower head was in the area of the individual's lower leg positioned away from the	W 149	All staff will be trained on the proper bathing protocol to include how to test the water temperature and recording the water temperature prior to the beginning of the bathing process. The water temperature log will be updated to include the proper water temperature range of 100 to 110 degrees. The water temperature log will include the procedure to test the water temperature and log the water temperature. If the water temperature is outside of the acceptable range, the staff will report the maintenance issue to the House Manager or Supervisor On Call and will not use the particular faucet until the repair has been completed.	6/19/2019 6/19/2019

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W 149	Continued From page 3 individual's leg with water running. DSP #1 reported during hygiene activities prior to completing the shower, DSP #1 noted the shower head had turned towards the individual's leg and water was spraying onto the individual's leg. DSP# 1 stated, the water was adjusted because at that point it "felt too warm." DSP #1 was asked if a temp was obtained of the shower water? The DSP #1 replied the temp felt to warm on her own arm. DSP#1 did not use the thermometer in the shower room. DSP #1 reported the individual moved her leg during hygiene which caused the shower head to face the individual's left leg. Review of the shower log specifically states that the temperature is to be recorded after running the water for two minutes. DSP # 1 reported the only temp taken with the thermometer was after the shower. DSP #1 was asked when water temperature should be reported and her reply was, "105." Temp log instructs notification to be made to a supervisor immediately if temp is above 110 degrees. DSP # 1 reported only one temperature was recorded with the thermometer which was after the shower. The recorded temp after the shower was documented as 99 degrees. After shower was completed and the Individual was dressed, DSP # 1 observed redness to Individual#3's lower left leg. DSP # 1 indicated blisters were observed in addition to reddened area. DSP #1 stated Individual #3 was taken to the nurse. The nurse assessed the individual and the individual was taken to medical facility emergency department and diagnosed with a superficial partial thickness burn to lower leg. : Finding: Based on preponderance of the	W 149	The Physical Environment policy will be reviewed and updated to include the water temperature testing procedure. All staff will be trained on the water temperature procedure and the updated policy. All water temperature logs will be submitted to the House Manager or designee for review. The House Manager or designee will complete random spot check to ensure staff are following the water temperature testing procedures and review the water temperature logs.	3/6/2020 2/28/202

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W 149	Continued From page 4 evidence: Neglect is FOUNDED A Nursing note dated 06/05/19 indicated: "Temp 97.8 individual comfortably resting in bed, awake and alert: no s/s pf distress or discomfort observed. Antibiotic started tonight. and well tolerated. Left leg elevated to pillow will continue to monitor for change in condition." Nursing Care Plan dated 06/05/19 indicated: Health Care Need: Prevention and wellness: Provide a safe environment. Nursing Care Objective: To achieve a timely wound healing free of infection and be afebrile over the next 30 days. Will complete antibiotic TIO (3) x 7 days and Wound treatment BID (2) X 2 weeks. Interventions: Vital signs once daily in the morning X 7 days Examine burn areas daily, note and document changes for appearance, odor and amount of drainage Provide wound treatment BID x 2 weeks. See order Administer antibiotic as ordered Monitor for medication adverse reaction Notify MD for any significant change in condition Wound Treatment: cleanse with normal saline spray, pat dry with 4 x 4 gauze, apply silvadene cream to affected area, covered with non-adherent sterile pad and wrapped with kirlix secured with tape, left leg elevated on pillow while in bed. PRN Ibuprofen. An outside Plumbing vendor was called to the facility on 06/05/19. The outside vendor took the water temperature in noted shower room and a reading of 119 degrees Fahrenheit was obtained.	W 149		

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W 149	Continued From page 5 An email dated 06/07/19 indicated: "Water Temps in living Unit 2752. Attached is the estimate for repair to the hot water system in big. 2752. 2 mixing valves need to be replaced and 3 check valves are installed in the wrong direction and need to be installed in the proper location. Due to these issues residents are having to go next door to 2756 in order to be bathed." A facility policy dated June 6, 2007 indicated: ' Physical Environment- Purpose: To provide a physical environment that promotes the health and safety, independence and learning of the individuals who live at the facility. Procedures: Client Bathroom- 3. Hot water will be 110 degrees or less in each bedroom, kitchen, and all hand washing sinks at the facility. Water temperature will be taken in all rooms on a weekly basis. An assigned staff person will check the water temperatures weekly and record the temperatures on the Water Temperature Checklist. Once completed, the sheets will be turned in to the house manager or the program manager. If the hot water temperature is above 110 degrees, staff will be instructed not to use the particular faucets involved until maintenance has been called and the situation corrected. During an interview on 01/23/20 at 11:15 A.M. with Supervisor II she stated, facility staff did not follow policy and procedures for giving individuals personal hygiene care. Staff did not follow policy and procedures for checking water temperatures prior to giving Individuals showers.	W 149		
W 368	DRUGADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure	W 36B		

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W 368	Continued From page 6 that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to administer medications as ordered by the physician for one Individual (Individual #6) in the survey sample of six individuals_ The findings included: Individual #6 had diagnoses of hydrocephalus, hypertension, depression, seizures and behaviors. Individual #6 requires total care for activities of daily living. An Incident Report dated 11/16/18 indicated: "While doing a random med audit it was discovered Individual # 6's physician ordered phenytoin and metoprolol doses were off_ Phenytoin (50 mg tabs) should have 90 remaining instead there were 95 tabs in cart and metopolol (100 mg) should have 15 but the count is 10. Investigation Summary: While doing a random med audit it was discovered Individual #6 phenytoin and metoprolol doses were off. Phenytoin (50 mg tabs) should have 90 remaining instead there were 95 tabs in cart and metoprolol (100 mg) should have 15 but the count is 10. During the investigation, it was discovered that a discrepancy was noticed and communicated on 11/6 that there were 5 extra phenytoin tabs on the bubble pack care than there should have been indicating that the error occurred between 11/1-11/5_	W 368	The staff involved in the medication error will be in-serviced on the look behind and medication administration procedure. Staff involved in the medication administration error received disciplinary action. The client was scheduled to receive six Dilantin tablets twice a day. The medication was changed to liquid medication to reduce the number of pills administered at one time and to reduce risk of error.	12/12/18 6/24/19

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W 368	Continued From page 7 It is notable that during the time frame in question, specifically the narrower time frame of 11/1-5/18, there were only two staff who administered the medication. No staff was able to or reported any discrepancy in their administration of medication. There was an attempt early in the month when staff notified nursing staff to identify a potential discrepancy; however this event was not explored further by staff or nursing staff. While a concern remains that the correct dosages of two different medications were not provided to the individual in accordance with the physician orders, there is no specific evidence that highlights when the errors could have and did occur. It is notable there have been no adverse effect on the individual. An Incident Reporting Form dated 06/14/19 indicated: "Med Tech made an audit of Individual #6's routine medications and found out that phenytoin 50 mg to give 6 tablets at (HS) were short of 4 tablets. The count supposed to be 102 tablets as of 6/14, but counted only 98 tablets and were off of 4 tablets. According to the count sheet, the count for phenytoin has been off since 6/5." An Incident Reporting Form dated 06/26/19 indicated: "At 1930 (7:30 P.M.) Med Tech informed the nurse in charge that Individual #6's Phenytoin 125 mg/5 ml susp in med cart that suppose to be given at 2200. Nurse found out that it was sent to day program today and they failed to send it back. During an interview on 1/23/20 with Supervisor II	W 368	All medication for all individuals scheduled to be administered will be counted by two medication administration trained staff at the end of each shift to ensure all mediations have been administered to all individuals. Any discrepancies will be reported to nursing staff. Nursing Staff will continue to implement every other day medication audits.	3/6/20 12/12/18

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W 368	Continued From page 8 she stated, "All staff were retrained in look behind and medication administration procedures. A medication count sheet was implemented and House Manager and Program supervisor would perform spot checks during medication administration times. Facility Policy Indicated: "All medications are to be administered in accordance to physician orders."	W 368'		
W 384	DRUG STORAGE AND RECORDKEEPING ; CFR(s): 483.460(1)(2) Clients who have been trained to self administer drugs in accordance with §483.460(k)(4) may have access to keys to their individual drug supply. This STANDARD is not met as evidenced by: Based on observations during the medication administration task and staff interviews, the facility's staff failed to ensure controlled substances were stored under double locks. The finding included: On 1/22/20 at approximately 7:10 p.m. during the medication administration task, the Direct Support Personnel (DSP) was observed removing and returning the medications Clonazepam (a schedule 4 medication with a potential for abuse) and Vimpat (a schedule 5 medication known to be addictive) from the general medication drawer which included high blood pressure medications, vitamins, muscle relaxants, stool softeners and others.	W 384	No individuals were affected. All controlled medications will be removed from the medication cart and will be placed in a locked safe in a locked cabinet in the locked medication room. Staff will be in serviced on the proper storage of controlled medications. The nurses will complete bi-monthly spot check to ensure all control medications are kept under double lock.	1/23/20 3/6/2020 1/23/20

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An interview was conducted with DSP #1 directly after the medication pass was completed and it was identified the controlled substances had not been accounted for by documenting administration in the controlled substance count book. DSP #1 stated the controlled substance book was in the cabinet and it was just an oversight not signing the two controlled medications as administered. DSP#1 didn't agree had the controlled substances been stored under a double lock it would have prompted signing the controlled medication book. DSP #1 also stated at one time the double locked box on the counter in the medication room was used but there were problems with its use therefore it was no longer utilized. DSP#1 further stated liquid controlled medications continue to be kept in the refrigerator.

An interview was also conducted with the Corporate Nurse on 1/23/20, at approximately 1:30 p.m., regarding the storage of controlled substances. The Corporate Nurse stated they had been exploring obtaining new medication carts to achieve the security necessary to accommodate the controlled substance and other needs they have with the medication carts but it hadn't been accomplished as of yet. The Corporate Nurse also stated all controlled substances would be moved from the general medication drawers to the double locked cabinets in the medication room that day and proceeded to make the changes.

On 1/23/20, at approximately 4:45 p.m.. the above findings were shared with the two Residential Managers, Supervisor II, the Administrator , the Corporate Nurse and two

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W 384 Continued From page 10

W 384

Qualified Intellectual Disabilities Professionals. The Corporate Nurse stated all controlled medications had been removed from the medication carts to the double locked cabinets in the medication room.

W 473 MEAL SERVICES
CFR(s): 483.480(b)(2)(ii)

W 473

Food must be served at appropriate temperature.

This STANDARD is not met as evidenced by:
Based on observation, clinical record review, facility documentation, staff interviews, and the facility policy, the facility's staff failed to serve hot foods during the 1/22/20, dinner meal at safe temperatures to 1 of 6 individuals (Individual #1), in the survey sample.

The findings included;

Individual #1 was originally admitted to the residence 12/1/16. The current diagnoses included; mild intellectual disability, traumatic brain injury, an organic mental disorder and left hemiparesis.

Individual #1's diet orders signed 9/3/19, read; 1800 calorie regular mechanical soft diet. Honey thick liquids/Tin liquids with Provale cup.

On 1/22/19, at approximately 5:45 p.m., during the dinner meal, Direct Support Personnel (DSP) #2 plated Individual #1's meal which consisted of chicken cutlet with gravy, collards, and peaches.

DSP #2 was asked for the recorded temperatures for the meal currently being served. DSP #2

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W 473	. Continued From page 11 stated the warmer was supposed to heat to 140 degrees but the food which had been on the warmer for three hours had not reached 140 degrees. DSP #2 obtained a temperature of the collards which read 128 degrees, and the chicken gravy temperature reading was 112 degrees. DSP #2 plated Individual #1's meal and readied it to serve. DSP #2 again asked "Can I serve the food at this temperature?" DSP #2 further stated I'm certain we were told 105 degrees is the correct serving temperature. Before DSP #2 prepared any additional meals the food was removed from the warmer and put in the oven until the chicken and gravy reached 150 degrees and the greens reached 145 degrees. DSP #3 informed DSP #2 the holding temperature for hot foods was 140 degrees or above and cold food was 41 degrees or below. On 1/23/20 at approximately 4:45 p.m., the above findings were shared with the two Residential Managers, the Administrator, the Corporate Nurse and two Qualified Intellectual Disabilities Professionals. Residential Manager #1 stated 105 degrees is the facility's recommended serving temperature and that the warmer had been assessed for maintaining temperatures at or above 140 degrees and no problem had been identified. The facility's policy with a revision date 3/18/19 included: Hot food holding temperature: Once food is cooked to the proper internal temperature, hot food will be maintained at 140 degrees or above. Use a thermometer to ensure proper temperature is maintained.	W 473	The Staff who prepared the food at the improper temperature will be retrained on the proper food holding temperatures and proper food plating temperatures. All staff will be retrained on the proper food holding temperatures and proper food plating temperatures. Potentially Hazardous Foods will be prepared at their proper temperature and maintained at 140 degrees. Staff will test the temperature and document the temperature of the food prior to plating the food to ensure the food was maintained at least at 140 degrees. The Food Preparation and Storage policy will be reviewed and updated with the changes. The Food Manager or designee will conduct random spot checks to ensure temperature checks are being completed.	2/28/20 2/28/20 2/28/20 2/28/20