City of Virginia Beach

DEPARTMENT OF HUMAN SERVICES
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ADMINISTRATION
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VIRGINIA BEACH, VA 23462-2591

October 23, 2020

Laura S. Veuhoff, Long Term Care Supervisor
Division of Long Term Care Services
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond VA 23233-1463

RE: Indian River Residence B
2533 Lifetime Cir, Virginia Beach VA 23456
Provider Number: 49G061

Dear Ms. Veuhoff:

Enclosed please find our completed copy of the CMS 2567, Statement of Deficiencies and Plan of Correction, for the above-named facility in response to the Medicaid Survey completed on October 8, 2020.

Sincerely,

Tom Nicholson
ICF Administrator

Donald R. Kirtland, Ph.D.
Deputy Director – Continuous Quality Improvement

Enclosure

cc: Tom Nicholson, ICF Administrator
Tim Capoldo, Developmental Services Division Director
Aileen Smith, Deputy Director, Department of Human Services
Donald R. Kirtland, Deputy Director of Continuous Quality Improvement

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G061	A. BUILDING _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE B	2533 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/6/20 through 10/8/20. The facility was not in substantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency	E 006	On 9/24/20, the Supervisor II instituted a procedure for actively screening visitors who must enter the facility, including vendors, contracted custodial personnel and repair persons, for symptoms of COVID. The Sign-In/ Screening procedure was emailed to all facility staff, who were asked to review the procedure and were given an opportunity to ask questions. A copy of the Sign-In/ Screening procedure was placed in the facility's Communication Binder, with a signature page for all staff to sign, indicating that they read and understood the procedure. All facility staff completed the procedure review and sign-off, indicating their understanding by 9/30/20.	9/30/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Nicholson per Tim Cyplelo — TITLE: ICF Administrator — (X6) DATE: 10/05/2020

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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E 006	Continued From page 1 Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility staff failed to identify Active Screening strategies for outside visitors and vendors to address COVID-19 as an emergency event. The findings included: During the Emergency Preparedness review at 9:54 A.M. on 10/07/20 with the Supervisor II, she stated the Emergency Preparedness Plan was updated on May 18, 2020.	E 006	On 10/7/20, other staff present witnessed the staff person completing the Sign-In/ Screening procedure with the stove repair vendor and placing his completed screening form in the envelope. The staff and residents then moved to another area of the house to distance while the repair person completed his work. Since his Screening form was not found in the envelope the next day, we are unsure if the vendor may have retrieved his Screening form from the envelope when he signed out and exited the facility. The Supervisor II will provide all facility staff with clarification of the Sign-In/ Screening procedure. This will include instruction for staff to remain present while the visitor/ vendor completes all steps of the Sign-In/ Screening process, so that they witness the visitor/ vendor sign the Visitor's Log, complete the Screening form, review the Screening form, and then ensure that the Screening form is placed in the labeled envelope. A cover page will be placed on the labeled envelope instructing visitors/ vendors not to remove their completed Screening form from the envelope. The Emergency Preparedness policy was updated to include the screening process. The Sign-In/ Screening procedure includes having the visitor: 1) Wear a mask at all times while in the facility; 2) Clean their hands with alcohol-based hand sanitizer upon entry; 3) Complete a temperature check upon entry; 4) Sign the Visitor's Log; 5) Complete a Screening form for symptoms of COVID; and 6) Maintain social distancing from residents and staff while in the facility. Any visitor answering "yes" to any of the questions on the Screening form for symptoms of COVID-19 will be asked to immediately leave the facility.	10/30/20 9/30/20

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E 006	Continued From page 2 A review of a risk assessment dated 3/16/20 indicated: Alert Type- Infectious Disease Outbreak - Event Summary: "Due to the COVID-19 pandemic all visitation and community outings have been suspended starting 3/17/20. Day Support was suspended starting 3/2/20. Resident's vitals will be monitored daily. All staff will take their temperature prior to their shift to ensure they do not have a temperature greater than 100 degree F. Letters have been mailed to AR/LG (authorized representatives/legal guardians) informing them of the pandemic, our precautions and our restrictions. Updated letters are sent on a regular basis. This restrictions will remain in place and will be reviewed on a regular basis in accordance with the recommendations from our regulatory agencies, CDC (Center for Disease Control) and VDH (Virginia Department of Health)." The following information in this paragraph was contributed to the deficient practice by Surveyor 2: A review of a Visitor's sign in/out form indicated various outside vendors were entering the facility from 03/20/20 through 9/23/20 without COVID-19 screening. On 9/23/20, the facility implemented a plan to conduct active COVID-19 screening for vendors that entered the facility. On 10/07/20, a vendor entered the facility to repair the stove. There was no evidence that COVID-19 Active Screening was conducted for this particular vendor. On 10/8/20 at approximately 3:30 p.m., the Supervisor II stated the process was that after the screening, the entering visitor/vendor is responsible for filling out the screening form and the form is then placed in a large envelope. The screening form could not be located by the Supervisor.	E 006	Additionally, the Program Patient Population section of Emergency Preparedness policy was updated to include information about individuals with respiratory compromise who may be at increased risk for COVID-19 or other infectious respiratory disease. Strategies for addressing COVID-19 were also added to the "Strategies to Provide Support During an Emergency" form referenced in the policy. All facility staff will receive their annual emergency preparedness training and testing in November. This training will include review of the above-stated policy revisions. Effective immediately, in order to ensure the Sign-In/ Screening process is being properly implemented, the House Manager will observe staff completing the Sign-In/ Screening procedure with vendors/visitors at least twice per week. In addition, the Supervisor II will complete spot-checks of documentation at least monthly, comparing names on the Visitor Sign-In Log with completed Screening forms.	9/30/20 11/8/20 ongoing

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E 006		E 006		

Continued From page 3

During an interview at 10:18 A.M. on 10/07/20 with the Supervisor II she stated, the agency attorney had sent out an email indicating that the facility could not take and record temperatures of visitors or outside vendors.
A review of an email document dated March 27, 2020 indicated: Temperature Checks- "We cannot take staff temperatures."

CDC recommendation for Active Screening included: Screen everyone entering the healthcare facility for symptoms consistent with COVID-19.
Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature > 100.0 F or subjective fever.
Ask them if they have been advised to self-quarantine because of exposure to someone with COVID-19.
Properly manage anyone with symptoms of COVID-19 or who has been advised to self- quarantine. According to the CDC, COVID-19 symptoms may include, but are not limited to the following: fever, cough, shortness of breath, headache, new loss of taste or smell, congestion or runny nose, sore throat, diarrhea, myalgia (muscle aches, body aches) tiredness or fatigue.

A review of the facility's Infection Control Procedures: Pandemic Influenza - indicated: Implement visitor restrictions, per CDC guidelines: wear a mask when visiting the ICF. Upon arrival temperatures will be taken and recorded.

The facility Supervisor II was asked why the

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E 006	Continued From page 4 facility's Infection control procedures were not implemented, she stated they were following the guidance of there legal advisor.	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's	E 013	During afternoon shift change on 9/23/20, the Supervisor II verbally reviewed the Sign-In/ Screening procedure to be used going forward for actively screening visitors entering the facility with the nine staff who were present. On 9/24/20, the Supervisor II instituted the written procedure for actively screening visitors, including vendors, contracted custodial personnel and repair persons, for symptoms of COVID. The Sign-In/ Screening procedure was emailed to all facility staff, who were asked to review the procedure and were given an opportunity to ask questions. A copy of the Sign-In/ Screening procedure was placed in the facility's Communication Binder, with a signature page for all staff to sign, indicating that they read and understood the procedure. All facility staff reviewed and signed-off on the procedure, indicating their understanding.	9/30/20

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E 013	Continued From page 5 geographic area. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to implement Active Screening strategies for outside visitors and vendors to address COVID-19 as an emergency event. The findings included: During the Emergency Preparedness review at 10:30 A.M. on 10/07/20 with the Supervisor II, she stated the Emergency Preparedness Plan was up dated on May 18, 2020. A review of a risk assessment dated 3/16/20 indicated: Alert Type- Infectious Disease Outbreak - Event Summary: "Due to the COVID-19 pandemic all visitation and community outings have been suspended starting 3/17/20. Day Support was suspended starting 3/2/20. Resident's vitals will be monitored daily. All staff will take their temperature prior to their shift to ensure they do not have a temperature greater than 100 degree F. Letters have been mailed to AR/LG (authorized representatives)/ (legal guardians) informing them of the pandemic, or precautions and our restrictions. Updated letters are sent on a regular basis. This restrictions will remain in place and will be reviewed on a regular basis in accordance with the recommendations from our regulatory agencies, CDC (Center for Disease Control) and VDH (Virginia Department of Health)." The following information in this paragraph was contributed to the deficient practice by Surveyor 2: A review of a Visitor's sign in/out form indicated	E 013	On 10/7/20, other staff present witnessed the staff person completing the Sign-In/ Screening procedure with the stove repair vendor and placing his completed screening form in the envelope. The staff and residents then moved to another area of the house to distance while the repair person completed his work. Since his Screening form was not found in the envelope the next day, we are unsure if the vendor may have retrieved his Screening form from the envelope when he signed out and exited the facility. The Supervisor II will provide all facility staff with clarification of the Sign-In/ Screening procedure. This will include instruction for staff to remain present while the visitor/ vendor completes all steps of the Sign-In/ Screening process, so that they witness the visitor/ vendor sign the Visitor's Log, complete the Screening form, and review the Screening form, and then ensure that the Screening form is placed in the labeled envelope. A cover page will also be added to the labeled envelope instructing visitors/ vendors not to remove their completed Screening form from the envelope. The Emergency Preparedness policy was updated to include the screening process. The Sign-In/ Screening procedure includes having the visitor: 1) Wear a mask at all times while in the facility; 2) Clean their hands with alcohol-based hand sanitizer upon entry; 3) Complete a temperature check upon entry; 4) Sign the Visitor's Log; 5) Complete a Screening form for symptoms of COVID; and 6) Maintain social distancing from residents and staff while in the facility. Any visitor answering "yes" to any of the questions on the Screening form for symptoms of COVID-19 will be asked to immediately leave the facility.	10/30/20 9/30/20

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E 013	Continued From page 6 various outside vendors were entering the facility from 03/20/20 through 9/23/20 without COVID-19 screening. On 9/23/20, the facility implemented a plan to conduct active COVID-19 screening for vendors that entered the facility. On 10/07/20, a vendor entered the facility to repair the stove. There was no evidence that COVID-19 Active Screening was conducted for this particular vendor. On 10/8/20 at approximately 3:30 p.m., the Supervisor II stated the process was that after the screening, the entering visitor/vendor is responsible for filling out the screening form and the form is then placed in a large envelope. The screening form could not be located by the Supervisor. During an interview at 10:48 A.M. on 10/07/20 with the Supervisor II she stated, the agency attorney had sent out an email indicating that the facility could not take and record temperatures of visitors or outside vendors. A review of an email document dated March 27, 2020 indicated: Temperature Checks- "We cannot take staff/visitors temperatures." CDC recommendation for Active Screening included: Screen everyone entering the healthcare facility for symptoms consistent with COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature > 100.0 F or subjective fever. Ask them if they have been advised to self-quarantine because of exposure to someone with COVID-19. Properly manage anyone with symptoms of COVID-19 or who has been advised to self- quarantine.	E 013	All facility staff will receive their annual emergency preparedness training and testing in November. This training will include review of the above-stated policy revisions. Effective immediately, in order to ensure the Sign-In/ Screening process is being properly implemented, the House Manager will observe staff completing the Sign-In/ Screening procedure with vendors at least twice per week. In addition, the Supervisor II will complete spot-checks of documentation at least monthly, comparing names on the Visitor Sign-In Log with completed Screening forms.	11/8/20 ongoing

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E 013	Continued From page 7 According to the CDC, COVID-19 symptoms may include, but are not limited to the following: fever, cough, shortness of breath, headache, new loss of taste or smell, congestion or runny nose, sore throat, diarrhea, myalgia (muscle aches, body aches) tiredness or fatigue. A review of the facility's Infection Control Procedures: Pandemic Influenza - indicated: Implement visitor restrictions, per CDC guidelines: wear a mask when visiting the ICF (Intermediate Care Facility). Upon arrival temperatures will be taken and recorded, they will be instructed to wash their hands, complete a temperature check, and self-report if they have symptoms of the emerging infectious disease. If asymptomatic, the visitor will be offered an area distance from remainder of residents, such visitor must sign in in case contact tracing becomes necessary. Any approved visitor that is symptomatic or has an elevated temperature of 100.0 F for higher when they arrive will be turned away. If the ICF's are under a 'No visitation and no community outing" status, this will include no home visits. Delivery persons will be instructed to unload supplies outside of the facility entrance and vendors will be instructed to complete their work outside, whenever possible. For vendors or repair persons who must enter the facility, the above process will used. The facility Supervisor II was asked why the facility's Infection control procedures were not implemented, she stated, they were following the guidance of there legal advisor.	E 013		

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E 013	Continued From page 8 The facility staff failed to implement Active Screening strategies for addressing COVID-19 for visitors and outside vendors.	E 013		
E 036	EP Training and Testing CFR(s): 483.475(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals a t §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain	E 036		

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E 036	Continued From page 9 an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to ensure all staff were trained and tested on the Emergency Preparedness Plan. The findings included: During the Emergency Preparedness Plan review at 11:10 A.M. on 10/07/20 with the Supervisor II, a list of employees identification numbers were selected for testing and training review. Employees were noted to sign in daily by their respective employee identification number.	E 036	On 9/28/20, the Supervisor II reviewed the Sign-In/ Screening procedure with the contracted custodian staff who is routinely assigned to the facility. This review included the requirement to wear a mask at all times while in the facility.	9/28/20

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E 036	Continued From page 10 One such employee number was identified by the Supervisor II as an outside vendor employee who was contracted for cleaning services. The Supervisor II was asked if this person worked at the facility on a weekly schedule and she stated, "Yes." A review of the employee sign in form for the previous 6 months indicated this employee had worked at the facility on a weekly schedule. The Supervisor II stated, this employee was not tested nor trained in the facility's Emergency Preparedness Plan because she was an outside vendor employee. The Supervisor II was asked if this employee would be responsible for ensuring COVID-19 recommended guidance was being followed. She stated, "Yes." The Supervisor II was asked who trained the employee on the facility's policy and procedures for Infection Control as it related to COVID-19. The Supervisor II stated she did not know. When asked who trained this employee on hand washing and the process for use and storage of masks, she stated, she did not know.	E 036	Contracted custodian staff who are routinely assigned to the facility will receive training and testing on the Emergency Preparedness policy and the Infection Control policy, focusing on COVID 19 and the use of appropriate PPE. Initial training and testing will occur by 11/18/20 and then annually thereafter. New contracted custodian staff will be informed of any infection control protocols that must be immediately adhered to when they begin work at the facility and will receive training and testing on emergency preparedness within 15 days of being routinely assigned to the facility, with their annual training then occurring each year in November. Throughout the year, contracted custodian staff will receive an in-service on any significant revisions to the plan applicable to them, which will be documented on a Training Attendance Roster.	11/8/20 ongoing
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 10/6/20 through 10/8/20. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 5 bed certified facility was 4 at	W 000		

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W 000	Continued From page 11 the time of the survey. The survey sample consisted of 3 Individual reviews (Individuals #1 through #3).	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observations, staff interviews, record review, and review of facility documentation, the facility staff failed to ensure an allegation of neglect was immediately reported to the administrator or designated official for 1 of 3 Individuals (Individual #3) in the survey sample. The findings included: Individual #3 was admitted to the Intermediate Care Facility for Individuals with Intellectual Disabilities on 2/25/14 with diagnoses that included profound intellectual disability, history of falls and fractured finger in 2016, severe hearing loss and blindness. Upon review of Individual #3's nurse's notes dated 11/19/19 at 8:30 a.m., the individual was found by the staff lying on the floor. The nurse's note indicated that staff was questioned and the fall was unwitnessed. Licensed Practical Nurse (LPN) #1 who wrote the nurse's note was not available for interview during the survey to	W 153		

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W 153	Continued From page 12 determine what staff was questioned, who found the individual on the floor, or why the incident was not reported to the Administrator. The Fall Risk Assessment dated 11/20/19 identified Individual #3 had a history of falls with a recent fall on 11/19/19 in the living area, but that it was noted the fall occurred while she was walking and staff was within eyesight. This entry was not in alignment with the above nurse's note, where it indicated the Individual was found on the floor in the living room. There was no incident report that documented the details surrounding the fall of 11/19/19. During an interview with Supervisor II and the Qualified Intellectual Disabilities Professional (QIDP) on 10/8/20 at 2:00 p.m., she stated there was no investigation of the incident, nor did she know which staff member actually found Individual #3 on the floor. They stated per their policy, the incident should have been reported to them, the Administrator, Medical Director and Continuous Quality Improvement Office (CQI) followed by submission of the incident report. The following phone interviews were conducted with the morning staff that worked on 11/19/19: On 10/8/20 at 3:00 p.m., Direct Support Professional (DSP) #4 stated she was assigned to Individual #3, but was not the one that found her on the floor, but remembered the incident. She stated if the Individual was placed in the black recliner, she had a tendency to reposition herself "side ways", lean down to touch the mat that was placed in the front of the chair for safety and at times would slide out of the chair to the floor on the mat, but did not know the	W 153	On 10/20/19, while Continuous Quality Improvement (CQI) staff was investigating a separate incident, the CQI staff received information about a fall that occurred on 11/19/19. The CQI staff brought this to the Supervisor II's attention and asked if it had been reported. It had not. The House Manager who was present with Individual #3 at the time of the 11/19/19 fall erroneously believed that the fall did not need to be reported since Individual #3 was not injured. At that time, as part of the facility's internal action plan, on 11/20/19, the Supervisors II provided instruction to all facility supervisors and nurses that all falls, regardless of whether they result in injury, must be reported to the Facility Administrator or designee to ensure that fall is investigated and an incident report must be completed. On 10/21/20, the QIDP added an addendum to the entry in the fall risk assessment for the fall on 11/19/19 to provide clarifying information. The addendum indicated that Individual #3 was seated in the recliner in the living room. The staff present was nearby but had briefly turned her back to Individual #3. The staff person heard a sound, then turned around to find Individual #3 on the floor near the chair. The QIDP will update Individual #3's fall prevention plan and Physical Management Plan to indicate that the floor pad that is placed in front of the chair where Individual #3 sits is to assist the individual, who is blind and deaf, with identifying grades and surfaces on the floor. The QIDP will provide training on this to all facility staff.	10/21/20 11/13/20

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W 153	Continued From page 13 circumstances around the 11/19/19 fall. She said the Individual was blind and deaf, but would independently stand and the mat would be there on the floor for protection in front of any chair in case she fell. On 10/8/20 at 3:25 p.m., DSP #5 stated, "I went to the other house briefly and when I returned the House Manager stated she found (Individual #3) on the floor in the living room, but she was back up in the chair when I got back." She stated, the individual required "eyes on" while in the living areas and every 30 minute checks in bed because she would abruptly try to stand at times. On 10/8/20 at approximately 3:40 p.m., the House Manager stated she worked on that Tuesday, but did not remember anything about a fall and or finding Individual #3 on the floor. She stated the floor pad was in place in front of whatever chair the Individual sat in to protect her if she fell. The DSP running documentation record titled "Weekly ICF Review Form" from 11/03/19 through 11/19/19 did not address the unwitnessed fall. On 10/8/20 at 4:00 p.m., the QIDP stated the mat was not intended to cushion Individual #3's falls or slips to the floor, but to help the Individual identify grades and surfaces on the floor since she was blind. She stated, "The incident was not reported to her or the administrative staff as it should have been, thus the specifics of the fall was not investigated or addressed." The Physical Therapy Assessment Report dated 10/22/19 did not identify the fall on 11/19/19.	W 153	In addition to Individual #3 who is at high fall risk, all other residents of the facility are at fall risk. One resident is at moderate fall risk and two others are at high fall risk. All facility staff will receive annual training on incident reporting and required follow-up, to include reporting of all falls. Additionally, as part of the facility's current practice, the Supervisor II provides instruction to all facility supervisors and nurses on incident reporting procedures upon hire and when there are revisions. These instructions address reporting requirements and follow-up required for of all types of incidents, including falls. Whenever the City or facility revises the incident reporting form or procedures, the Supervisor II updates these instructions and provides them to all facility supervisors and nurses. To ensure the solutions are sustained, instructions on the facility's Shift Report form will be revised. The form's instructions will be updated to instruct staff to immediately report to the supervisor on duty any incident that occurs with a resident, including any falls, and to document on the Shift Report. Each shift, the oncoming staff will meet with the out-going staff to review information on the Shift Report and to sign the report. The instruction on the Shift Report will serve as a visual reminder to staff on each shift of the need to report and to ensure all staff are aware of any falls or other incidents that may have occurred.	11/22/20 ongoing 11/13/20

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W 153	Continued From page 14 Additionally, the Person-Centered Quarterly Review dated 12/1/19 through 2/29/20, the Person Centered Assessment dated 11/21/19, the Treatment Plan dated 12/1/19 through 11/30/20, or the Physical Management Plan dated 12/1/19. All of the aforementioned reviews and assessments identify that Individual #3 was at high risk for falls. No further information was provided by the facility staff.	W 153		
W 362	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to obtain input from the pharmacist on each individuals drug regimen review at least quarterly for three individuals (Individual #1, #2, and #3) in the survey sample of four individuals. The findings included: 1. Individual #1 was admitted to the facility in January 2015 with diagnoses which included Profound Intellectual Disorder, PICA, Autism Spectrum Disorder, Hypertension, Chronic Eczema, Blepharitis, Hyperopia, Seasonal Allergies, History of Constipation, Basal Gangliar Dysfunction, Dysphagia (due to high palate) Other: History of lower back spasms, History of left chin cyst (benign), History of Insomnia, Past	W 362	On 10/10/20, copies of documentation required for the Consultant Pharmacist to complete Pharmacy Reviews for all residents of the facility were delivered to his office. The Consultant Pharmacist completed the drug regimen reviews for all residents of the facility on 10/12/20. Going forward, drug regimen reviews will be completed quarterly for all residents of the facility. If visitor restrictions remain in place or are put in place in the future, documentation required by the Consultant Pharmacist to complete the quarterly Pharmacy Reviews will be faxed or hand-delivered to his office to be completed off-site.	10/12/20 ongoing

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W 362	Continued From page 15 DX of ADHD, at risk for Osteopenia. The review of the Pharmacist Record of Medication Regimen Review dated 2/13/20 was the last quarterly review. Individual #1 was noted to receive the medications Culturelle Sprinkle Capsule, Docusate sodium (Colace) 100 mg Cap, Miralax Powder, Omeprazole 20 mg capsule, Loratadine (Claritin) 10 mg tab, and Valium 10 mg PRN (as needed). During an interview at 2:15 P.M. on 10/07/20 with the ID-Supervisor II, she stated, due to the COVID-19 pandemic the pharmacist had not visited the facility or reviewed the drug regimens. 2. Individual #2 was admitted to the ICF/IID on 9/13/17 with diagnoses that included profound intellectual disability, cerebral palsy, seizure disorder and spastic quadriplegia. Upon review of the Individual's Record of Medication Regiment Reviews, the last record of the review of medications was 2/13/20, revealing the May 2020 and August 2020 medication regimen reviews by the pharmacy consultant were not conducted as required. On 9/20/17, Individual #2 was ordered Keppra 100 milligrams (mg) twice a day (BID), Valproic acid 250 mg/ml BID and Clobazam 10 mg BID. All three medications require ongoing close monitoring and review to ensure maintenance of the individuals health and medication management. On 10/8/20 at approximately 1:00 p.m., the Supervisor II stated due to the Global Pandemic	W 362	To prevent reoccurrence, two weeks prior to each quarterly due date, the RN Supervisor or designee will email the Consultant Pharmacist, reminding him of the due date and requesting a reply to inform the facility of the date he intends to visit. If visitation restrictions are in place, the RN Supervisor or designee will confirm when required documentation will be faxed or delivered to him. On or immediately following the intended completion date, the RN Supervisor will check each chart to ensure that the quarterly drug regimen review has been completed. If the review has not been completed by the intended date, the RN Supervisor or designee will contact the Consultant Pharmacist to confirm an alternate date within the required timeframe. She will again check the charts and continue to communicate with the pharmacist as needed to ensure the review takes place within required timeframe.	ongoing ongoing

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W 362	Continued From page 16 and restriction of visitors, they had not considered making arrangements for the consultant pharmacist to review any of the individual's medication regimens onsite or remotely. 3. Individual #3 was admitted to the ICF/IID on 8/25/15 with diagnoses that included profound intellectual disability, hypothyroidism and bipolar disorder. Upon review of the Individual's Record of Medication Regiment Reviews, the last record of the review of medications was 2/13/20, revealing the May 2020 and August 2020 medication regimen reviews by the pharmacy consultant were not conducted as required. On 8/25/15, Individual #3 was ordered levothyroxine 75 mcg daily on an empty stomach for hypothyriodism, the anti-psychotic Risperidone 0.5 milligram (mg) at bedtime and the anti-convulsant divalproex 250 mg three times a day (TID) for the treatment of bipolar disorder. All of the aforementioned medications require ongoing close monitoring and review to ensure maintenance of the individual's health and medication management. On 10/8/20 at 1:00 p.m., the Supervisor II stated due to the global pandemic and restriction of visitor, they had not considered making arrangements for the consultant pharmacist to review any of the individual's medication regimens onsite or remotely.	W 362		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under	W 441		

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W 441	Continued From page 17 varied conditions. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to conduct evacuation drills during various times of the day or night. The findings included: During a review of the fire drills the following was revealed: The facility had evacuation drills on the following shift: (6:00 A.M.-1:59 P.M.) Fire Drills were conducted on 7/10/20 at 1:07 P.M., 4/10/20 at 1:20 P.M., 1/10/20 at 12:45 P.M., 10/11/19 at 8:50 A.M., and 7/17/19 at 1:58 P.M. Four of the five drills conducted were between 12:45 P.M. and 1:58 P.M. The facility had evacuation drills on the following shift: (2:00 P.M. - 10:59 P.M.) Fire Drills were conducted on 8/13/20 at 5:15 P.M., 5/7/20 at 5:00 P.M., 2/15/20 at 2:06 P.M., 11/4/19 at 2:06 P.M., 8/14/19 at 2:42 P.M., and 5/8/19 at 2:40 P.M. Four of the six drills conducted were between 2:06 P.M. and 2:40 P.M. The facility had evacuation drills on the following shift: (11 P.M.- 5:59 A.M.) Fire Drills were conducted on 9/17/20 at 5:15 A.M., 6/13/20 at 5:35 A.M., 3/6/20 at 5:00 A.M., 12/13/20 at 11:00 P.M., 9/24/19 at 5:05 A.M., and 6/12/19 at 5:18 A.M. Five of the six drills conducted were between 5:00 A.M. and 5:35 A.M. A review of the facility's policy and procedures for Conducting Fire/Safety Drills up-dated 2/18 indicated:	W 441	To ensure that evacuation drills occur at various times throughout the day and night, the Supervisor II developed an Evacuation Drill Schedule for the year, assigning an approximately 2.5 hour block in which the evacuation drill is scheduled to be completed each month. The Supervisor II will review the Evacuation Drill Schedule and the process with the House Managers and their designees who complete evacuation drills. The Evacuation Drill Schedule is located in the front of the fire drill section of the Safety and Health Binder. Each month, the House Manager (or designee responsible for completing the evacuation drill) will check the Evacuation Drill Schedule and complete the drill within the assigned timeframe. After completing the drill, they will note the date and time the drill was completed in the designated space on the Evacuation Drill Schedule form and initial. If a drill could not be completed within the assigned timeframe, they will inform the Supervisor II so the schedule for future drills may be adjusted. This process will begin with the November 2020 evacuation drill.	10/21/20 11/13/20

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W 441	Continued From page 18 Policy- It is the policy of the ICF/IID Program to conduct Fire drills at the facility once per month and Safety drills quarterly. The Community Living Manager and staff will be responsible for conducting, monitoring, and documenting each drill including putting the fire alarm system in and out of test. Procedures: 1. A Fire and Safety Drill will be conducted monthly, on varying shifts. during varying times, and during various weather conditions (e.g. rain, snow, cold. hot, etc.). During an interview with the Supervisor II on 10/08/20 at 1:45 P.M. she stated, the staff failed to conduct a fire drill on each shift during various times.	W 441	Each month, the Supervisor II will check the fire drill forms and Evacuation Drill Schedule form to verify that the drills are being completed at various times throughout the day and night.	ongoing
W 455	INFECTION CONTROL CFR(s): 483.470(I)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to implement Active Screening strategies for outside visitors and vendors to address COVID-19 as an emergency event. The findings included: During Emergency Preparedness review at 9:45 A.M. on 10/07/20 with the Supervisor II the she	W 455		

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W 455	Continued From page 19 stated the Emergency Preparedness Plan was updated on May 20, 2020. A review of a risk assessment dated 3/16/20 indicated: Alert Type- Infectious Disease Outbreak - Event Summary: "Due to the COVID-19 pandemic all visitation and community outings have been suspended starting 3/17/20. Day Support was suspended starting 3/2/20. Resident's vitals will be monitored daily. All staff will take their temperature prior to their shift to ensure they do not have a temperature greater than 100 degree F. Letters have been mailed to AR/LG (authorized representatives/legal guardians) informing them of the pandemic, or precautions and our restrictions. Updated letters are sent on a regular basis. This restrictions will remain in place and will be reviewed on a regular basis in accordance with the recommendations from our regulatory agencies, CDC (Center for Disease Control) and VDH (Virginia Department of Health)." The following information in this paragraph was contributed to the deficient practice by Surveyor 2: A review of a Visitor's sign in/out form indicated various outside vendors were entering the facility from 03/20/20 through 9/23/20 without COVID-19 screening. On 9/23/20, the facility implemented a plan to conduct active COVID-19 screening for vendors that entered the facility. On 10/07/20, a vendor entered the facility to repair the stove. There was no evidence that COVID-19 Active Screening was conducted for this particular vendor. On 10/8/20 at approximately 3:30 p.m., the Supervisor II stated the process was that after the screening, the entering visitor/vendor is responsible for filling out the screening form and	W 455	During afternoon shift change on 9/23/20, the Supervisor II verbally reviewed the Sign-In/ Screening procedure to be used going forward for actively screening visitors entering the facility with the nine staff who were present. On 9/24/20, the Supervisor II instituted the written procedure for actively screening visitors, including vendors, contracted custodial personnel and repair persons, for symptoms of COVID. The Sign-In/ Screening procedure was emailed to all facility staff, who were asked to review the procedure and were given an opportunity to ask questions. A copy of the Sign-In/ Screening procedure was placed in the facility's Communication Binder, with a signature page for all staff to sign, indicating that they read and understood the procedure. All facility staff reviewed and signed-off on the procedure, indicating their understanding, by 9/30/20. On 10/7/20, other staff present witnessed the staff person completing the Sign-In/ Screening procedure with the stove repair vendor and placing his completed screening form in the envelope. The staff and residents then moved to another area of the house to distance while the repair person completed his work. Since his Screening form was not found in the envelope the next day, we are unsure if the vendor may have retrieved his Screening form from the envelope when he signed out and exited the facility.	9/30/20

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W 455	Continued From page 20 the form is then placed in a large envelope. The screening form could not be located by the Supervisor. During an interview at 10:48 A.M. on 10/07/20 with the Supervisor II she stated, the agency attorney had sent out an email indicating that the facility could not take and record temperatures of visitors or outside vendors. A review of an email document dated March 27, 2020 indicated: Temperature Checks- "We cannot take staff/visitors temperatures." CDC recommendation for Active Screening included: Screen everyone entering the healthcare facility for symptoms consistent with COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature > 100.0 F or subjective fever. Ask them if they have been advised to self-quarantine because of exposure to someone with COVID-19. Properly manage anyone with symptoms of COVID-19 or who has been advised to self- quarantine. According to the CDC, COVID-19 symptoms may include, but are not limited to the following: fever, cough, shortness of breath, headache, new loss of taste or smell, congestion or runny nose, sore throat, diarrhea, myalgia (muscle aches, body aches) tiredness or fatigue. A review of the facility's Infection Control Procedures: Pandemic Influenza - indicated: Implement visitor restrictions, per CDC guidelines: wear a mask when visiting the ICF (Intermediate Care Facility). Upon arrival	W 455	The Supervisor II will provide all facility staff with clarification of the Sign-In/ Screening procedure. This will include instruction for staff to remain present while the visitor/ vendor completes all steps of the Sign-In/ Screening process, so that they witness the visitor/ vendor sign the Visitor's Log, complete the Screening form, and then ensure that the Screening form is placed in the labeled envelope. A cover page will also be added to the labeled envelope instructing visitors/ vendors not to remove their completed Screening form from the envelope. The Emergency Preparedness policy was updated to include this screening process. The Sign-In/ Screening procedure includes having the visitor: 1) Wear a mask at all times while in the facility; 2) Clean their hands with alcohol-based hand sanitizer upon entry; 3) Complete a temperature check upon entry; 4) Sign the Visitor's Log; 5) Complete a Screening form for symptoms of COVID; and 6) Maintain social distancing from residents and staff while in the facility. Any visitor answering "yes" to any of the questions on the Screening form for symptoms of COVID-19 will be asked to immediately leave the facility. All facility staff will receive their annual emergency preparedness training and testing during the month of November. This training will include review of the above-stated policy revisions.	10/30/20 9/30/20 11/8/20

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W 455	Continued From page 21 temperatures will be taken and recorded, they will be instructed to wash their hands, complete a temperature check, and self-report if they have symptoms of the emerging infectious disease. If asymptomatic, the visitor will be offered an area distance from remainder of residents, such visitor must sign in in case contact tracing becomes necessary. Any approved visitor that is symptomatic or has an elevated temperature of 100.0 F for higher when they arrive will be turned away. If the ICF's are under a 'No visitation and no community outing" status, this will include no home visits. Delivery persons will be instructed to unload supplies outside of the facility entrance and vendors will be instructed to complete their work outside, whenever possible. For vendors or repair persons who must enter the facility, the above process will used. The facility Supervisor II was asked why the facility's Infection control procedures were not implemented, she stated they were following the guidance of there legal advisor.	W 455	Effective immediately, in order to ensure the Sign-In/ Screening process is being properly implemented, the House Manager will observe staff completing the Sign-In/ Screening procedure with vendors at least twice per week. In addition, the Supervisor II will complete spot-checks of documentation at least monthly, comparing names on the Visitor Sign-In Log with completed Screening forms.	ongoing
W 463	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to have the Interdisciplinary Team (IDT) including the Dietitian to review the	W 463		

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W 463		W 463		

Continued From page 22

nutritional and health status for two Individuals (Individual #1 and #2) which described relevant nutritional interventions for the individual's diet, in the survey sample of four individuals.

The findings included:

1. Individual #1 was admitted to the facility in January 2015 with diagnoses which included Profound Intellectual Disorder, PICA, Autism Spectrum Disorder, Hypertension, Chronic Eczema, Blepharitis, Hyperopia, Seasonal Allergies, History of Constipation, Basal Gangliar Dysfunction, Dysphagia (due to high palate) Other: History of lower back spasms, History of left chin cyst (benign), History of Insomnia, Past DX of ADHD, at risk for Osteopenia.

A weekly menu for the week of 10/2/20 through 10/07/20 indicated: Individual #1 was to receive 1/2 cup of Sorbet as part of his diet. (Sorbet) is a frozen dessert made from sugar-sweetened water with flavoring typically fruit juice, and fruit puree. A review of the menu during this week indicated that Individual #1 was to receive Sorbet 1/2 cup on 10/6/20 and 10/7/20 during the dinner meal.

Observations made by Surveyor #2 on 10/6/20 revealed that Individual #1 did not receive the 1/2 cup of Sorbet during dinner.

During an interview on 10/08/20 at 2:40 P.M. with the Licensed Practical Nurse (LPN), she stated after calling the dietary consultant Sorbet was being used as a summer menu to give extra hydration and bowel management. When asked if the Sorbet was a part of Individual #1's individual program plan the nurse stated, No.

1.

The Registered Dietitian (RD) will complete a revision to Individual #1's Nutrition Plan to indicate that a variety of fruits and vegetables will be provided for hydration and bowel management. The RD will update the menu to indicate substitutions within the same food group that may be made when Sorbet or another fruit item on the menu is unavailable. 11/13/20

The Registered Dietitian is revising the menus for all other residents to indicate substitutions within the same food group that may be made when Sorbet or another fruit item on the menu is unavailable. 11/13/20

All facility staff will receive virtual training from the Registered Dietitian on appropriate substitutions within the same food group that may be made when an item on the menu is unavailable, as well as training on how to properly document food and fluid intake and substitutions on the menu. 11/20/20

To ensure substitutions and food and fluid intake are being made and documented correctly, the House Managers, who also serve as the facility's Food Service Managers, will regularly monitor meal preparation and mealtimes. Monitoring will occur at least three times per week. The observations will take place across shifts and with varying staff. In addition, the Supervisor II will complete spot-checks of meal preparation/mealtimes at least monthly to ensure compliance. ongoing

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W 463	Continued From page 23 A Nutrition Progress Note dated April 2020 did not include the use of Sorbet for hydration or constipation. A Nutrition Progress Note dated July 2020 did not include the use of Sorbet for hydration or constipation. When the Qualified Intellectual Development Professional (QIDP) was asked during an interview at 1:55 P.M. on 10/08/20 if the Dietitian had reviewed the dietary interventions with the IDT she stated, "No." She was not aware of the dietary interventions nor had the interventions been discussed during Individual #1's Quarterly IDT meeting in June of 2020 nor as resent as the annul IDT meeting which was conducted on 10/07/20. A review of Individual #1's physician orders indicated bowel management medications were administered due to a history of constipation to include: Culturelle sprinkle capsule 1 cap 1 time daily, Colace 100 mg cap 1 cap 2 times daily, and Bisacodyl 5 mg tab one tab 1 time daily. A Quarterly Nutrition Progress Note dated 7/31/20 indicated: "Individual #1 has been walking outside and has problems with chewing or swallowing. Diet Order: No added salt, ground consistency, cut up solids, thin liquids, yogurt twice a day, fibersource with breakfast. Skin intact- bowel-good." A Quarterly Nursing Assessment dated 7/31/20 indicated: Bowel Movement Pattern - average of 3 to 4 times weekly.	W 463		

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W 463	Continued From page 24 2. The Interdisciplinary Team (IDT) failed to develop a complete dietary plan that included whole milk to ensure caloric needs for Individual #2. During mealtime observations on 10/6/20 at 5:45 p.m., 10/7/20 at 12:05 p.m. and 10/8/20 at 12:13 p.m., Individual #2 was not offered milk. The menu listed 12 oz of Fat-free milk for each of these meals, as well as with the breakfast meal. The assigned Direct Support Professionals (DSPs) that assisted the individual during each of the aforementioned meals entered that "100%" of the meal was consumed to include 12 oz of Fat-free milk. There was no Fat-free milk observed in the refrigerator, only whole milk. The most recent Nutrition Assessment dated 6/4/20 indicated Individual #2's diet order included puree diet with thin liquids, water or juice with meals, Jevity 1.5 8 oz when less that 50% meal consumed via g-tube (feeding tube)followed by 200 ml water flush. It was recorded by the Registered Dietitian (RD) that the goal was to maintain a desirable body weight range of 80-95 pounds (lb) with 1000-1170 calories per day, protein 31-39 grams per day and fluids 1200 mls or 40 oz per day. Weight stable in the past four to seven months. Milk was not listed in the dietary plan. On 10/8/20 at 1:20 p.m., DSP #8 stated she gave Individual #2 12 oz of whole milk at breakfast. Supervisor II, QIDP and the Licensed Practical Nurse (LPN) joined the interview. Supervisor II stated there was no fat-free milk in the refrigerator, the QIDP stated if it was recorded 100% consumed written in on the menu for a specific meal, all of the items were consumed	W 463	2. The RD will complete a revision to the Nutrition Plan for Individual #2 to indicate that she will be recommending fat-free milk to meet Individual #2's dietary needs since her weight continues to remain stable. Fat-free milk will remain on Individual #2's menu. The instructions on Individual #2's menu will be updated to note that, per her Treatment Plan, Individual #2 prefers to drink her fluids after she has finished eating her meal and her fluids may be offered up to 20 minutes after she has finished eating. The RD will review the Nutrition Plans for all other residents of the facility and, if applicable, will provide a revised Nutrition Plan to indicate if a particular milk type is recommended for dietary or weight management purposes. The RD will check the menu of each resident to ensure it accurately reflects the recommended milk type. All facility staff will receive virtual training from the Registered Dietitian, which will include a review of the recommended milk type for each resident, as well as appropriate substitutions if the recommended milk type is not available. The training will also address as how to properly document fluid intake on the menu and how to document on the menu when fluids are refused.	11/13/20 11/13/20 11/20/20

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W 463	Continued From page 25 unless there was a substitution. The QIDP stated Individual #2 may have possibly been admitted from the previous facility on fat-free milk. This surveyor shared with the group that there were no substitutions for milk during the observed meals on 10/6, 7, and 8/20. The LPN stated she was going to place a call to the RD to find out if milk, fat-free or whole milk was recommended as a part of the Individual #2's dietary plan. They could not provide evidence that the milk had been addressed during the IDT meeting on 7/1/20 or the quarterly review on 9/30/20. On 10/8/20 at 1:55 p.m., the LPN returned with information from her phone call with the RD. She stated although it was not in the RD's plan, "The RD wants (Individual #2's name) to have the whole milk to maintain her weight. The milk keeps her weight managed if she is on cusp of losing weight." None of those in the interview could explain why fat-free milk was on the menu instead of whole milk as recommended by the RD, and or why the staff consistently recorded milk (fat-free or whole milk) consumed that was not observed given to Individual #2. The facility staff could not provide a health care, nursing or nutritional plan that was addressed during the annual or quarterly IDT meetings to include milk to support the individual's weight.	W 463	To ensure substitutions are being made and documented correctly and fluid intake is being documented accurately, the House Managers, who also serve as the facility's Food Service Managers, will regularly monitor meal preparation and mealtimes. Monitoring will occur at least three times per week. The observations will take place across shifts and with varying staff. In addition, the Supervisor II will complete spot-checks of meal preparation at least monthly to ensure compliance.	ongoing