| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49G033 | A. BUILDING _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW RESIDENCE | 1206 RED TOP ORCHARD ROAD WAYNESBORO, VA 22980 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 07/12/2022. The facility was in substantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. | E 000 | | |
| W 000 | INITIAL COMMENTS<br><br>An unannounced Fundamental Medicaid re-certification survey was conducted 07/12/2022. 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.<br><br>The census in this six (6) certified bed facility was six (6) at the time of the survey. The survey sample consisted of three (3) individual reviews (Individuals #1 through Individual #3). | W 000 | | |
| W 368 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(1)<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br>This STANDARD is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to administer medications per physician orders for two of six individuals.<br><br>1a. Individual #3 was administered a Vitamin B-12 injection seven days before it was scheduled.<br><br>1b. Individual #3 did not receive Zofran 4 mg QID | W 368 | 1a. ICF Supervisor and Director of Developmental Disabilities met with nursing team (Part Time RN and Medical Support Specialists) to discuss med error.<br><br>1b. Medical Director Discontinued Ondansetron (Zofran) QID for individual #3 on EMAR updated to reflect the medication change. | 4/15/2022<br><br>7/13/2022 |

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

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| W 368 | Continued From page 1<br>(four times per day) as ordered by the physician on 11/15/2021.<br><br>2. Individual #4 was not receiving Zofran 4 mg at the physician ordered times.<br><br>Findings were:<br><br>1a. On 07/12/2022, at approximately 11:00 a.m., incident and accident reports for the previous six months were reviewed. An incident report dated 04/07/2022 for Individual #2 contained the following information, including, but not limited to:<br><br>"Type of Incident: Medication Error<br>Type of Medication Error: Medication is give to individual at wrong time or not at all<br>Date of Alleged Incident: 04/06/2022<br>Time of Alleged Incident: 3:30 p.m.<br>Brief Description of Incident...: ...Informed (Name of RN #1) that (Individual #2) got her injection today without looking at EMAR to confirm...(RN #1) went to (residence) and gave the injection but then....informed me after administering that she was not able to sign the EMAR. I realized the injection wasn't actually scheduled for administration until 4/13/2022."<br><br>The medical specialist (staff member #6) was interviewed on 07/12/2022 at approximately 3:00 p.m. regarding the incident. She stated, "I contacted the nurse to come her and look at something else. I asked her to give (Individual #3) her B-12 shot while she was here. it wasn't due until the next week it was my error."<br><br>1b. A medication pass observation was conducted during the survey at three different times on 07/12/2022. During reconciliation of the | W 368 | 2. Order was written to specify Individual #4's Zofran be administered as follows "Ondanesteron TID 30 minutes before meals at 6:30, 11:30a, and 4:30p". 7/13/2022<br><br>ICF Coordinator to review all existing orders for accuracy, make corrections to existing orders, compare orders to MAR, update MAR to reflect any corrections. 7/22/2022<br><br>Orders (including necessary corrections) reviewed/signed by ICF Medical Director and scanned/faxed to pharmacy. 7/25/2022<br><br>Moving forward, upon receiving physicians' orders from the pharmacy each quarter, the orders will be reviewed by a member (or members) of the ICF Medical Support Team and/or ICF Leadership Team. The person/persons that review the Physicians Orders will document any necessary changes/corrections on the orders. The Medical Director will review the orders for accuracy, note any changes deemed necessary, and sign the orders. A member of the ICF Medical Support Team and/or ICF Leadership Team will fax or scan the corrected orders to the pharmacy. The orders will be scanned individually into each client's electronic record. A hard copy of the orders will be placed in each client's designated section of the "Physicians' Orders" binder. When a new order is written, the physician will be asked to specify the start date of the order and to note the specific administration times. Should an order be written in which the physician does not specify the start date, the medication will be started upon receipt from the pharmacy. Should an order be written in which the physician does not specify prescribed administration times, administration times will be followed as per the pharmacy's default administration | |

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| | | | schedule. Additionally, if changes are made to an order for an existing medication or treatment, a written order will be provided that indicates the discontinuation of the previous order(s). The written order will include the date of discontinuation for the medication or treatment that is being changed. | 8/25/2022 |
| | | | The system for assuring that all drugs are administered according to physicians' orders will be further supported by the development of a "Physicians Orders" binder that will allow physicians orders to be readily accessible by those administering medications. The binder will contain a designated section for each individual. Each individuals' section will include paper copies of the quarterly physicians' orders that have been corrected and signed by the physician. New orders (orders that are written after the quarterly physicians orders are reviewed and signed) are sent to the pharmacy and a paper copy of new order(s) will be placed in the binder on top of the existing physicians orders to assure the newest orders supersede previous orders. A "Med Alert" sheet will accompany the new order(s) in the binder to assure medication technicians are alerted to any medication changes. | 8/25/2022 |
| | | | The following ICF Standard Operating Procedures will be reviewed and updated for accuracy and to ensure the above action steps are reflected: "Drug Administration" and "Medication Management/Pharmacy Services". | 8/25/2022 |
| | | | All ICF Medication Technicians, members of ICF Medical Support Team, and members of ICF Leadership Team will read and sign off on the updated "Drug Administration" and "Medication Management/Pharmacy Services" Standard Operating Procedures. | 8/25/2022 |

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| W 368 | Continued From page 2<br>medications with the physician orders, it was discovered that Individual #3 had a physician order to receive Zofran 4 mg under her tongue every six hours for nausea. The order was written on 11/15/2021 and the medication was scheduled to be given every day at 6:00 a.m., 12 noon, 6:00 p.m., and midnight. The medication had not been observed during the medication pass at 11:30 a.m. or 12:23 p.m. on 07/12/2022. Further review of the clinical record showed that Individual #3 had never received the medication as ordered.<br><br>The medical specialist (staff member #6), the house coordinator (staff #1), and the house supervisor (staff #3) were interviewed on 07/12/2022 at approximately 4:00 p.m. about the medication. The medical specialist and the house coordinator both stated that they did not think Individual #3 had ever received the physician ordered medication. Review of the electronic MAR (medication administration record) did not include the physician ordered Zofran.<br><br>2. Individual #3 had the following diagnosis including but not limited to: Moderate ID (intellectual disability), diabetes mellitus (insulin dependant), stage III Kidney disease, asthma, and iron deficiency anemia.<br><br>A medication pass observation included medications given to Individual #4. During reconciliation of the medications given with the physician orders, it was discovered that Individual #4 was ordered to receive Zofran 4 mg by mouth at 8:00 a.m., 2:00 p.m., and 8:00 p.m. beginning 10/29/2021. The medication was administered by the facility staff at 6:30 a.m., 11:30 a.m., and 4:30 p.m. The timing of administration had never been | W 368 | | |

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| W 368 | Continued From page 3<br>changed per the physician order.<br><br>Individual #4 had the following diagnoses, including but not limited to: Moderate ID, gastroparesis, autism, and mood disorder.<br><br>An interview was conducted with the medical specialist (Staff #2) and the house supervisor (staff #3) at approximately 4:30 p.m. They were asked who compared the physician orders each month with the EMAR. The medical specialist stated, "The cycle (scheduled) meds arrive every month...we go through and check the meds against the EMAR...we make sure it's the right meds, we write the time they are suppose to be given on the med cards, we make sure there is a pill in each bubble, they aren't damaged or missing. ..the cards get pulled to be used when the current card runs out." She was asked who entered the information into the EMAR regarding the medications. She stated, "The other med specialist and I do." She was asked how the EMAR was compared to the physician orders. She stated, "We compare our EMAR to the paper MAR from the pharmacy."<br><br>The paper MARs for both individual #3 and #4 were requested. The paper MAR for Individual #3 contained an entry for Zofran 4 mg QID. The entry had been marked out and "D/C (discontinue)" written on the card. The medical specialist and the house supervisor were asked if an order had been written to D/C the Zofran. Neither could find an order to discontinue the medication.<br><br>The paper MAR for Individual #4 was reviewed. There were two orders listed on the paper MAR for Zofran. The first was written 06/08/2021 and | W 368 | | |

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| W 368 | Continued From page 4<br>was for "Zofran 4 mg...1 tab TID (three times per day). Take 1/2 hour before meals..." The times of administration were : 6:30 a.m., 11:30 a.m., and 4:30 p.m. The second order on the MAR written 10/29/2021 was for "Zofran 4 mg take 1 tablet by oral route three times per day." The times ordered were 8:00 a.m., 2:00 p.m., and 8:00 p.m. The order written on 10/29/2021 had been marked through and D/C written on the MAR.<br><br>The house supervisor stated, "We use to have an RN who checked the medications for us. We don't have that anymore. We have a part time RN now." The house supervisor and medical support specialist were asked if anyone was checking the physician orders against the MARs. The medical specialist stated, "No, not unless (name of part time nurse) is doing it." They were asked if there was a policy or procedure regarding how medication were reconciled with the MARs when they arrived or how the physician orders were reviewed to ascertain that medication were being given per order. The medical support specialist stated, "We don't have a policy or procedure for that."<br><br>On 07/12/2022 at 5:00 p.m. RN #1 was interviewed regarding the medication error on 04/06/2022 with Individual #3's B-12 injection and review of the medications on the MAR with the physician orders. She stated, "I only work PRN (as needed). I pop in and out one to two times per week...if there is an injection or something I need to look at I do it while I'm there...I don't have anything to do with the EMARs or transferring information from the orders to the EMAR or checking them. The medical support specialists do that." She was asked about Individual #3's B-12 injection being given too early. She stated, | W 368 | | |

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| W 368 | Continued From page 5<br>"I'll take most of the responsibility for that...I rely on text messages from the staff when something is due...the med tech told me that the B-12 was due...I gave it and then when I went to the EMAR I saw that it was a week early..." She was asked if she had checked the orders or the EMAR prior to administration. She stated, "No, I did not."<br><br>The facility policy, "Dedication Administration" included: "...Medications can be administered only within the time frame prescribed by the physician...Staff compare(s) the medication with the prescription label to assure the individual receives the correct dosage at the correct time, to the correct individual and through the correct route... When medications are delivered from the pharmacy, they are checked against the physician orders, prescription labels, and the medication chart to assure accuracy. "<br><br>The above information was discussed with the house supervisor, the medical support specialist, and the QIDP on 07/12/2022 at approximately 5:15 p.m. Concerns were voiced that Individual #3 had not received her physician ordered Zofran for over seven months and Individual #4 had not been given her Zofran at the physician ordered times for almost nine months.<br><br>No further information was received prior to the exit conference on 07/12/2022. | W 368 | | |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: | W 369 | Medical Director Discontinued Ondansetron (Zofran) QID for individual #3 on EMAR updated to reflect the medication change.<br><br>Order was written to specify Individual #4's Zofran be administered as follows "Ondanesteron TID 30 minutes before meals at 6:30, 11:30a, and 4:30p". | 7/13/2022<br><br>7/13/2022 |

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| W 369 | Continued From page 6<br>Based on medication pass and pour observation, staff interview, clinical record review, and facility document review, the facility staff failed to administer medications without error. Eleven opportunities were observed on 07/12/2022 with two errors, resulting in a medication error rate of 18.8%.<br><br>Findings were:<br><br>A medication pass and pour observation was conducted during the survey at three different times on 07/12/2022 (11:30 a.m., 12:23 p.m., and 2:00 p.m.) A total of ten medications were observed.<br><br>During reconciliation of the medications with the physician orders, it was discovered that Individual #3 had a physician order to receive Zofran 4 mg under her tongue every six hours for nausea. The order was written on 11/15/2021. The medication was scheduled to be given every day at 6:00 a.m., 12 noon, 6:00 p.m., and midnight. The medication had not been observed during the medication pass at 11:30 a.m. or 12:23 p.m. on 07/12/2022.<br><br>Individual #4 was given Zofran 4 mg by mouth during the 11:30 a.m. medication pass. Review of her orders showed the medication was ordered to be given at 8:00 a.m., 2:00 p.m., and 8:00 p.m. beginning 10/29/2021.<br><br>The facility policy, "Dedication Administration" included: "...Medications can be administered only within the time frame prescribed by the physician...Staff compare(s) the medication with the prescription label to assure the individual receives the correct dosage at the correct time, to | W 369 | ICF Coordinator to review all existing orders for accuracy, make corrections to existing orders, compare orders to MAR, update MAR to reflect any corrections.<br><br>Orders (including necessary corrections) reviewed/signed by ICF Medical Director and scanned/faxed to pharmacy.<br><br>The system for assuring that all drugs are administered according to physicians' orders will be further supported by the development of a "Physicians Orders" binder that will allow physicians orders to be readily accessible by those administering medications. The binder will contain a designated section for each individual. Each individuals' section will include paper copies of the quarterly physicians' orders that have been corrected and signed by the physician. New orders (orders that are written after the quarterly physicians orders are reviewed and signed) are sent to the pharmacy and a paper copy of new order(s) will be placed in the binder on top of the existing physicians orders to assure the newest orders supersede previous orders. A "Med Alert" sheet will accompany the new order(s) in the binder to assure medication technicians are alerted to any medication changes.<br><br>The following ICF Standard Operating Procedures will be reviewed and updated for accuracy and to ensure the above action steps are reflected and to elaborate on the drug administration procedure inclusive of a checks and balances system that assures medications are administered per physicians orders "Drug Administration" and "Medication Management/Pharmacy Services".<br><br>All ICF Medication Technicians, members of | 7/22/2022<br><br>7/25/2022<br><br>8/25/2022<br><br>8/25/2022 |

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| | | | ICF Medical Support Team, and members of ICF Leadership Team will read and sign off on the updated "Drug Administration" and "Medication Management/Pharmacy Services" Standard Operating Procedures. | 8/25/2022 |

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| W 369 | Continued From page 7<br>the correct individual and through the correct route. .. When medications are delivered from the pharmacy, they are checked against the physician orders, prescription labels, and the medication chart to assure accuracy. "<br><br>The above information was discussed with the house supervisor, the medical support specialist, and the QIDP on 07/12/2022 at approximately 5:15 p.m. Concerns were voiced that Individual #3 was not receiving her physician ordered Zofran and Individual #4 was receiving her Zofran at the incorrect times.<br><br>No further information was received prior to the exit conference on 07/12/2022. | W 369 | | |

Marcel Harris/Supervisor 7/21/2022