STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G004	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(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
W 000	INITIAL COMMENTS An unannounced Medicaid ICF/IID abbreviated survey was conducted 2-14-23 through 2-16-23. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually disabled. The census in this 100 bed facility was 91 at the time of the survey. The survey sample consisted of 3 Individual reviews (Individuals #1 through #3). Three complaints were investigated during the survey. VA00057475 Substantiated with deficiency VA00052965 Substantiated with deficiency VA00050792 Substantiated without deficiency	W 000		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to notify the designated family member of Individual # 3 of changes in condition. Findings included: For Individual # 3, the facility staff failed to notify the family member of changes in condition regarding two conditions: (A) G tube site (B) the	W 148	Individual # 3's guardian was notified about the changes in his condition that required treatment. As a reminder for staff to notify Individual # 3's guardian of any changes in condition that require medical treatment, a symbol will appear on the front page of the electronic health record. All individuals at the Home will also have the reminder symbol to ensure that all guardians will be notified of any changes in condition that require medical treatment. Medical records will check that all individuals have this symbol by the assigned date and report to the Chief of Nursing and Clinical services for any needed follow up.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
H. Wayne Jones	CEO	3/15/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G004	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(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
W 148	Continued From page 1 eyes. Individual # 3 was admitted to the facility in 2012 with diagnoses that included but not limited to: Spastic Hemiplegic Cerebral Palsy, Seizures and Gastrostomy. Review of the clinical record was conducted on 2/14/2023-2/16/2023. (A) Review of the clinical record revealed documentation that Individual # 3's family member found the skin around Individual # 3's Gastrostomy tube site reddened. There was no noted documentation of the facility staff notifying family member of changes in the skin around the Gastrostomy tube even though there were orders for treatment of the skin breakdown around the G tube site. Review of the record revealed there were two treatment orders for the G-tube site for the medication, Nystatin topical cream, one written on 4/12/21 for 7 days and the other on 4/16/2021 for 30 days. The orders were: "Nystop (Nystatin) 100,000 unit/gram topical cream apply by topical route 3 times per day for 7 days to G-site. Start date 4/12/2021 at 11:30 a.m." "Nystatin 100,000 unit/gram topical cream apply by topical route 3 times per day for 30 days to the G-site the skin irritation around the G-tube site" Start date 4/16/2021 at 12:00 a.m. Review of the Progress revealed documentation of the G tube site including the following excerpt:	W 148	Notification to all guardians of changes requiring treatment will be reiterated to all department heads, QIDPs, the nursing department during meetings and by nursing supervisors during daily nursing 'huddles'. Email reminders will be sent regarding the need to document every contact with guardians. The updated communication policy will be placed on the electronic training platform with staff mandated to read and sign off. The Director of Professional Development will provide a list to senior management for follow up with any staff who have not completed the assignment. Ongoing communication with guardians will be added to the internal event reporting system, and will be monitored by the Risk Manager with regular reports going to the Quality Improvement Committee.	3/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G004	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(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
W 148	Continued From page 2 04/25/2021 11:29 pm "Small scratches noted around G-site button, small amount of bleeding, writer saw him scratch area (fingernails trimmed as ordered 4/22/21). No further problems noted, 2x2 split gauze applied to G-site after shower." Further review of the Progress Notes revealed there was no documentation of the facility staff notifying the family member of Individual # 3 concerning the changes around Individual # 3's G-tube site. (B) Review of the Progress Notes revealed the following documentation: "8/14/2021 09:30 a.m.- Incident Report- event description On 8/31/2021-staff noted area to left upper eye lid, slightly swollen appearing as of a sty was developing (sic) The eye lid was monitored thru out the day. (sic) On 08/14/201 (sic) left eye assessed again appears to have cut to upper eye lid, swollen with area on cheek below eye. Additional information: 8/18- Dr. [name redacted] -progress notes-Assessment Small abrasion on lateral left upper eyelid. Etiology is not clear."..... Recommendation erythromycin ophthalmic ointment to left upper eyelid TID (three times a day) X 5 days. I have chosen this antibiotic because there will be no harm if it is rubbed in the eye itself." Review of the Progress Notes revealed no documentation of the family member being notified of the eye when it was discovered.	W 148		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G004	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(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
W 148	Continued From page 3 On 2/14/2023 at 11:50 a.m., an interview was conducted with the Director of Social Services. The Director of Social Services stated the facility staff was supposed to notify the designated family member according to their wishes. She stated there were signed forms on each Individual's record. She also stated their were some families who only wanted to be notified of "important information" while others wanted "notification of everything including small scratches." She stated Individual # 3's family wanted "to be notified of everything." During the end of day debriefing on 2/15/2023, the Chief Nursing Officer stated the facility staff did not notify Individual # 3's family member of the change in condition of the G-tube site and bruises around the eye. She stated the expectation was that the designated family member would be notified of any changes in condition. The Chief Nursing Officer also stated the staff should honor the wishes of the designated family member regarding preferences about notification of changes. She stated the G tube site changes warranted notification of the family member by the facility staff. She also stated the observation of changes regarding the eyes should have been reported to the family member when it was first discovered. No further information was provided.	W 148		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by:	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G004	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(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
W 368	Continued From page 4 Based on staff interview, family interview, clinical record review, and facility document review, the facility staff failed to ensure medications were administered as prescribed by the physician for 2 of 3 Individuals in the survey sample, (Individual #1, and #2). The findings included: 1. Individual #1 was not administered Clonidine on 1-10-23 for agitation and dystonia. According to facility record review, Individual #1 went out to the hospital on 1-12-23, with severe dystonia and was found at the hospital to have no Clonidine medication patch under the adhesive patch on the Individual's skin. The facility was notified by the hospital. Review of the facility's Incidents since last survey revealed an incident on 1-12-23 where Individual #1 did not receive his Clonidine ordered to be applied every 3 days, and was due on 1-10-23. According to the report, the Clonidine box in the facility contained 7 adhesive covers, and 8 transdermal medication patches. The medication patch had not been applied, only the adhesive cover which held the medication patch in place had been placed on the Individual's skin. The medication was due on 1-10-23 however, Individual #1 did not get the Clonidine patch on 1-10-23 and thus had no medication being administered via the patch on 1-10-23, 1-11-23, and 1-12-23. 2. Individual #2 was not administered Pulmicort,	W 368	Individuals # 1 and # 2 no longer reside at the home. All other individuals' medications were checked and only one was found to use the same medication under a patch. If administration concerns arise, discussion will be held with this individual's guardian regarding the risks and benefits and potential use of alternative non-manufactured recommended dressings. The same discussion will be held if a similar situation arises in the future. An audit will be conducted for all individuals using respiratory medications to ensure easy to follow prescriptions as well as a physical environment that minimizes the risk of look- alike medications. Proper storage and organization of these medications will also be checked. The audit results will be provided to the Chief of Nursing and Clinical Services. Any policy changes needed will be shared with the Quality Improvement Committee. All nurses will receive medication administration training review via the electronic training platform. This will include Clonidine patch training. The Director of Professional Development will provide the list to the Chief of Nursing and Clinical Services for follow up with any staff who have not completed the assignment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G004	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(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
W 368	Continued From page 5 Albuterol, and Ventolin Respiratory medications per physician's orders during an acute illness from 11-27-22 through 12-7-22. Individual #2 suffered from an acute respiratory illness from 11-27-22 through 12-7-22. Bronchodilation medications were ordered for the Individual, however, they were omitted on several occasions. Individual #2's Medication and Treatment Administration Records (MARs/TARs) were reviewed and revealed that Individual #2 had a routine order issued on 12-1-22 for Pulmicort to be given every 12 hours at 6:00 a.m., and 6:00 p.m. The inhaled bronchodilation medication was omitted on 12-6-22 at 6:00 p.m., and on 12-7-22 at 6:00 a.m. culminating in a 12 hour lapse of Bronchodilation during an acute respiratory illness. The individual also had 2 physician's orders for PRN (as needed) inhaled medications for "wheezing", or "SOB" (shortness of breath). They were as follows; 1. Ventolin inhaled every four hours as needed, which was a standing order, and was ordered 10-20-2020. However, the Ventolin was never administered from 11-27-22 through 12-7-22. 2. Albuterol inhaled every four hours by nebulizer for 5 days ordered 12-1-22. However the Albuterol was omitted on 12-6-22 at 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., and on 12-7-22 at 2:00 a.m., 6:00 a.m., and 10:00 a.m. culminating in a 28 hour lapse where the bronchodilation medication was not given during the acute respiratory illness.	W 368	New nursing employees will receive a medication audit within the first 90 days. The report of this audit will go to the Chief of Nursing and Clinical Services.	3/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G004	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(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
W 368	Continued From page 6 On 2-15-23 at 2:00 p.m., the Director of Nursing (DON) was questioned as to the omitted medications. She stated, "I will look into it." However, no answer was ever given to the survey team. On 2-16-23 at 1:30 p.m., the Administrator and DON were notified of above findings. They stated they had no further information to provide.	W 368		