STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G048	A. BUILDING ______ B. WING ______	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINBURN PLACE	71 BROGDEN LANE HAMPTON, VA 23666

(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 09/06/23 through 09/07/23. 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. No emergency preparedness complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 09/06/23 through 09/07/23. 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 certified bed facility was 5 at the time of the survey. The survey sample consisted of 4 Individual reviews (Individuals 1 through 4).	W 000		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, the facility staff failed to ensure 2 of 4	W 436		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Scott	Residential Manager	9/22/23

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.

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

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W 436	Continued From page 1 Individuals' mobility wheelchairs were in safe operating condition for individuals (Individual #3 and #4) in the survey sample. The findings included: 1. The facility staff failed to ensure Individual #3's wheelchair footrest was in good repair. Individual #3 was admitted to the facility on 03/16/10. The primary diagnoses included but not limited to profound intellectual disability, Cerebral Palsy, and seizure disorder. A review of Individual #3's current physician orders for August 2023 revealed an order for wheelchair footrest.	W 436		
	On 09/06/23 at 11:50 am., Individual #3 observed sitting up in her wheelchair. The wheelchair footrest observed with leather covering coming apart. The covering was torn and ripped. On the same day at 5:35 p.m., the rest remained unchanged. Individual #3 arrived at the day program on 09/07/23 at 10:23 a.m. The wheelchair footrest remained unchanged, leather covering coming apart, torn, and ripped.		The Residential Supervisor has contacted National Seating and Mobility and secured the information that the wheelchair parts for the Individual have been ordered.	9/8/23
	A review of Physical Therapy (PT) consultant services work log dated 04/20/23 indicated Individual #3 was evaluated for new wheelchair parts (parts not specified). An interview was conducted with the house supervisor on 09/07/23 at 4:55 p.m. She said (name of company) orders all equipment for the individuals. The facility was not able to provide evidence that Individual's #3's footrest had been		A process was established with National Seating and Mobility to check on the status of all parts and repair orders. The Residential Supervisor will utilize a portal on the supplier's website that will verify the status of the work order (i.e. if paperwork is needed, financial covering process, order status, and delivery date). Once the order has been established an email from National Seating and Mobility will be received as confirmation of the order.	9/8/23

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W 436	Continued From page 2 ordered since the recommendation was made by PT on 04/20/23. 2. The facility staff failed to ensure Individual #4's wheelchair arm rest was in good repair. Individual #4 was admitted to the facility on 04/15/10. The primary diagnoses included but not limited to profound intellectual disability, and history of epilepsy (seizures). On 09/06/23 at 11:55 am., Individual #4 observed sitting up in her wheelchair. The bilateral armrest pads on the wheelchair were wrapped with black tape. On the same day at 5:35 p.m., the armrest pads remained unchanged. Individual #4 arrived at the day program on 09/07/23 at 10:26 a.m. The bilateral armrest pads on the wheelchair remained unchanged, wrapped with black tape. A summary note written by the Physical Therapy (PT) dated 04/13/23 indicated Individual #4 needed new armrest pads. An interview was conducted with the house supervisor on 09/07/23 at 4:55 p.m. She stated she wrapped Individual #4's armrest pads with tape to protect the skin from injury. She said (name of company) orders all equipment for the individuals. The facility was not able to provide evidence that Individual's #4's armrest pads had been ordered. On 09/07/23 at approximately 4:49 p.m., the above information was shared with the house supervisor and Residential Manager. The Regional Manager stated ordering parts for wheelchairs is an ongoing issue.	W 436	The Residential Supervisor contacted National Seating and Mobility and the armrest pads were ordered. National Seating and Mobility has agreed to provide loaner wheelchair arm rest until the new armrest pads arrive. The Supervisor will contact the medical equipment supplier within 24 hours of receiving a recommendation from the consultant about the need of a replacement for a defective adaptive equipment part. A process was established with National Seating and Mobility to check on the status of all parts and repair orders. The Residential Supervisor will utilize a portal on the supplier's website that will verify the status of the work order (i.e. if paperwork is needed, financial covering process, order status, and delivery date). Once the verification of the order has been established an email from National Seating and Mobility will be received as confirmation of the order. The Weekly Personal Medical Checklist is used to provide a log of any concerns or issues with all adaptive equipment within the facility and or needs specific to the individual. The Residential Supervisor reviewed the "Weekly Personal Medical Checklist" with the Direct Support Professional staff.	9/8/23 10/1/23 9/8/23/ongoing 9/8/23 Ongoing

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	Continued From page 3 The facility's policy titled Adaptive Equipment/Assistive Devices and Maintenance revised on 03/15. It is the facility policy to ensure that all staff uses adaptive equipment/assistive devices safety and correctly. Individuals who service needs include utilization of medical equipment or adaptive devices will be supported in the safe and accurate use of and maintenance of such equipment. Procedures: When adaptive equipment/assistive devices are necessary for individual include but not limited to: 7. Staff will comply with manufacture's guidelines on routine maintenance. Maintenance logs will be maintained for each individual require medial and/or adaptive equipment.		The Manger reviewed the Adaptive Equipment/Assistive Devices and Maintenance policy with the Residential Supervisor.	9/27/23
			The "Weekly Personal Medical Checklist" is used to provide a log of any concerns or issues with all adaptive equipment within the facility and or needs specific to the individual. The Residential Supervisor reviewed the "Weekly Personal Medical Checklist" with the Direct Support Professional staff.	Ongoing
			The Checklist will be maintained in the Supervisor's office to verify that adaptive equipment has been checked and/or needs repairs.	9/27/23

HAMPTON NEWPORT NEWS COMMUNITY SERVICES BOARD

WEEKLY PERSONAL MEDICAL EQUIPMENT SAFETY CHECKLIST

Client: ______________________ ID #: ______________ Program: ______________

	Weekly Walker Maintenance Check	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**
	General Operations: Check locking device for correct operation Check rubber tips, wheels or other covering on the end of walker legs for correct operation												
	Weekly Cane/Crutches Maintenance Check-N/A	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**
	General Operations: Check cane tip(s) for wear												
	Weekly Wheelchair Maintenance Check	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**
	General Operations: Wheel locks: Engage and disengage with ease Armrests: Securely attached Hand rims: Check for rough edges Wheels: Check for looseness or wobbles Tires: Check for wear and tear and/or flat areas General: Chair opens and closes easily												
	Weekly Glucometer Maintenance Check	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**
	General Operations: Check for digital display operation and battery power Check lancet for proper spring action												
	Weekly Electric Bed Check	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**
	General Operations: Check for operation Ensure bed is in locked position Check bedrails for functioning and padding is present (if applicable)												
	Weekly Blood Pressure Cuff Check	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**	**Date: Initial:**
	General Operations: Check for digital display operation and battery power Check cuff for proper inflation during operation Check for secure fit to arm.												

*** TO BE COMPLETED EACH WEEK ON SUNDAY, BY 3RD SHIFT!!***

	Weekly Electronic Thermometer Check	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**
	General Operations: Check for digital display operation and battery power												
	Weekly Digital Scale Check	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**
	General Operations: Check that scale is balanced to "0"												
	Weekly Tub Lift Chair Check	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**
	General Operations: Check the battery pack to ensure it is charged Ensure the spare battery pack is on the charger in the supply room Check the brake to ensure it works												
	Weekly Hoyer Lift Check	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**	**Date:** **Initial:**
	Check the battery pack to ensure it is charged Ensure the spare battery pack is on the charger in the supply room Check the brake to ensure it works Check the hand held control buttons to ensure it works and is in good working order												

*** TO BE COMPLETED EACH WEEK ON SUNDAY, BY 3RD SHIFT!!***