STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
Office of Health Facility Licensure and Certification
408 Leon Sullivan Way, Suite 120
Charleston, West Virginia 25301-1713
Telephone: (304) 558-0050 Fax: (304) 558-2515

Bill J. Crouch
Cabinet Secretary

Jolynn Marra
Interim Inspector General

November 15, 2019

Mark Landis - Executive Director
ResCare WV - Eastern Agency
87 North Main Street, Suite 1
Keyser, WV 26726

VIA CERTIFIED MAIL
7013-3020-0000-7594-3644

Dear Mr. Landis:

Enclosed, please find an **Administrative Order**. Please pay special attention to your due process rights as outlined in the last paragraph of the **Administrative Order**. If your have questions or concerns, please contact Susan File, Program Manager, at the telephone number above.

Sincerely,

Jolynn Marra

Jolynn Marra
Director

cc: Bill J. Crouch, Cabinet Secretary
Cynthia Beane, Commissioner, Bureau of Medical Services
Pat Nisbet, Bureau of Medical Services
Susan File, Program Manager
Jessica Y. Whitmore, Assistant General Counsel

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

In re:

ResCare WV - Southside Group Home
1207 West Virginia Avenue
Martinsburg, WV 25401

ResCare WV - Northside Group Home
1200 Third Street
Martinsburg, WV 25401

ResCare WV - Gaboya Place Group Home
201 South Water Street
Martinsburg, WV 25401

Mailing Address:

Mark Landis, Executive Director
ResCare WV, Inc. - Eastern Agency
87 North Main Street, Suite 1
Keyser, WV 26726

ADMINISTRATIVE ORDER

Pursuant to *W. Va. Code §§ 27-1-1, et seq.*, and the regulations duly promulgated thereunder at *W. Va. Code R. §§ 64-11-1, et seq.*, specifically *W. Va. Code R. §§ 64-11-4.6.11., 64-11-7.1.*, and *64-11-13.1.3.*, it is hereby **ORDERED** that ResCare WV - Southside Group Home, Northside Group Home, and Gaboya Place Group Home are subject to an **Admissions Ban**, ***effective immediately***, and until such time as the Office of Health Facility Licensure and Certification (OHFLAC) determines that these facilities are in substantial compliance with the licensure requirements.

During the most recent OHFLAC complaint investigations, which were completed on September 19, 2019 and October 17, 2019, it was determined that ResCare WV - Southside Group Home, Northside Group Home, and Gaboya Place Group Home are operating in a way that jeopardizes the health, safety, welfare, and clinical treatment of the consumer as set forth in the Statements of Deficiencies dated September 19, 2019 and October 17, 2019. Pursuant to these complaint investigations, ResCare WV - Southside Group Home failed to:

a) Provide sufficient staff to provide protective oversight to all clients on multiple occasions and staff are working shifts in excess of 20 consecutive hours (*42 C.F.R. §§483.420* and *483.420(a)(5)*);

b) Ensure that clients are not at a risk to health and safety from items such as an unsafe stove exhaust fan in the kitchen, a broken toilet with shar porcelain edges, to an old refrigerator lying unsecure outside which present immediate physical safety hazards (*42 C.F.R. §§ 483.420* and *483.420(a)(5)*);

c) Provide adequate health care monitoring and services, including appropriate and timely follow-up, based upon their individualized need for service (*42 C.F.R. §§ 483.420* and *483.420(a)(5)*);

d) Ensure all nursing staff have a current license to practice in the state (*42 C.F.R. §§ 483.420* and *483.420(a)(5)*);

e) Ensure clients are free from abuse (*42 C.F.R. § 483.420(a)(5)*);

f) Ensure clients have the opportunity to participate in social, religious, and community group activities by failing to ensure the clients the opportunity to participate in church services (*42 C.F.R. § 483.420(a)(11)*);

g) Ensure that they prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment (*42 C.F.R. § 483.420(d)(1)(iii)*);

h) Ensure the Condition of Participation of Facility Staffing was met (*42 C.F.R. § 483.430*);

i) Ensure they must not depend upon clients or volunteers to perform direct care services for the facility. The failure of the facility to provide appropriate staffing levels necessary to provide appropriate staffing levels necessary to provide direct care services to the clients that reside in the home, ad relying on clients to reside in the home, and relying on clients to perform necessary facility tasks does not meet the intent of the regulation (*42 C.F.R. §§ 483.430* and *483.430(c)(1)*);

j) Provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. The facility consistently neglected to provide client care and supervision in accordance with their individual program plans and needs (*42 C.F.R. §§ 483.430* and *483.430(d)(1-2)*);

#) Ensure that direct care staff are provided by the facility in the minimum ratios does not meet the intent of the regulation for each defined residential living unit servicing children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior (*42 C.F.R. § 483.430*);

k) Provide the minimum 1:3.2 staff ratio on multiple occasions which does not meet the intent of the regulation requiring the facility to ensure direct care staff are provided by the facility in the following minimum ratios of direct care staff to clients: (i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2; and (ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4 (*42 C.F.R. § 483.430(d)(3)*);

l) Ensure the Condition of Participation of Active Treatment Services was met (*42 C.F.R. § 483.440*);

m) Implement the active treatment programs of clients. By failing to provide active treatment to clients as specified in their individual program plans, the facility does not meet the intent of the regulation that each client must receive a continuous active treatment program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services (*42 C.F.R. §§ 483.440* and *483.440(a)(1)*);

n) Ensure the Condition of Participation of Health Care Services was met (*42 C.F.R. § 483.460*);

o) Ensure to provide clients with nursing services in accordance with their needs (*42 C.F.R. §§ 483.460* and *483.460(c)*);

p) Ensure nurses providing services in the facility have a current license to practice in the State (*42 C.F.R. §§ 483.460* and *483.460(d)(1)*);

q) Ensure comprehensive dental treatment services that include restoration of teeth. The facility failed to address a client's need for dentures which does not meet the intent of the regulations that the facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health (*42 C.F.R. §§ 483.460* and *483.460(g)(2)*);

r) Ensure all drugs are administered in compliance with the physician's orders (*42 C.F.R. §§ 483.460* and *483.460(k)(1)*);

s) Ensure that drugs are stored under proper conditions of security (*42 C.F.R. §§ 483.460* and *483.460(l)(1)*);

t) Ensure the Condition of Participation of Physical Environment was met (*42 C.F.R. § 483.470*);

u) Provide toilet and bathing facilities appropriate in number, size and design to meet the needs of the clients (*42 C.F.R. §§ 483.470* and *483.470(d)(1)*);

v) Ensure that clients are not at a risk to health and safety (*42 C.F.R. § 483.470*);

w) Ensure each client receives a nourishing, well-balanced diet including modified and specially-prescribed diets (*42 C.F.R. § 483.480(a)(1)*); and

x) Ensure menus must be prepared in advance (*42 C.F.R. § 483.480(c)(1)(i)*).

Pursuant to these complaint investigations, ResCare WV - Northside Group Home failed to:

a) Keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. Observations included open shelving and unsecured client medical records in the nursing office. Observation also revealed the narcotics book was missing from the nursing office (*42 C.F.R. §§ 483.410* and *483.410(c)(2)*);

b) Ensure the Condition of Participation of Client Protections was met (*42 C.F.R. § 483.420*);

c) Implement a client's physician's order as written. The client was prescribed a seizure medication to be administered as needed; however, nursing staff were unsure how to implement the order and were unsure how to implement the order and made no effort to gain clarification. Consequently, the client's order for seizure medication was not implemented. The facility's failure to appropriately implement the client's medical intervention places the client in danger of immediate harm (*42 C.F.R. §§ 483.420* and *483.420(a)(5)*);

d) 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 by failing to notify a client's guardian following an injury that required hospitalization (*42 C.F.R. §§ 483.420* and *483.420(c)(6)*);

e) Ensure the Condition of Participation of Active Treatment Services was met (*42 C.F.R. § 483.440*);

f) Ensure a continuous active treatment was provided to all clients residing in the group home by failing to develop treatment plans and deprived all clients of opportunities to practice new and existing skills (*42 C.F.R. §§ 483.440* and *483.440(a)(1)*);

g) Ensure that each client has an individual program plan developed by an interdisciplinary team that represents the professions, disciplines, or service areas that are relevant to identifying the client's needs as described by the comprehensive functional assessments and designing programs that meet the client's needs (*42 C.F.R. §§ 483.440* and *483.440(c)(1)*);

h) Implement appropriate behavioral interventions to clients. Staff were observed providing an ad hoc behavior program to a client that involved hitting the arms of the chair and calling out to client to wake him in the living room after he had fallen asleep in an attempt to startle the client awake. On other occasion, staff also moved the same client away from the wall in his wheelchair and locked the wheels toward the middle of the room. (*42 C.F.R. §§ 483.450(b)(2)* and *483.450(b)(4)*);

i) Provide appropriate interventions to manage inappropriate client behavior and failed to ensure interventions are employed with sufficient safeguards and

supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected (*42 C.F.R. § 483.450(b)(2)*);

j) Ensure that the Condition of Participation of Health Care Services was met (*42 C.F.R. § 483.460*);

k) Provide or obtain preventive and general care as well as annual physical examinations of each client. There was no documented evidence in the record that an annual physical examination was completed (*42 C.F.R. §§ 483.460* and *483.460(a)(3)*);

l) Provide all clients residing in the group home with nursing services in accordance with their needs. The nurse is required to conduct assessments as indicated, effect timely and appropriate interventions, communicate with the clients' physicians and other health care professionals as indicated, provide evaluations as ordered and monitor clients' health care as ordered (*42 C.F.R. §§ 483.460* and *483.460(c)*);

m) Ensure that nursing assessments were documented on a quarterly or more frequent basis depending on client need for all clients residing in the group home. It is the responsibility of the registered nurse to perform assessments. Licensed practical nurses do not have assessment capabilities in their scope of practice (*42 C.F.R. §§ 483.460* and *483.460(c)(3)(iii)*);

n) Ensure that all drugs are administered in compliance with physician's orders. The facility was provided a physician's order for a client that was to be used as needed to intervene for seizures. However, nursing staff were unsure how to implement the order and made no documented effort to clarify it (*42 C.F.R. §§ 483.460* and *483.460(k)(1)*);

o) Ensure that drugs are stored under proper conditions of temperature. Drugs are required to be stored according to the manufacturer's recommendations. Although a combination of thermometer/barometer were present in the medication room, the facility failed to ensure that temperatures were documented, bringing into question the efficacy of the medication being stored for client use (*42 C.F.R. §§ 483.460* and *483.460(l)(1)*);

p) Ensure that drugs are stored under proper conditions of humidity. Drugs are required to be stored according to the manufacturer's recommendations. Although a combination of thermometer/barometer were present in the medication room, the facility failed to ensure that temperatures were documented, bringing into question the efficacy of the medication being stored for client use (*42 C.F.R. §§ 483.460* and *483.460(l)(1)*);

q) Store drugs under proper conditions of security. Open drug storage units were observed in the nursing office and medications were found in the bedroom of a client (*42 C.F.R. §§ 483.460* and *483.460(l)(1)*);

r) Remove from use outdated drugs. Outdated medications were found in the bedroom of a client (*42 C.F.R. §§ 483.460* and *483.460(m)(2)(i)*);

s) Ensure that if a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. The facility acquires laboratory specimens for analysis, yet does not have a current, valid Clinical Laboratory Improvement Amendment (CLIA) certificate (*42 C.F.R. §§ 483.460* and *483.460(n)(1)*);

t) Ensure that the Condition for Physical Environment was met (*42 C.F.R. § 483.470*);

u) Provide each client with a clean, comfortable mattress. A client's mattress was stained in multiple locations and had a strong foul odor (*42 C.F.R. §§ 483.470* and *483.470(b)(4)(ii)*);

v) Provide bedding appropriate to the weather and climate by failing to provide a client with sheets for his bed and he was noted to be sleeping on a bare mattress (*42 C.F.R. §§ 483.470* and *483.470(b)(4)(iii)*);

w) Provide each client with functional furniture appropriate to the client's needs. A client's dresser had three broken drawers (*42 C.F.R. §§ 483.470* and *483.470(b)(4)(iv)*);

x) Provide a sanitary environment to avoid sources and transmission of infections. The facility failed to provide sanitary conditions, as mice and ants were both discovered and frozen hamburgers was sitting on the counter in the kitchen (*42 C.F.R. §§ 483.470* and *483.470(l)(1)*);

y) Ensure that each client receives a nourishing, well-balanced diet including modified and specially-prescribed diets. The facility failed to ensure that clients received the proper food and in the proper proportion as per their physicians' orders and dietician approved menus (*42 C.F.R. §§ 483.480* and *483.480(a)(1)*); and

z) Ensure food is served in a form consistent with the developmental level of the client. The facility failed to ensure a client's food was served in the proper consistency as per their physician's orders (*42 C.F.R. §§ 483.480* and *483.480(b)(2)(iii)*).

Pursuant to these complaint investigations, ResCare WV - Gaboya Place Group Home failed to:

a) Ensure the Condition of Participation of Client Protections was met (*42 C.F.R. § 483.420*);

b) Ensure clients are free from abuse. The facility provided an environment where clients developed decubitus ulcers and were not treated appropriately for these injuries; a client was not properly supervised to the point of receiving a head

injury of unknown origin and was not immediately treated for this injury; and all clients were observed to receive medications late on two separate days (*42 C.F.R. §§ 483.420* and *483.420(a)(5)*);

c) Provide sufficient staff to provide protective oversight to all clients on multiple occasions (*42 C.F.R. §§ 483.420* and *483.420(a)(5)*);

d) Ensure all clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment. The facility created an environment in the bathroom of clients where injury by electrocution could occur. The facility's treatment of all clients has resulted in actual harm and created scenarios where further harm could occur (*42 C.F.R. §§ 483.420* and *483.420(a)(5)*);

e) Ensure the Condition of Participation of Facility Staffing was met (*42 C.F.R. § 483.430*);

f) Provide sufficient direct care staff at all times to meet the care and supervision needs of all clients residing in the group home. The facility consistently neglected to provide direct care staff and supervision in accordance with their individual program plans and needs. The facility, on multiple occasions, did not provide the minimum 1:3.2 ratio for all clients residing in the group home (*42 C.F.R. §§ 483.430*, *483.430(d)(1-2)*, and *483.430(d)(3)*);

g) Ensure the Condition of Participation of Active Treatment Services was met (*42 C.F.R. § 483.440*);

h) Provide each client with a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized implementation of a program of specialized and generic training, treatment, health services and related services. The facility failed to implement active treatment programs for all clients residing in the group home. Without implementing active treatment programs as designed, the facility cannot provide active treatment to clients (*42 C.F.R. §§ 483.440* and *483.440(a)(1)*);

i) Ensure the Condition of Participation of Client Behavior and Facility Practices was met (*42 C.F.R. § 483.450*);

j) Ensure that interventions to manage inappropriate client behavior are employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected (*42 C.F.R. §§ 483.450* and *483.450(b)(2)*);

k) Ensure the Condition of Participation of Health Care Services was met (*42 C.F.R. § 483.460*);

l) Provide clients with nursing services in accordance with their needs. The failure of the facility to provide all clients with timely interventions, physician ordered

medication, monitoring and procedures does not meet the intent of the regulation (*42 C.F.R. §§ 483.460* and *483.460(c)*);

m) Ensure that all drugs are administered in compliance with the physician's orders for all clients (*42 C.F.R. §§ 483.460* and *483.460(k)(1)*);

n) Ensure that the Condition of Participation of Physical Environment was met (*42 C.F.R. § 483.470*);

o) Provide functional furniture, appropriate to the client's needs, as the client's bed was broken and not functioning as designed (*42 C.F.R. §§ 483.470* and *483.470(b)(4)(iv)*);

p) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients by failing to ensure that lights were working in the client's bathroom and refrain from illuminating the bathroom in an unsafe manner (*42 C.F.R. §§ 483.470* and *483.470(d)(1)*);

q) Provide a sanitary environment to avoid sources and transmission of infections. The facility was noted to have numerous issues with cleanliness affecting all clients residing in the group home including the following: (i) In the kitchen, the cabinet under the sink had a bottom that was stained, distorted, misshapen with evidence of past or present water leak, (ii) In the living room, the faux leather ottoman and two chairs had large worn areas where the protective barrier was breached, presenting cleaning and sanitation difficulty, (iii) Air vents and returns and the baseboards throughout the group home were covered with dust and debris, (iv) A five pound roll of hamburger was thawing out in a tub of water on the sink in the kitchen and not under cold running water as required for food safety if not thawed in the refrigerator, (v) Laundry room freezer and refrigerator freezer temperatures were not documented from 01/01/2019 through 09/12/2019, and (vi) the kitchen refrigerator temperatures were not documented from 01/01/2019 through 09/12/2019 (*42 C.F.R. §§ 483.470* and *483.470(l)(1)*);

r) Ensure that nursing staff are accurately documenting and tracking infectious and communicable diseases on their required tracking form. The failure of the facility to make certain that the necessary treatment of head lice was documented on the proper tracking form does not meet the intent of the regulation that there must be an active program for the prevention, control, and investigation of infection and communicable diseases which has the potential to affect all clients residing in the group home (*42 C.F.R. §§ 483.470* and *483.470(l)(1)*);

s) Ensure the Condition of Participation of Dietetic Services was met (*42 C.F.R. § 483.480*); and

t) Provide each client with a nourishing, well-balanced diet including modified and specially-prescribed diets by failing to ensure clients receive specially-prescribed diets. Documentation on the diets for clients revealed they are not receiving the food consistency ordered for their individual needs. The physician's orders for

these clients do not match the recommendations made by dietary consultants. A client has had a weight loss of 15.9 pounds (*42 C.F.R. §§ 483.480* and *483.480(a)(1)*).

It was also found that ResCare WV - Southside Group Home, Northside Group Home, and Gaboya Place Group Home are subject to an Admissions Ban, effective immediately, including new admissions and readmissions. OHFLAC will conduct at least one (1) revisit survey of the facility every six (6) months to determine compliance. If after two (2) consecutive revisit surveys OHFLAC determines that no issues related to consumer health, safety, welfare, or clinical treatment exist, the Admissions Ban may be provisionally lifted at that time. If OHFLAC determines that issues remain related to consumer health, safety, welfare, or clinical treatment exist, OHFLAC will continue to conduct at least one (1) revisit survey of the facility every six (6) months until substantial compliance is achieved.

After the Admissions Ban is provisionally lifted, OHFLAC will conduct at least one (1) revisit survey to determine continued substantial compliance. If at that time OHFLAC determines that no issues related to consumer health, safety, welfare, or clinical treatment exist, the Admissions Ban may be fully lifted. If OHFLAC determines that the revisit survey reveals issues related to consumer health, safety, welfare, or clinical treatment exist, the Admissions Ban will be immediately reinstated.

Additionally, it is **ORDERED** that ResCare WV - Southside Group Home, Northside Group Home, and Gaboya Place Group Home shall provide monthly updates on the 10th day of each month until the Admissions Ban is lifted to OHFLAC regarding any reportable incidents including deaths, hospital transfers, and incidents of abuse or neglect; documentation regarding all incident reports; documentation regarding all medication errors; documentation regarding staff census and vacancies; documentation regarding the status of each consumer; and records of any training provided to staff; and documentation of timecard punch in and punch out times for all staff for each shift. ResCare WV - Southside Group Home, Northside Group Home, and Gaboya Place Group Home shall also report within two (2) hours of any shift that is insufficiently staffed based on federal regulation and consumer needs to the following email

address: DHHROHFLACAdmin@wv.gov. ResCare WV - Southside Group Home, Northside Group Home, and Gaboya Place Group Home shall cooperate with OHFLAC and respond to any request made by OHFLAC regarding the health and safety of consumers.

If you believe that you were aggrieved by this **ORDER**, you have the right to a formal administrative hearing. You also have the right to request an informal meeting with the Director prior to any formal hearing. Any request for either a meeting or a hearing shall be made in writing within ten (10) days of receipt of this **ORDER** and addressed as follows: Legal Division, Office of Health Facility Licensure and Certification, 408 Leon Sullivan Way, Suite 120, Charleston, West Virginia 25301-1713. Any request for either a meeting or hearing will not stay or supersede the enforcement of this **ORDER**.

Entered this 15th day of November, 2019.

Jolynn Marra, Director
Office of Health Facility Licensure and Certification