STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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 The unannounced Medicaid survey was conducted on 05/09/17 through 05/11/17. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities (ICF/ID) Federal Regulations. The Life Safety Code report will follow. The census in this 12 bed facility at the time of the survey was 12. The survey sample consisted of 4 current Individual records (Individual #1 through #4).	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility staff failed to ensure the security alarm was functioning properly. The findings included: Individuals of the facility had signed consents for the use of door alarms for safety. During the entrance tour on 5/9/17 a service technician was observed assessing the exit door alarms. The service tech was heard asking direct care staff how long had the alarm system been malfunctioning. The direct care staff stated, off and on for over three months. A review of Individual #1's behavior plan indicated: This individual had 22 incidents of	W 104	1) On 3/31/17 the governing body completed requisition #65883 to request that TYCO personnel come out to look at either updating the panel box and/or moving the panel box for purposes of being able to hear the annunciator better, or place a separate system just on the doors with door chimes that could be utilized with the current system, and training of features on current system. Facility staff, on the direction of the governing body on 4/9/17 made immediate verbal request to TYCO for an immediate repair, due to an indicator of a low battery. On 4/11/17 TYCO responded to the order #84734438 and determined a phone line knocked out of service due to a storm was draining the battery, creating a low battery indicator. On 4/26/17 there was a total inspection of the TYCO fire panel system which also connects to the security system. The TYCO technician confirmed the entire system was communicating properly. On 4/28/17 a TYCO technician provided training to facility staff on how to set a door bypass setting and additional features. The technician noted the alarm may be triggered on the French doors when other doors or sudden movement inside the facility causes the windows to rattle on the french doors, thus sending an alarm to the security system. A request was made for a TYCO representative to explore the possibility of an upgrade of the system to include door annunciators. On 5/1/17 a TYCO account representative came on site and after talking with the governing body referred the matter to a sales representative and an appointment was set for 5/9/17. A requisition #64893 was made to address recommendations for the eppointment on 5/9/17. On 5/9/17 TYCO sales representative Gregory Foley responded to the site. He sent the facility a quote on 5/15/17 for wired zoned expander relay board and adjustable door	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darlene M Daniels, Dir		6/7/17

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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W 104	Continued From page 1 running out of the building from 2/ 23/17 until 5/11/17. A review of an Incident Log indicated the following: January 18th 2017 the staff documented, Security key pad sticking, can the Security Company be notified. January 28, 2017 Security pad still sticking making it difficult to set alarm. February 14, 2017 Alarm keeps going off throughout the overnight. It happened twice. The alarm indicated patio door had breakage. April 9, 2017 Battery is low and the alarm company called to replace the battery. April 29, 2017 The alarm system was on a two doors were on by-pass (Recreation Room and Staff Entrance). Staff noticed that the hallway patio door was crack open and the alarm did not sound and we did not receive a call from the security system. On 5/11/17 at 11: 15 A.M. during an environmental tour, the lower level back door leading to an apartment complex located behind the facility was observed to be open. All Individuals were noted out of the facility around 9:20 A.M. A sign throughout the facility indicated: alarm system is on between 9: A.M. and 5 P.M. entrance to the building will be through the staff entrance door during these hours. During an interview with the Residential Coordinator she stated, the door alarm and the	W 104	chimes for all exterior doors to identify when doors are opened from inside or outside of the building. Although this will be programmed through the existing alarm system in place, the chimes will be programmed so that the police are not notified unless the existing alarm system is set to operate as it is used currently. Please note there is no repair that needs to be made to the existing alarm system currently in place. It is not in disrepair. This quote (#9154UE01) for an upgrade is only a supplement to the existing system. On 5/17/17 an email was received from Mr. Foley with quote adjustment to include one additional door with the new chime system and notification that the work would start within 2 weeks of the date of the email, barring any unforeseen circumstances. On 5/11/17 the Clinical Services Administrator, after being questioned about the sign on the facility wall stating that the system was on, informed the surveyors that the security system had been disarmed by facility staff to accommodate multiple visitors entering and exiting the building as they did not have the knowledge of the door that the facility staff utilize when the alarm system is on during the day. There were no residents at home during the time of that inquiry. 2) The governing body took steps after the TYCO visit on 4/28/17 to train all staff on the features of the current existing system. Training was provided on 4/28/17 through 5/3/17 until all staff were trained. Written directions were posted by the panel on 4/28/17 for facility staff to also follow. The governing body facilitated a staff meeting with all facility staff on both 5/11 and 5/12/17 stressing the importance of keeping the security alarm activated at all times and bypassing the chosen staff entry way Monday through Friday from 9:00am to 5:00pm. While TYCO directly contacts the governing body when there is a notification received by the system, the facility staff are also required to report any notice of malfunction of the security devices to the governing body. 3) The terms and conditions of the security system vendor contract was reviewed to ensure written specifics regarding appropriate call response time and maintenance expectations.	6/25/17 5/11/17 5/12/17 5/12/17

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W 104	Continued From page 2 fire alarm pad gets stuck. The facility staff failed to ensure safety equipment was operating properly.	W 104	Based on the final quote that was received from TYCO regarding security system upgrades, the facility reviewed all of the needs of all the residents and determined the upgrades should meet the needs of all residents.	5/17/17
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility staff failed to ensure staff supervision and management was available to ensure that direct care supervision management was provided for Individual #1's Person Centered Plan (PCP) for wandering and leaving the building and for Individual #3 in accordance with her approved PCP for disrobing. The findings included: 1. Individual #1 was admitted to the facility on 6/6/03 with diagnoses which included Severe Intellectual Disability, autistic and anxiety. A PCP dated 12/23/16 indicated: what is important to me. Goal -To be healthy and safe as agreed upon in my plan. Objectives- What does success look like? Desired Outcomes: Supervision for wandering and intruders. How often- daily. Who is going to support me? Residential staff. A review of an April 28, 2017 Adverse Incident	W 186	1) The Clinical Services Administrator and program manager have reviewed the current staff work schedule to ensure sufficient direct care staff coverage and it has been recommended that an additional full time position will be added to the current direct support FTEs to the facility. Given the suggested ratio in TAG W187 based on individuals' functioning levels and behavioral support plans the facility ratio in a 24 hour period should be 3.5. By adding another FTE, the facility ratio will be raised. Until hire, it will be achieved by utilizing PRN staff. The facility is currently recruiting for the position. Policy #943 Staff Work Schedule will be updated to address the individual needs of an individual that is admitted if ever with the need for one on one direct care supervision. Neither Individual #1's current ISP nor Behavioral Support Plan indicates that he must have a male staff person at all times. As male staff are available, they are assigned to work with all male consumers in the house. Individual #1's privacy was not invaded by female staff, as female staff were monitoring him from outside the bathroom door ensuring he has all items as needed, as do the male staff. His plan does not call for direct hands-on care for ADLs in the bath room. On 5/9/17 there was a male staff person upstairs with Individual #1 while he was showering	6/25/17 6/25/17

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W 186	Continued From page 3 Report indicated: "About 3:00 P.M. Individual #1 exited the building. Staff opened all the exterior doors so that Individual #1 could return to the building. One staff stood between the road and the building for safety. Individual #1 returned to the building (no approximate time given for Individual #1 being out of the building). After about an hour and a half Individual #1 exited the building again. Staff opened all the exterior doors so that Individual #1 could return to the building. Individual #1 returned inside the building after fifteen minutes. Individual #1 sat at his table and watched television. Staff then asked him if he was ready for his shower. He said yes and staff led him to the bathroom. Staff and Individual #1 went into the laundry room to get his hygiene materials, he then snatched his towel and wash cloth and ran into the shower slamming the door. Staff then got his body wash and deodorant out the hygiene closet right next to the bathroom. Staff knocked on the door and handed Individual #1 his hygiene items. Staff monitored Individual #1 outside the bathroom giving Individual #1 his privacy. Staff realized Individual #1 did not have his night clothes, so staff went inside the laundry room for a moment to get Individual #1's clothing. Staff returned to the hallway and staff noticed the bathroom door was open and Individual #1 was gone, leaving the shower running. Staff informed the other staff to open all the exterior doors so that Individual #1 could return to the building and that he was "naked". As staff opened all doors they didn't see Individual #1 so staff walked around the building and that's when the other staff inside the house yelled, "He is In."	W 186	during dinner time and the male staff was monitoring from the hallway. The facility's electronic time-keeping system indicates his presence. In addition, 4 staff were in the kitchen area and 2 were in the living room area during the physical observation prior to dinner. During the interview on 5/11/17 at 1:50 pm, regarding Individual #3's disrobing, a surveyor made a statement that there was no male staff on shift on 5/9/17. No response was given by any of the facility staff in the room as it was not a question, it was a statement. 2) Per facility Policy #943 Staff Work Schedule, the Residential Manager ensures the staff work schedule is developed at least 2 weeks in advance, and submitted to the Clinical Services Manager for review and approval. The work schedule will ensure that the direct care staff-to-client ratio will in a 24 hour period will be 1 to 3.5. The staff work schedule will be implemented and maintained as necessary to sufficiently manage and supervise individuals in accordance with their individual program plans. On 5/11/17 and 5/12/17 the Clinical Services Administrator facilitated a staff meeting to emphasize appropriate deployment of direct care staff services and duties. The meeting included a debriefing of the event involving Individual #3 that occurred 5/9/17 as noted by the surveyors. Staff reviewed how it could have been managed	5/12/17 5/11/17 5/12/17

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W 186	Continued From page 4 Between the time staff went in the laundry room and noticed Individual #1 was not in the shower, Individual #1 was probably out side between 5-10 minutes. A note in the Incident Report indicated: " An employee of the facility arrived at the facility and informed staff that Individual #1 was outside the building naked. The employee stated a friend who lives in the apartment in the back of the facility gave her a call and told her about Individual #1". On Call Nurse was contacted to give PRN (as needed) Ativan for agitation. Individual #1's Authorized Representative (AR) was contacted, a message was left on the answering machine. On 4/29/17 at 10:45 A.M. the AR called back to the facility in regards to the incident. The AR voice tone seemed to be upset as she asked staff why they monitoring Individual #1 when his PCP called for a male to monitoring him during shower time. The staff responded, "Unfortunately a male staff wasn't on shift." The AR apologized to staff and stated the facility should be ashamed of themselves putting staff safety in jeopardy. She said she was upset with the agency management because she and the facility had put in place in PCP that a male staff was to be with him, especially when taking a shower. The AR stated, Individual #1 is "very disrespectful towards women and he will fight them." On 5/9/17 during the afternoon shift there were no males on duty. The Residential Coordinator and the Program manager were asked during an interview on 5/11/17 at 1:50 P.M. if a male staff was on duty for the evening shift of 5/9/17 and they stated, "No". A data sheet for challenging behaviors indicated	W 186	appropriately with the staff on shift. A strategy was reviewed to consistently communicate with each other before attending to another activity, in order to verify which staff will be responsible for supervising the individuals. Since two staff were occupied writing an incident report in another room during the event, prioritizing direct client care was also emphasized. 3) Facility Policy #943 Staff Work Schedule, has been updated and renamed Facility Staffing and Supervision. The policy has been revised to state: There shall be sufficient direct care staff to manage and supervise individuals in accordance with the individuals' program plans. Direct care staff's primary duties include all aspects of client care. There should also be sufficient numbers of support staff to support the routine maintenance of the facility's day to day operations. The accompanying procedure has been revised to state: Effective deployment of both direct care and support staff will be scheduled by facility management to ensure adequate staffing to implement program planning and responded to injuries, illness, and emergencies promptly. Staffing should reflect the active treatment needs of individuals as it fluctuates throughout the day including periods of enhanced supports for specialized needs. In the event that that an individual's plan must be updated to include enhanced direct care	6/2/17

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W 186	Continued From page 5 "Running Out of Building". Individual #1 A review of Individual #1's behavior plan indicated: This individual had 22 incidents of running out of the building from 2/ 23/17 until 5/11/17. During an interview on 5/11/16 at 1:45 P.M. with the Residential Coordinator, she stated, "The facility did not have a policy for supervision of Individuals." The facility staff failed to provide supervision to prevent Individual for wandering and to implement his Person Centered program Plan. 2. The facility staff failed to ensure that direct care supervision management was provided for Individual #3 on 5/9/17 in accordance with her approved Personal Center Plan for disrobing. Individual #3 was a 52 year old admitted to the facility on 3/29/04 with diagnoses to include: (1) Profound Mental Retardation, (2) Intermittent Explosive Disorder and (3) Seizures. On 5/9/17 from 4:50 p.m. until 5:05 p.m. Individual #3 was observed in the community dining room with 10 other in house individuals. The 10 in house individuals were all seated around 3 different tables; however, Individual #3 was ambulating back and forth with her black leotard off of both arms and down around her waist from the tables to the kitchen counter serving door that was closed. Individual #3 was naked from her waist up and continued to walk back and forth to the closed kitchen counter	W 186	supervision or overall care, a team meeting will be called to thoroughly discuss the individual's needs and assessment of continued need for enhanced supervision. If the need is found to be permanent the facility staff along with the individual, the individual's surrogate decision maker and Case Manager will discuss the determined level of care and supports required to meet that need. If referral for a more appropriate placement is deemed necessary, Case Management will assist the individual in appropriate placement. All facility staff will record time worked in the facility's electronic time keeping system. Staff requesting leave must do so utilizing the electronic time keeping system and adequate coverage secured. Changes due to last minute staffing issues or need for additional direct support staff due to an individual injury, illness or facility emergencies will be adjusted and all staff deployed as needed at that given time. A review of all of the needs of the Individuals determined that the modified Staff Work Schedule, with a raised direct care staff to client ratio, should meet the needs of all the residents. Individual #1's Behavioral Support Plan was updated by the psychologist consultant 5/16/17 with procedures for staff to implement should Individual #1 run out of the building and is not	5/19/17 5/16/17

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serving door with her arms against her chest and bilateral breasts exposed for approximately 15 minutes. The full door from the kitchen to the dining room was also closed. There were no staff members in the community dining room with the 11 individual for approximately 15 minutes. There was also no visualization from the kitchen into the community dining room because the counter serving door and the full door were closed. Two staff members were sitting in the front room of the facility near the exit working on a computer approximately 30 feet from the community dining room. At 5:05 p.m. a Residential Technician that was in the front room entered the community dining room and assisted Individual #3 with putting her black leotard back on and remained in the dining area. At 5:10 p.m. this surveyor entered the kitchen area from the hallway and observed 4 staff members in the kitchen preparing the dinner meal around the center island. The surveyor asked the 4 staff members if they were aware that (Name of Individual #3) was in the dining room undressed from the waist up. The Clinical Services Administrator stated, "I just put her leotard back on her." The Residential Manager then stated, "And I have just done it once already myself also." The surveyor asked, "Why is the counter serving door and kitchen door closed?" The Clinical Services Administrator stated, "Because (Name of Individual #3) keeps reaching in and grabbing the plates so we closed it." All Individual dinner plates were observed to be on the center island in the kitchen. The only food item noted on the counter near the counter serving doors was multiple glasses of pink lemonade which was over to the right side. Individual #3 was observed by the surveyor peaking through the crack of the counter serving doors while the staff were being

W 186 wearing clothes. Other related updated strategies include: moving his table to a different location and consider sitting with his back to the wall to reduce anxiety associated with people moving around behind him; encouraging him to take walks outdoors near the home or in a public walking area, as he likes to walk outdoors; Individual #1 should attend a vocational program if one becomes available, otherwise he should take part in activities at home and in the community.

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addressed in the kitchen. After being informed of Individual #3's current garment situation none of the 4 staff members in the kitchen stopped to assist Individual #3 but continued with the meal preparation. For 15 minutes there was no direct care supervision at any time noted for Individual #3 disrobing or the other 10 Individuals in the community dining area waiting on dinner.

Individual #3's Person Centered Plan dated 4/4/17 at 11:00 a.m. is documented in part, as follows:

ICF (Intermediate Care Facility) Part 5
Important To Me:
Goal: Inappropriate Behaviors
List the actions/supports needed: Verbal, Physical, Gestural Support
Describe how this will be provided based on individual preferences (support instructions) and location where program strategy can be found: I will not display any inappropriate behaviors,
a) I will follow my behavior support plan as written by the Psychologist.
How often or by when?: Daily
Responsible Partner: FAR (Finney Avenue Residential) Staff
Start Date: 05/01/2017
End Date: 4/30/2018

Goal: Wear Leotard
List the actions/supports needed: Verbal, Physical, Gestural Support
Describe how this will be provided based on individual preferences (support instructions) and location where program strategy can be found: I will wear my leotard to ensure appropriate dress.
a) DSP (Direct Support Partner) will support me by helping me put on my leotard.

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W 186	Continued From page 8 b) DSP will ensure I have leotards available and keep the leotard on. How often or by when?: Daily Responsible Partner: FAR (Finney Avenue Residential) Staff Start Date: 05/01/2017 End Date: 4/30/2018 Individual #3's BEHAVIORAL SUPPORT PLAN date written 6/19/15 and signed by the Clinical Psychologist on 6/30/15 is documented in part, as follows: TARGET BEHAVIORS: *Removing her clothes in public PROCEDURES: 3. Staff will ensure (Name) Individual #3 does not wear short-sleeved shirts and that the shirts that she wears are of at least three-quarter length (that is, sleeves below the elbow). 4. (Name of Individual #3) also will wear a one-piece body suit or bathing suit under her clothing each day. This should remain on during all waking hours unless she clearly seems not to want to wear it. 13. If (Name of Individual #3) removes her clothing, staff will assist her in replacing her clothing and will attempt to redirect her to an ongoing activity. If she removes her clothes a second time, staff will accompany her to a private area (such as her bedroom) if one is available and will continue with her activities in that setting. Staff should not leave her alone in the private area. 17. Staff will document incidents of each of the target behaviors on the data sheets in (Name of	W 186		

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W 186	Continued From page 9 Individual #3's) program binder and elsewhere as required by (name of community service board) and Finney Avenue ICF/IID. Individual #3's DATA SHEET FOR CHALLENGING BEHAVIOR-RESIDENTIAL for May 2017 is documented in part, as follows: Target Behaviors: Removing Clothes Instructions: Tally behaviors as they occur, but do not record more than one incident of self-injury, overturning chairs or removing clothes in an hour. Record food stealing each time it occurs. Date May 9 2017: Remove Clothes 3X (3 times) The facility policy titled "Staff Work Schedule" revised 1/13 is documented in part, as follows: POLICY: There shall be methods established and maintained whereby adequate staff coverage is assured and the work schedule of staff is readily available. PROCEDURE: The Director of Community Support Services and the (Name of Community Services Board) Personnel Office will ensure adequate support staff will be employed so that direct care staff is not required to perform support services to the extent that these duties interfere with the exercises of their primary duties (implementation of Person Centered Plan). "Adequate" coverage is defined as that which is necessary to implement and maintain the program described in this manual.	W 186		

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(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 186	Continued From page 10 On 5/11/17 at approximately 3:00 p.m. a pre-exit debriefing was conducted with the Clinical Services Administrator and the Residential Manager in attendance and the above findings were shared. Prior to exit no further information was provided. (1) Profound Mental Retardation: a disorder characterized by subaverage general intellectual function with IQ under 20 with deficits or impairments in the ability to learn and to adapt socially. (2) Intermittent Explosive Disorder: a mental disturbance beginning in childhood and characterized by discrete episodes of violence and aggressive behavior and destruction of property in otherwise normal individuals. (3) Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that causes a sudden, violent involuntary series of contractions of a group of muscles. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	W 186		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of	W 242	1) The Residential Manager corrected the PCP Quarterly Review to accurately reflect the data collected on Individual #2's Medication data sheets for February, March and April 2017. A review of all Individual's records will be conducted by the Program	5/11/17

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W 242	Continued From page 11 acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interviews, clinical record review, and facility document review the facility staff failed to ensure documentation was collected to yield an accurate measurement of the criteria of medication management progress for 1 of 4 Individuals in the survey sample, Individual #2. The facility staff failed to ensure documentation was collected and reported correctly to yield an accurate measurement of Individual #2's criteria of medication management for punching his medication out as outlined in his Person-Centered Plan for the months of February, March and April 2017. The findings included: Individual #2 was a 62 year old admitted to the facility on 5/21/14 with diagnoses to include: (1) Moderate Mental Retardation, (2) Depression and (3) Seizures. On 5/9/17 at 4:20 p.m. a Medication Administration observation was conducted with Individual #2 and Residential Technician (RT) #1. Individual #2 was given Prozac 10 mg (milligrams) 1 capsule that the RT removed from a multidose package and placed in a cup for administration. The RT also punched Clonazepam 1 mg 1 tablet from a blister bubble medication pack and placed it into the medication cup with the Prozac. The medication cup with the 2 medications were handed to Individual #2 along with a cup of water and swallowed by Individual	W 242	Manager to ensure that data collected is being accurately reported on each Individual's most recent PCP Quarterly Review. 2) The Program Manager will instruct the Residential Counselor to correct the Monthly Criteria Report for February, March, April to accurately depict the data that was collected. The Clinical Services Administrator will facilitate a training on data collection and reporting for all of the facility's QIDPs. A PCP Change Note will be completed to modify Individual #2's Person-centered plan outcome for Medication. The description shall read "I will punch out my medications from its bubble pack and access my other medications by tearing the multi-dose packaging." Support instructions will be added to include temporary mechanical supports if determined after assessment it is needed. The frequency will specify all medication administration times, daily. The Medication outcome data sheet format for Individual #2 will be revised to record data for all shifts in which medication administration	6/25/17 6/25/17 6/25/17 6/25/17 6/25/17

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W 242	Continued From page 12 #2. The RT never verbally, physically, or gesturally encouraged or allowed Individual to independently punch out his own medication to take. On 5/10/17 at 3:35 p.m. a Medication Administration observation was conducted with Individual #2 and Residential Counselor (RC) #1. RT #2 allowed Individual #2 to punch his Clonazepam 1 mg 1 tablet and Tylenol Arthritis 650 mg 2 tablets from blister bubble medication packs into a medication cup, while giving verbal support. After Individual #2 successfully punched the above mediations into the medication cup he stated, "I did it, I punched my own pills so I can stay independent." Individual #2 then swallowed the medications in the cup. The surveyor asked RC #1 about Individual #2's Prozac 10 mg from the multidose package he was also due for. RC #1 stated, "Oh I had already opened that and it was in his medication cup." The surveyor asked, "Why didn't you allow him to open that medication package?" The RC stated, "I thought he would drop it." The surveyor then stated, "He did not drop the other medications when he punched them out." There was no further response from the RC. Individual #2's Person Centered Plan dated 2/13/17 at 1:45 a.m. was reviewed and is documented in part, as follows: ICF (Intermediate Care Facility) Part 5 Important To Me: Goal: Medication List the actions/supports needed: Verbal, Physical, Gestural Support Describe how this will be provided based on individual preferences (support instructions) and	W 242	occurs. It will also be updated to reflect the revised outcome as written. Once the program outcome is updated the QIDP/Nursing staff will train all facility staff on proper implementation of the outcome. 3) A review of facility Policy #857 Interdisciplinary Team, determined that it continues to meet state and federal requirements for evaluating needs, planning outcomes, reviewing responses and revising outcomes. A review of facility Policy #860 Person-Centered Plan, determined that it continues to meet state and federal requirements for the development and implementation of a person-centered plan to ensure continuous, aggressive active treatment for each individual. A review of facility Policy #864 Data Collection/Monitoring, determined it continues to meet state and federal requirements for an established reliable method of collecting data for each individual outcome of an individual's IPP.	6/25/17 6/25/17 5/25/17 5/25/17

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location where program strategy can be found: I will punch out medications to take.
a) DSP (Direct Support Partner) will support me by providing supervision and supporting me verbally and physically.
b) DSP will document.
How often or by when?: Daily
Responsible Partner: FAR (Finney Avenue Residential) Staff
Start Date: 06/01/2016
End Date: 5/31/2017

Individual #2's Medication Management Skills Checklist dated 5/4/16 was reviewed and is documented in part, as follows:

Medication Management:
Date: 5/4/16
Skills: Punched medication from prepared medication card- Score Level 3

Score Code:
Level 3:
Type of Performance: Verbal and Partial Physical of Gestural Prompting.
Description of Level of Performance: The individual requires partial assistance in the form of multiple prompts (verbal, gestural, and/or physical to complete task.
Examples: While the resident is performing the task, staff places his/her hands in the proper position and provides verbal clues to aid him/her completing the task.

Individual #2's most current signed Physician Orders dated 2/1/17 were reviewed and are documented in part, as follows:

1/17/17: Clonazepam 1 mg tablet, 1 tablet by

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mouth three times daily. (Anticonvulsant)
9/22/16: Prozac 10 mg capsule, take 1 capsule at 4 p.m. (Antidepressant)
9/29/16: Tylenol Arthritis ER (Extended Release) 650 mg, 2 caplets by mouth every 8 hours as needed for limb pain. (Analgesic)

Individual #2's Interdisciplinary Team Meeting Report that was held on 2/22/17 at 3:01 p.m. was reviewed and is documented in part, as follows:

SCHEDULE OF SUPPORTS: (Name) Residential Manager presented (Name) Individual #2's Schedule of Supports.
IMPORTANT FOR (F3): F3.2- Medication-stable.

(ndividual #2's (ndividual Support Program F3.2 Medication Data Sheets for February, March and April 2017 were reviewed and are documented in part, as follows:

F3.2: Medication
I will punch out medication to take.
1:a) DSP will support me by providing supervision and supporting me verbally and physically.
b) DSP will document.

Code:
punch put meds= check
did not punch out meds = X
Refuses =R

February 2017
Check: 3 days
X: 25 days
R: 0 days

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March 2017
Check: 31 days
X: 0 days
R: 0 days

April 2017
Check: 2 days
X: 28 days
R: 0 days

Individual #2's Monthly Criteria Report dated 5/8/17 at 8:23 a.m. was reviewed and is documented in part, as follows:

Goal#: F3.2 Medication
Objective: 30 days
G (goal): Important For Me: I will punch out medication to take.

Individual #2's Person-Centered Program 1st Quarterly Review dated 5/8/17 at 5:12 p.m. completed by the Residential Manager was reviewed and is documented in part, as follows:

This Person-Centered review covers information from: 02/01/2017 To: 04/30/2017
Instructions: Include the full outcome as reflected on the shared plan or in a previous update in the Desired Outcome field. Include the start date and status for each outcome in the Start Date and Status fields. Evaluate each outcome in the last two text fields.

DESIRED OUTCOME (Enter Outcome Number and Statement): F3.2: Medication: I will punch out medication to take daily.
Start Date: 06/01/2016
Status of Outcome: Partially Met
Describe what has been tried and learned since

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W 242	Continued From page 16 the last review. What are you pleased about and concerned about? DSP supported me by providing supervision to ensure my medications were taken and with verbal and physical support with punching out my medications daily for a total of 89 days in this quarter. February: Punched medications 28 days. March: Punched medications 31 days April: Punched medications 30 days. Describe what will be changed or improved and what will stay the same: CONDITION: Stable On 5/10/17 at approximately 5:00 p.m. an interview was conducted with the Residential Manager regarding Individual #2's Individual Support Program F3.2 Medication Data Sheets for February, March and April 2017, Individual #2's Monthly Criteria Report dated 5/8/17, and Individual #2's Person-Centered Program 1st Quarterly Review dated 5/8/17. The surveyor asked, "What is the purpose of the data collect on facility individuals?" The Residential Manager stated, "It represents their outcomes toward their goals and it shows the progress or decline that they are making." The surveyor then asked, "Where did you get the data for your Quarterly Report for (Name of Individual #2)?" The Residential Manager stated, "Mostly from the Criteria Report and the Individual's Data Sheets." The inconsistencies between Individual #2's Individual Support Program F3.2 Medication Data Sheets for February, March and April 2017, Individual #2's Monthly Criteria Report dated 5/8/17, and Individual #2's Person-Centered Program 1st Quarterly Review dated 5/8/17 that	W 242		

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the Residential Manager completed were reviewed with her. The surveyor asked, "Is (Name) Individual #2's Person-Centered Program 1st Quarterly Review dated 5/8/17 that was completed by you data accurate and represent him correctly for the months mentioned?" The Residential Manager stated, "No, its not."

The facility policy titled "Person-Centered Plan" revised 1/13 is documented in part, as follows:

POLICY:
It is the policy of Finney Avenue Residence ICF/IID that an individual's PCP/IPP (Person-Centered Plan/Individual Program Plan) will be developed and implemented to ensure continuous, aggressive active treatment for each individual. An individual's PCP/IPP will serve as a guide for DSP decisions regarding individual training, treatment, activities, and use of supports. The PCP/IPP stands as a working document that evolves with the individuals need for supports.

PROCEDURE:
A. The entire PCP/IPP process is a composite of the following data:
1. All professional evaluations, including social, medical, nutritional, communication and/or OT/PT (Occupational Therapy/Physical Therapy), and psychological.
9. Behavior Support Data.
10. Schedule of Supports.

B. The PCP/IPP components and function are as follows:
2. Active treatment needs are prioritized based on an individual's hierarchy of need according to their evaluations, functional assessments and individual's desires.

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3. PCP/IPP will state the identified supports (need area) and written outcome for each support outcomes; will be expressed in behavioral terms that are both measurable and realistic to that individuals needs. The outcome will state the frequency of implementation.
4. PCP/IPP will also have a goal for each need as listed on the form. This goal will indicate any needed supports to implement the outcomes as well as environment, consumer choice, duration and times to implement the outcome.
6. Data sheets will be developed for each outcome to collect information to report progress, regression or stability.

C. Access to the PCP/IPP is as follows:
1. Any discipline or DSP providing care to the individual will have access to the individual's record and daily Program Book for implementation and monitoring of Active Treatment.

On 5/11/17 at approximately 3:00 p.m. a pre-exit debriefing was conducted with the Clinical Services Administrator and the Residential Manager in attendance and the above findings were shared. The Residential Manager stated, "We will have to modify his plan to include the multidose packaging."

Prior to exit no further information was provided.

(1) Moderate Mental Retardation: a disorder characterized by subaverage general intellectual function with IQ between 35 to 50 with deficits or impairments in the ability to learn and to adapt socially.

(2) Depression: an abnormal emotional state

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W 242	Continued From page 19 characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality. (3) Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that causes a sudden, violent involuntary series of contractions of a group of muscles. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	W 242		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility staff failed to ensure staff supervision and management was available to ensure Individual #1 was supervised in accordance with his Person Centered Plan (PCP) for wandering and leaving the building and Individual #3 was supervised in accordance with her Person Centered Plan (PCP) for disrobing. The findings included:	W 249	1) Neither Individual #1's current Person-Centered Plan nor his Behavioral Support Plan indicates that he must have a male staff person to monitor him at all times. His Authorized Representative (AR) has not requested the IDT to provide for exclusively male staff monitoring of Individual #1, and has approved his person-centered plan and Behavioral Support Plan as written. The AR has expressed her opinion about Individual #1's demeanor toward male versus female staff directly with the Director of Community Supports. The AR was informed that as male staff are available, they are assigned to work with all male consumers in the house. On 5/9/17 there were appropriate and sufficiently trained staff to implement	

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1. Individual #1 was admitted to the facility on 6/6/03 with diagnoses which included Severe Intellectual Disability, autistic and anxiety. A PCP dated 12/23/16 indicated: what is important to me. Goal -To be healthy and safe as agreed upon in my plan. Objectives- What does success look like? Desired Outcomes: Supervision for wandering and intruders. How often- daily. Who is going to support me? Residential staff.

A review of Individual #1's Person Centered Plan Quarterly review dated 3/9/2017 indicated:
Household Safety/Monitoring.
Status of Outcome: Partially Met
Describe what has been tried and learned since the last review. What are you pleased about and concerned about?
Individual #1 received support in his living environment to maintain household safety and remain safe in the community and protected from home intruders. DSP (Direct Service Providers) ensured that the facility doors were locked, Monitoring cameras were active and the security system was activated as directed.

A data sheet for challenging behaviors indicated "Running Out of Building".

A review of Individual #1's behavior plan indicated: This individual had 22 incidents of running out of the building from 2/ 23/17 until 5/11/17.

A review of an Incident Log indicated the following: January 18th 2017 the staff documented, Security key pad sticking, can the Security Company be notified.

W 249 Individual #1's person-centered plan. On 5/9/17, during dinner time, there was a male staff person upstairs with Individual #1, monitoring from the hallway while he was showering. In addition, 4 staff were in the kitchen area and 2 were in the living room area during the physical observation prior to dinner. During the interview on 5/11/17 at 1:50 pm, regarding Individual #3's disrobing, a surveyor made a statement that there was no male staff on shift on 5/9/17. No response was given by any of the facility staff in the room as it was not a question, it was a statement. On 5/9/17 plates were moved to the center island in order to close the kitchen serving window.

Individual #1's person-centered plan includes the Outcome: Support for Wandering and Intruders. The description of how it will be provided reads "I will respond to DSP support to ensure safety when I leave the building." Support instructions include "DSP will support me by ensuring daily facility doors are locked, monitoring cameras are activated and security system activated as directed in facility Policy #819" and "DSP will support me by following my plan for safety if I leave the building without supervision." On 4/28/17 facility staff appropriately implemented Individual #1's

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W 249	Continued From page 21 January 28, 2017 Security pad still sticking making it difficult to set alarm. February 14, 2017 Alarm keeps going off throughout the overnight. It happened twice. The alarm indicated patio door had breakage. April 9, 2017 Battery is low and the alarm company called to replace the battery. April 29, 2017 The alarm system was on a two doors were on by-pass (Recreation Room and Staff Entrance). Staff noticed that the hallway patio door was cracked open and the alarm did not sound and we did not receive a call from the security system. On 5/11/17 at 11:15 A.M. during an environmental tour, the lower level back door leading to an apartment complex located behind the facility was observed to be open. All Individuals were noted out of the facility around 9:20 A.M. A sign throughout the facility indicated: alarm system is on between 9: A.M. and 5 P.M. entrance to the building will be through the staff entrance door during these hours. During an interview with the Residential Coordinator she stated, the door alarm and the fire alarm pad gets stuck. A review of an April 28, 2017 Adverse Incident Report indicated: "About 3:00 P.M. Individual #1 exited the building. Staff opened all the exterior doors so that Individual #1 could return to the building. One staff stood between the road and	W 249	person-centered plan Outcome: Support for Wandering and Intruders, by following his plan for safety as written in his current Behavioral Support Plan when he left the building without supervision, and by ensuring the security system was activated. On 5/9/17 there were 4 staff in the kitchen area and 2 in the living room area during the physical observation prior to dinner, in addition to a male staff upstairs. On 5/11/17 and 5/12/17 the Clinical Services Administrator facilitated a staff meeting to emphasize appropriate deployment of direct care staff services and duties. The meeting included a debriefing of the event involving Individual #3 that occurred 5/9/17 as noted by the surveyors. Staff reviewed how it could have been managed appropriately with the staff on shift. A strategy was reviewed to consistently communicate with each other before attending to another activity in order to verify which staff will be responsible for supervising the individuals. Since two staff were occupied writing an incident report in another room during the event, prioritizing direct client care was also emphasized. 2) The Clinical Services Administrator and Program Manager have reviewed	5/11/17 5/12/17

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the building for safety. Individual #1 returned to the building (no approximate time given for Individual #1 being out of the building). After about an hour and a half Individual #1 exited the building again. Staff opened all the exterior doors so that Individual #1 could return to the building. Individual #1 returned inside the building after fifteen minutes.

Individual #1 sat at his table and watched television. Staff then asked him if he was ready for his shower. He said yes and staff led him to the bathroom. Staff and Individual #1 then into the laundry room to get his hygiene materials, he then snatched his towel and wash cloth and ran into the shower slamming the door. Staff then got his body wash and deodorant out the hygiene closet right next to the bathroom. Staff knocked on the door and handed Individual #1 his hygiene items. Staff monitored Individual #1 outside the bathroom giving Individual #1 his privacy.

Staff realized Individual #1 did not have his night clothes, so staff went inside the laundry room for a moment to get Individual #1's clothing. Staff returned to the hallway and staff noticed the bathroom door was open and Individual #1 was gone, leaving the shower running. Staff informed the other staff to open all the exterior doors so that Individual #1 could return to the building and that he was "naked". As staff opened all doors they didn't see Individual #1 so staff walked around the building and that's when the other staff inside the house yelled, "He is In."

Between the time staff went in the laundry room and noticed Individual #1 was not in the shower, Individual #1 was probably out side between 5-10 minutes. On Call Nurse was contacted to give

W 249 the current staff work schedule to ensure sufficient direct care staff coverage and it has been recommended that an additional full time position will be added to the current direct support FTEs to the facility. Given the suggested ratio in TAG W187 based on individuals' functioning levels and behavioral support plans the facility ratio in a 24 hour period should be 3.5. By adding another FTE, the facility ratio will be raised. Until hire, it will be achieved by utilizing PRN staff. The facility is currently recruiting for the position. 6/25/17

Policy #943 Staff Work Schedule will be updated to address one to one direct care supervision in the event it is needed on a temporary basis. 6/25/17

A review of all of the needs of the Individuals determined that the modified Staff Work Schedule will ensure there are appropriate and sufficiently trained staff available to meet the needs of all the residents. 5/19/17

The Clinical Services Administrator will request a review of Individual #1's Behavioral Support Plan by the psychologist consultant to determine if procedures to address his target behavior of running out of the building require any revision. The psychologist 6/25/17

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	49G009	A. BUILDING _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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 249	Continued From page 23 PRN (as needed) Ativan for agitation. Individual #1's Authorized Representative (AR) was contacted, a message was left on the answering machine. On 4/29/17 at 10:45 A.M. the AR called back to the facility in regards to the incident. The AR voice tone seemed to be upset as she asked staff why they monitoring Individual #1 when his PCP called for a male to monitoring him during shower time. The staff responded, "Unfortunately a male staff wasn't on shift." The AR apologized to staff and stated the facility should be ashamed of themselves putting staff safety in jeopardy. She said she was upset with the agency management because she and the facility had put in place in PCP that a male staff was to be with him, especially when taking a shower. The AR stated, Individual #1 is very disrespectful towards women and he will fight them." On 5/9/17 during the afternoon shift there were no males on duty. The Residential Coordinator and the Program manager were asked during an interview on 5/11/17 at 1:50 P.M. if a male staff was on duty for the evening shift of 5/9/17 and they stated, "No". The facility staff failed to consistently implement Individual #1's Person Centered Plan. 2. The facility staff failed to ensure that Individual #3's approved Person Centered Plan and Behavior Support Plan for disrobing was consistently implemented on 5/9/17. Individual #3 was a 52 year old admitted to the facility on 3/29/04 with diagnoses to include: (1) Profound Mental Retardation, (2) Intermittent	W 249	consultant will provide an in-service for facility staff to review Behavioral Support Plans for Individual #1 and Individual #3.	6/25/17
			3) A review of facility Policy #943 Staff Work Schedule, determined it continues to meet state and federal requirements for providing adequate staff coverage to implement and maintain the program. However, it will be updated to address the individual needs of an individual that is admitted if ever with the need for one to one direct care supervision.	5/19/17 6/23/17

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Explosive Disorder and (3) Seizures.

On 5/9/17 from 4:50 p.m. until 5:05 p.m. Individual #3 was observed in the community dining room with 10 other in house individuals. The 10 in house individuals were all seated around 3 different tables; however, Individual #3 was ambulating back and forth with her black leotard off of both arms and down around her waist from the tables to the kitchen counter serving door that was closed. Individual #3 was naked from her waist up and continued to walk back and forth to the closed kitchen counter serving door with her arms against her chest and bilateral breasts exposed for approximately 15 minutes. The full door from the kitchen to the dining room was also closed. There were no staff members in the community dining room with the 11 individual for approximately 15 minutes. There was also no visualization from the kitchen into the community dining room because the counter serving door and the full door were closed. Two staff members were sitting in the front room of the facility near the exit working on a computer approximately 30 feet from the community dining room. At 5:05 p.m. a Residential Technician that was in the front room entered the community dining room and assisted Individual #3 with putting her black leotard back on and remained in the dining area. At 5:10 p.m. this surveyor entered the kitchen area from the hallway and observed 4 staff members in the kitchen preparing the dinner meal around the center island. The surveyor asked the 4 staff members if they were aware that (Name of Individual #3) was in the dining room undressed from the waist up. The Clinical Services Administrator stated, "I just put her leotard back on her." The Residential Manager then stated, "And I have just done it

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once already myself also." The surveyor asked, "Why is the counter serving door and kitchen door closed?" The Clinical Services Administrator stated, "Because (Name of Individual #3) keeps reaching in and grabbing the plates so we closed it." All Individual dinner plates were observed to be on the center island in the kitchen. The only food item noted on the counter near the counter serving doors was multiple glasses of pink lemonade which was over to the right side. Individual #3 was observed by the surveyor peaking through the crack of the counter serving doors while the staff were being addressed in the kitchen. After being informed of Individual #3's current garment situation none of the 4 staff members in the kitchen stopped to assist Individual #3 but continued with the meal preparation. For 15 minutes there was no direct care supervision at any time noted for Individual #3 disrobing or the other 10 Individuals in the community dining area waiting on dinner.

Individual #3's Person Centered Plan dated 4/4/17 at 11:00 a.m. is documented in part, as follows:

ICF (Intermediate Care Facility) Part 5
Important To Me:
Goal: Inappropriate Behaviors
List the actions/supports needed: Verbal, Physical, Gestural Support
Describe how this will be provided based on individual preferences (support instructions) and location where program strategy can be found: I will not display any inappropriate behaviors,
a) I will follow my behavior support plan as written by the Psychologist.
How often or by when?: Daily
Responsible Partner: FAR (Finney Avenue

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Residential) Staff
Start Date: 05/01/2017
End Date: 4/30/2018

Goal: Wear Leotard
List the actions/supports needed: Verbal, Physical, Gestural Support
Describe how this will be provided based on individual preferences (support instructions) and location where program strategy can be found: I will wear my leotard to ensure appropriate dress.
a) DSP (Direct Support Partner) will support me by helping me put on my leotard.
b) DSP will ensure I have leotards available and keep the leotard on.
How often or by when?: Daily
Responsible Partner: FAR (Finney Avenue Residential) Staff
Start Date: 05/01/2017
End Date: 4/30/2018

Individual #3's BEHAVIORAL SUPPORT PLAN date written 6/19/15 and signed by the Clinical Psychologist on 6/30/15 is documented in part, as follows:

TARGET BEHAVIORS:
*Removing her clothes in public

PROCEDURES:
3. Staff will ensure (Name) Individual #3 does not wear short-sleeved shirts and that the shirts that she wears are of at least three-quarter length (that is, sleeves below the elbow).

4. (Name) Individual #3 also will wear a one-piece body suit or bathing suit under her clothing each day. This should remain on during all waking hours unless she clearly seems not to

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want to wear it.

13. If (Name) Individual #3 removes her clothing, staff will assist her in replacing her clothing and will attempt to redirect her to an ongoing activity. If she removes her clothes a second time, staff will accompany her to a private area (such as her bedroom) if one is available and will continue with her activities in that setting. Staff should not leave her alone in the private area.
17. Staff will document incidents of each of the target behaviors on the data sheets in (Name) Individual #3's program binder and elsewhere as required by (name of Community Services Board) and Finney Avenue ICF/IID.

Individual #3's DATA SHEET FOR CHALLENGING BEHAVIOR-RESIDENTIAL for May 2017 is documented in part, as follows:

Target Behaviors: Removing Clothes
Instructions: Tally behaviors as they occur, but do not record more than one incident of self-injury, overturning chairs or removing clothes in an hour. Record food stealing each time it occurs.

Date May 9 2017: Remove Clothes 3X (3 times)

The facility policy titled "Person-Centered Plan" revised 1/13 is documented in part, as follows:

POLICY:
It is the policy of Finney Avenue Residence ICF/IID that an individual's PCP/IPP (Person-Centered Plan/Individual Program Plan) will be developed and implemented to ensure continuous, aggressive active treatment for each individual. An individual's PCP/IPP will serve as a guide for DSP decisions regarding individual

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training, treatment, activities, and use of supports. The PCP/IPP stands as a working document that evolves with the individuals need for supports.

PROCEDURE:
A. The entire PCP/IPP process is a composite of the following data:
1. All professional evaluations, including social, medical, nutritional, communication and/or OT/PT (Occupational Therapy/Physical Therapy), and psychological.
9. Behavior Support Data.
10. Schedule of Supports.
14. Support Intensity Scale as required.

B. The PCP/IPP components and function are as follows:
2. Active treatment needs are prioritized based on an individual's hierarchy of need according to their evaluations, functional assessments and individual's desires.
3. PCP/IPP will state the identified supports (need area) and written outcome for each support outcomes; will be expressed in behavioral terms that are both measurable and realistic to that individuals needs. The outcome will state the frequency of implementation.
4. PCP/IPP will also have a goal for each need as listed on the form. This goal will indicate any needed supports to implement the outcomes as well as environment, consumer choice, duration and times to implement the outcome.
6. Data sheets will be developed for each outcome to collect information to report progress, regression or stability.

C. Access to the PCP/IPP is as follows:
1. Any discipline or DSP providing care to the individual will have access to the individual's

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record and daily Program Book for implementation and monitoring of Active Treatment.

The facility policy titled "Staff Work Schedule" revised 1/13 is documented in part, as follows:

POLICY:
There shall be methods established and maintained whereby adequate staff coverage is assured and the work schedule of staff is readily available.

PROCEDURE:
The Director of Community Support Services and the (name of Community Services Board) Personnel Office will ensure adequate support staff will be employed so that direct care staff is not required to perform support services to the extent that these duties interfere with the exercises of their primary duties (implementation of Person Centered Plan).

"Adequate" coverage is defined as that which is necessary to implement and maintain the program described in this manual.

On 5/11/17 at approximately 3:00 p.m. a pre-exit debriefing was conducted with the Clinical Services Administrator and the Residential Manager in attendance and the above findings were shared.

Prior to exit no further information was provided.

(1) Profound Mental Retardation: a disorder characterized by subaverage general intellectual function with IQ under 20 with deficits or impairments in the ability to learn and to adapt

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W 249	Continued From page 30 socially. (2) Intermittent Explosive Disorder: a mental disturbance beginning in childhood and characterized by discrete episodes of violence and aggressive behavior and destruction of property in otherwise normal individuals. (3) Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that causes a sudden, violent involuntary series of contractions of a group of muscles. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	W 249		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, staff interviews, clinical record review, and facility document review the facility staff failed to follow the Person-Centered Plan for 1 of 4 Individuals in the survey sample which included a Self Medication Program, Individual #2. The facility staff failed to involve Individual #2 according to his Person-Centered Plan for the Self Administration of Medications by not allowing him to punch out his medications during	W 371	1) Individual #2's person-centered plan Outcome for Medication self-administration was appropriately developed according to his Medication Management Skills Checklist dated 5/4/16, when his medications were packed by the pharmacy in blister bubble packs. As of February 2017, the agency's newly contracted pharmacy utilizes multi-dose packaging for all medications except controlled medications. Individual #2 continues to have controlled medications in blister bubble packs, in addition to other medications in multi-dose packaging. A review of all Individuals'	

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W 371	Continued From page 31 Medication Administration Observations on 5/9/17 and 5/10/17. The findings included: Individual #2 was a 62 year old admitted to the facility on 5/21/14 with diagnoses to include: (1) Moderate Mental Retardation, (2) Depression and (3) Seizures. On 5/9/17 at 4:20 p.m. a Medication Administration observation was conducted with Individual #2 and Residential Technician (RT) #1. Individual #2 was given Prozac 10 mg (milligrams) 1 capsule that the RT removed from a multidose package and placed in a cup for administration. The RT also punched Clonazepam 1 mg 1 tablet from a blister bubble medication pack and placed it into the medication cup with the Prozac. The medication cup with the 2 medications were handed to Individual #2 along with a cup of water and swallowed by Individual #2. The RT never verbally, physically, or gesturally encouraged or allowed Individual to independently punch out his own medication to take. On 5/10/17 at 3:35 p.m. a Medication Administration observation was conducted with Individual #2 and Residential Counselor (RC) #1. RT #2 allowed Individual #2 to punch his Clonazepam 1 mg 1 tablet and Tylenol Arthritis 650 mg 2 tablets from blister bubble medication packs into a medication cup, while giving verbal support. After Individual #2 successfully punched the above mediations into the medication cup he stated, "I did it, I punched my own pills so I can stay independent." Individual #2 then swallowed the medications in the cup. The surveyor asked	W 371	person-centered plans will be conducted to ensure that appropriate medication outcomes are written to accommodate the new medication packaging system. 2) A new Skills Checklist form #1859 will be updated under Fine Motor Development to include pincer grasp for both left and right hands for tearing paper. A new Skills Checklist will be performed for Individual #1 by the Residential Counselor. A PCP Change Note will be completed to modify Individual #2's Person-centered plan outcome for Medication. The description shall read "I will punch out my medications from its bubble pack and access my other medications by tearing the multi-dose packaging." Support instructions will be added to the program that may include mechanical supports based on the assessment. The frequency will specify all medication administration times and data will be collected for all times. The Medication outcome data sheet format for Individual #2 will be revised to record data for all shifts in which medication administration occurs. It will also be updated to reflect the revised outcome as written.	6/25/17 6/25/17 6/25/17 6/25/17

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W 371	Continued From page 32 RC #1 about Individual #2's Prozac 10 mg from the multidose package he was also due for. RC #1 stated, "Oh I had already opened that and it was in his medication cup." The surveyor asked, "While didn't you allow him to open that medication package?" The RC stated, "I thought he would drop it." The surveyor then stated, "He did not drop the other medications when he punched them out." There was no further response from the RC. Individual #2's Person Centered Plan dated 2/13/17 at 1:45 a.m. was reviewed and is documented in part, as follows: ICF (Intermediate Care Facility) Part 5 Important To Me: Goal: Medication List the actions/supports needed: Verbal, Physical, Gestural Support Describe how this will be provided based on individual preferences (support instructions) and location where program strategy can be found: I will punch out medications to take. a) DSP (Direct Support Partner) will support me by providing supervision and supporting me verbally and physically. b) DSP will document. How often or by when?: Daily Responsible Partner: FAR (Finney Avenue Residential) Staff Start Date: 06/01/2016 End Date: 5/31/2017 Individual #2's Medication Management Skills Checklist dated 5/4/16 was reviewed and is documented in part, as follows: Medication Management:	W 371	3) A review of facility Policy #860 Person-Centered Plan determined that it continues to meet state and federal requirements for the development and implementation of program planning.	5/25/17

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W 371	Continued From page 33 Date: 5/4/16 Skills: Punched medication from prepared medication card- Score Level 3 Score Code: Level 3: Type of Performance: Verbal and Partial Physical of Gestural Prompting. Description of Level of Performance: The individual requires partial assistance in the form of multiple prompts (verbal, gestural, and/or physical to complete task. Examples: While the resident is performing the task, staff places his/her hands in the proper position and provides verbal clues to aid him/her completing the task. Individual #2's most current signed Physician Orders dated 2/1/17 were reviewed and are documented in part, as follows: 1/17/17: Clonazepam 1 mg tablet, 1 tablet by mouth three times daily. (Anticonvulsant) 9/22/16: Prozac 10 mg capsule, take 1 capsule at 4 p.m. (Antidepressant) 9/29/16: Tylenol Arthritis ER (Extended Release) 650 mg, 2 caplets by mouth every 8 hours as needed for limb pain. (Analgesic) Individual #2's Interdisciplinary Team Meeting Report that was held on 2/22/17 at 3:01 p.m. was reviewed and is documented in part, as follows: SCHEDULE OF SUPPORTS: (Name) Residential Manager presented (Name) Individual #2's Schedule of Supports. IMPORTANT FOR (F3): F3.2- Medication-stable.	W 371		

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The facility policy titled "Person-Centered Plan" revised 1/13 is documented in part, as follows:

POLICY:
It is the policy of Finney Avenue Residence ICF/IID that an individual's PCP/IPP (Person-Centered Plan/Individual Program Plan) will be developed and implemented to ensure continuous, aggressive active treatment for each individual. An individual's PCP/IPP will serve as a guide for DSP decisions regarding individual training, treatment, activities, and use of supports. The PCP/IPP stands as a working document that evolves with the individuals need for supports.

PROCEDURE:
A. The entire PCP/IPP process is a composite of the following data:
1. All professional evaluations, including social, medical, nutritional, communication and/or OT/PT (Occupational Therapy/Physical Therapy), and psychological.
9. Behavior Support Data.
10. Schedule of Supports.
14. Support Intensity Scale as required.

B. The PCP/IPP components and function are as follows:
2. Active treatment needs are prioritized based on an individual's hierarchy of need according to their evaluations, functional assessments and individual's desires.
3. PCP/IPP will state the identified supports (need area) and written outcome for each support outcomes; will be expressed in behavioral terms that are both measurable and realistic to that individuals needs. The outcome will state the frequency of implementation.
4. PCP/IPP will also have a goal for each need

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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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as listed on the form. This goal will indicate any needed supports to implement the outcomes as well as environment, consumer choice, duration and times to implement the outcome.
6. Data sheets will be developed for each oulcome to collect information to report progress, regression or stability.

C. Access to the PCP/IPP is as follows:
1. Any discipline or DSP providing care to the individual will have access to the individual's record and daily Program Book for implementation and monitoring of Active Treatment.

On 5/11/17 at approximately 3:00 p.m. a pre-exit debriefing was conducted with the Clinical Services Administrator and the Residential Manager in attendance and the above findings were shared. The Residential Manager stated, "We will have to modify his plan to include the multidose packaging."

Prior to exit no further information was provided.

(1) Moderate Mental Retardation: a disorder characterized by subaverage general intellectual function with IQ between 35 to 50 with deficits or impairments in the ability to learn and to adapt socially.

(2) Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality.

(3) Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that

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W 371	Continued From page 36 causes a sudden, violent involuntary series of contractions of a group of muscles. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	W 371		