	TMENT OF HEALTH	AND HU ISERVICES			PRINTED: 03/15/201 FORM APPROVE DMB_NO_0938-039	
STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:			(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
		49G039	B. WING		03/14/2017	
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	3	TREET ADDRESS, CITY, STATE, ZIP CODE 018 FOREST HILL CIRCLE YNCHBURG, VA 24501 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
W 000	INITIAL COMMENT	rs	wood	W 120	4/15/17	
W 120	was conducted on OThe facility was not Part 483 Requirement Facilities for Individual Disabilities (ICFIIID) investigated during The census in this fat the time of the succonsisted of 4 currer (Individual's #1 through 483.410(d)(3) SERVOUTSIDE SOURCE The facility must assement the needs of each of the succonsisted of the succonsisted of 4 currer (Individual's #1 through 483.410(d)(3) SERVOUTSIDE SOURCE The facility must assement the needs of each of the succonsisted of the succonsistency of the succo	10 certified bed facility, was 10 arvey. The survey sample and Individual reviews ugh 4). VICES PROVIDED WITH ES sure that outside services each client. Is not met as evidenced by: view and clinical record ure the Day Program attive Treatment Plan (ATP) for in the survey sample, \$\frac{1}{2}1\$. Individual \$\frac{1}{2}4\$. Stive Treatment Plan (ATP) and for toileting at the day	w 120	 1.) Address the corrective action taken for the a. Staff at the day support at Lutheral Services will receive an in-service of treatment plan for Individual #1 by the ID Team feels the program can meet Individual #1's needs. b. Staff at the day support at the ARC an in-service on the active treatmer Individual #4 by 4/15/17 if the ID To the program can currently meet Individual #4's needs. 2.) Address how the facility will identify simil occurrences of the problem. All day support providers will receive service on each individual's active to plans by 4/15/17. The in-services will be coordinated QIDP. They will consult/collaborate utilize the other ID Team Members expertise is needed (nurses, OT, PT c. To keep the day support providers ongoing medical issues. Horizon with to provide monthly nursing assessed. In servicing will occur annually or mif there is a change in condition afficient practices will not recur. Identify measures/systemic changes to endeficient practices will not recur. The QIDP will visit each day support quarterly to ensure the Direct Support Professionals supporting our individing familiar with all aspects of the active plan. If the QIDP finds staff are not complicate as defined, we will retrain and the address the occurrences with the Mitheir respective program. In an effort to improve communication of the Day Support Programs, the IC Worker will contact each Day Suppoweekly to address any concerns or contact and contact each Day Suppoweekly to address any concerns or contact each Day Suppoweekly to address any concerns or contact each Day Suppoweekly to address any concerns or contact each Day Suppoweekly to address any concerns or contact each Day Suppoweekly to address any concerns or contact each Day Suppoweekly to address any concerns or contact each Day Suppoweekly to address any concerns or contact each each each	n Family n the active 14/15/17 if currently will receive nt plan for eam feels dividual lar ve an in- treatment by the e with as their . ETC.) aware of all ill continue ments. more often ecting the insure provider ort uals are e treatment etting the then anager at cion with all if Social ort Manager	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

1. Individual#4 was admitted to the facility on

TITLE (X6) DATE (X6) DATE (J) DATE (J)

condition manager would like addressed.

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.

	TMENT OF HEALTH	I AND HU \ \SERVICES E & MEDICAID SERVICES			(FORM	: 03/15/201 IAPPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUC	TION	(X3) DAT	0938-039 E SURVEY IPLETED
		49G039	B. WING			03/	14/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP COL		14/2017
FOREST	HILLS GROUP HOME	=		3018 FOREST LYNCHBURG	HILL CIRCLE G,VA 24501		
(X4) 10 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRI H CORRECTIVE ACTION SH REFERENCED TO THE APP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 120	profound and a mee bowel (bowel protrue of the bowel (bowel protrue) on 3/14/17 at 10:30 Individual #4's day a surveyor to observe bathroom with conceptolapsed bowel. To observed protruding the rectum and was staff or Individual #4 DSP#1 verbalized the made the facility aw facility has not provitake care of the profused that Individual #4 be reinserted. On 3/14/17 at 2:15 to (RN #1) was intervited RN #1 verbalized that Individual #4's prolapse came aware of the Individual #4 discoming the surgice of the Individual #4 discoming the Individual #	ellectual development of dical diagnoses of prolapsed ding from rectum). a.m. during observations at program, DSP #1 asked the Individual #4 while in the ern to Individual #4's the prolapsed bowel was approximately 3 inches from a not able to be reinserted by the interest of the situation, but the de any instruction on how to apsed bowel. DSP #1 also idual #4's bowel has gotten few weeks and the bowel the facility's registered nurse ewed regarding Individual #4, at the facility was aware of osed bowel, and recently the bowel was causing fort. The physician was all consult was ordered and bing to assess it himself (this	W 13	4.) Indica a	tinued Ite how facility will monitor. The QIDP will visit each day provider quarterly to ensure Support Professionals worki individuals are familiar with the active treatment plan. If we find staff are not proviexpected and defined, we we then address it with the Mai program. In an effort to improve com all of the Day Support Progras. Social Worker will contact each Manager weekly to address changes in condition manage addressed. RECOMMAR 2	support the the Direct ing with our all aspects of iding the care as vill retrain and nager at the munication with ams, the ICF ach Day Support any concerns or er would like	4/15/17
	program not having	ed in regard to the day an ATP regarding the care of l. RN #1 presented a plan of			VDH/(o 2017 Olc	3

RN #1 was questioned in regard to the day program not having an ATP regarding the care of Individual #4's bowel. RN #1 presented a plan of care dated 1/29/17 that gave instructions on how to care for Individual #4's prolapsed bowel. RN #1 was asked to provide evidence that the day program was informed of the updated plan of care. RN #1 verbalized that she was not aware

PRINTED: 03/15/2017

FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A BUILDING

(X3) DATE SURVEY COMPLETED

49G039

B. WING

03/14/2017

NAME OF PROVIDER OR SUPPLIER

FOREST HILLS GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

3018 FOREST HILL CIRCLE

LYNCHBURG, VA 24501

(X4) ID PRÉFIX 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)

DATE

Continued From page 2

that the day program did not have an ATP regarding the care of Individual #4's prolapsed bowel.

On 3/14/17 at 3:45p.m. the QIDP (Qualified Intellectual Disability Professional) was interviewed concerning the day program not having an ATP for Individuals #4's prolapsed bowel. The QIDP verbalized that she is responsible for ensuring that the day program receives an ATP for all individuals and was not aware that the ATP for Individual #4 was not sent to the day program regarding the prolapsed bowel.

No other information was provided prior to exit conference on 3/14/17.

Individual #1's Active Treatment Plan (ATP) was not implemented for toileting.

On 03/14/17 at approximately 1:00 p.m., Individual# 1 was observed at the offsite day program. Individual#1 stated that she had to go to the bathroom. A day program staff member, identified as DSP # 3 (direct staff provider) approached Individual# 1 and again stated, "I have to go to the bathroom." The DSP # 3 stated (to the individual), "You have a brief on, so you can go ahead and go and we'll change you later."

At approximately 1:15 p.m., Individual#1 again stated that she had to go to the bathroom. DSP #3 stated, "Ok, we'll go in just a minute, (we're] waiting on the bathroom to free up...we are on a W 120

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:L6PQ11

Facility ID: VAICFMR40

If continuation sheet Page 3 of 10

MAR 28 2017 VDH/OLG

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

PRINTED: 03/15/2017 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN CORRECTION

(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A BUILDING---

(X3) DATE SURVEY COMPLETED

49G039

B. WING

03/14/2017

NAME OF PROVIDER OR SUPPLIER

FOREST HILLS GROUP HOME

STREET ADDRESS. CITY. STATE, ZIP CODE

3018 FOREST HILL CIRCLE

LYNCHBURG, VA 24501

(X4) 10 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)

(XS) COMPLETION DATE

W 120 Continued From page 3 different schedule."

Individual# 1 had still not been taken to the bathroom at 1:30 p.m.

At approximately 4:00p.m., the administrator, QIDP (Qualified Intellectual Disability Professional), assistant residential manager and residential manager were made aware in a meeting with the survey team of the observations. The residential manager stated that Individual# 1 knows if she has to go to the bathroom or if she is wet, if she is taken to the bathroom she will either use the bathroom or has become soiled and will need changed. The facility staff stated that this was not part of the individual's active treatment plan, to let the individual void in her brief and then take her to the bathroom.

Individual# 1's ATP (active treatment plan) and physical care plans were reviewed and documented, "(name of individual) uses a wheelchair for mobility and she requires supports for personal hygiene...will indicate her discomfort or distress level (I can communicate my needs effectively)...will express her discomfort level...staff will assist...in addressing and correcting the discomfort issue (she may need toileting, repositioning, change of position out of her wheelchair...Hands on to assist with weight bearing transfers-2 person assist-to and from commode..."

The facility staff were made aware that the DSP remained in the same room as Individual# 1 during the request to go to the bathroom, there was no evidence that the bathroom was checked to determine if was full. The facility staff stated that Individual# 1's day program did not open

W 120

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:L6PQ11

Facility ID: VAICFMR40

40 | f continuation sheet Page 4 of 10

MAR 28 2017

WOH/OLC

MAR 28

FORM APPROVED

PRINTED: 03/15/2017 DEPARTMENT OF HEALTH AND HU(**ISERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDERJSUPPLIERJCLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A.BUILDING----49G039 B. WING 03/14/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3018 FOREST HILL CIRCLE FOREST HILLS GROUP HOME LYNCHBURG, VA 24501 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 120 Continued From page 4 W 120 W1S9 4/15/17 unti110:00 a.m., but did not know why that would 1.) Address the corrective action taken for the make a difference, as far as being on a different problem. schedule (related to toileting). Staff at the day support at Lutheran Family Services will receive an in-service on the No further information or documentation was active treatment plan for Individual #1 by presented prior to the exit conference on 4/15/17 if the ID Team feels the program 03/14/17. can currently meet Individual #1's needs. 2.) Address how the facility will identify similar W 159 483.430(a) QIDP W 159 occurrences of the problem. Each client's active treatment program must be a. All day support providers will receive an inintegrated, coordinated and monitored by a service on each individual's active qualified intellectual disability professional. treatment plans by 4/15/17. This STANDARD is not met as evidenced by: The in-services will be coordinated by the Based on staff interview and clinical record QIDP. They will consult/collaborate with review, the Qualified Intellectual Disabilities utilize the other ID Team Members as their expertise is needed (nurses, OT, PT. ETC.) Professional (QIDP) failed to ensure the ATP

(Active Treatment Plan) was integrated and coordinated for one of 4 Individuals in the survey sample, Individual #4.

The facility did not provide the day program with an ATP in regards to taking care of a prolapsed bowel for Individual #4.

The findings include:

Individual #4 was admitted to the facility on 3/1/2005 with an intellectual development of profound and a medical diagnoses of prolapsed bowel (bowel protruding from rectum).

On 3/14/17 at 10:30 a.m. during observations at Individual #4's day program, DSP #1 asked the surveyor to observe Individual #4 while in the bathroom with concern to Individual #4's prolapsed bowel. The prolapsed bowel was observed protruding approximately 3 inches from the rectum and was not able to be reinserted by

- To keep the day support providers aware of all ongoing medical issues. Horizon will continue to provide monthly nursing assessments.
- In servicing will occur annually or more often if there is a change in condition affecting the overall treatment plan.
- 3.) Identify measures/systemic changes to ensure deficient practices will not recur.
 - a. The QIDP will visit each day support provider quarterly to ensure the Direct Support Professionals supporting our individuals are familiar with all aspects of the active treatment plan.
 - If the QIDP finds staff are not completing the care as defined, we will retrain and then address the occurrences with the Manager at their respective program.
 - In an effort to improve communication with all of the Day Support Programs, the ICF Social Worker will contact each Day Support Manager weekly to address any concerns or changes in condition manager would like addressed.

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Event ID:L6PQ11

Facility ID: VAICFMR40

If continuation sheet Page 5 of 10



MAR 28 2017

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDERISUPPLIERICLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PFAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A.BUILDING-49G039 B. WING 03/14/2017

NAME OF PROVIDER OR SUPPLIER

FOREST HILLS GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

3018 FOREST HILL CIRCLE LYNCHBURG, VA 24501

(X4)1D PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUFATORY OR LSC IDENTIFYING INFORMATION)

1D **PREFIX** TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLÉTION OATE

W 159 Continued From page 5 staff or Individual #4.

> DSP#1 verbalized that the day program has made the facility aware of the situation, but the facility has not provide any instruction on how to take care of the prolapsed bowel. DSP #1 also verbalized that Individual #4's bowel has gotten worse over the last few weeks and the bowel can't be reinserted.

On 3/14/17 at 2:15 the facility's registered nurse (RN #1) was inteFViewed regarding. Individual #4. RN #1 verbalized that the facility was aware of Individual #4's prolapsed bowel, and recently became aware of the bowel was causing Individual #4 discomfort. The physician was notified and a surgical consult was ordered and the physician was going to assess it himself (this week) as he is also a surgeon.

RN #1 was questioned in regard to the day program not having an ATP regarding the care of Individual #4's bowel. RN #1 presented a plan of care dated 1/29/17 that gave instructions on how to care for Individual #4's prolapsed bowel. RN #1 was asked to provide evidence that the day program was informed of the updated plan of care. RN #1 verbalized that she was not aware that the day program did not have an ATP regarding the care of Individual #4's prolapsed bowel.

On 3/14/17 at 3:45p.m. the QIDP (Qualified Intellectual Disabilities Professional) was inteFViewed concerning the day program not having an ATP for Individuals #4's prolapsed bowel. The QIDP verbalized that she is responsible for ensuring that the day program receives an ATP for all individuals and was not W 159

W159 Continued

4/15/17

- 4.) Indicate how facility will monitor its performance.
 - The QIDP will visit each day support provider quarterly to ensure the Direct Support Professionals working with our individuals are familiar with all aspects of the active treatment plan.
 - If we find staff are not providing the care as expected and defined, we will retrain and then address it with the Manager at the program.
 - In an effort to improve communication with all of the Day Support Programs, the ICF Social Worker will contact each Day Support Manager weekly to address any concerns or changes in condition manager would like addressed.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: L6PQ11

Facility ID: VAICFMR40

If continuation sheet Page 6 of 10



DEPAR*		AND HU I SERVICES & MEDICAID SERVICES			(FOR	D: 03/15/201 MAPPROVE 0. 0938-039	
		(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) D/	(X3) DATE SURVEY COMPLETED	
		49G039	B. WING				3/14/2017	
	DEFICIENCY MU	EMENT OF DEFICIENCIES (EACH UST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	3018 FO LYNCH	ADDRESS, CITY, STATE, ZIP COEREST HILL CIRCLE BURG, VA 24501 PROVIDER'S PLAN OF CORRECTORRECTIVE ACTION SHOULD REFERENCED TO THE APPR DEFICIENCY)	TION (EACH BE CROSS-	(X5) COMPLETION DATE	
W 263	W 159 Continued From page 6 aware that the ATP for Individual #4 w to the day program regarding the probowel. No other information was provided proconference on 3/14/17. W 263 483.440(f)(3)(ii) PROGRAM MONITO CHANGE The committee should insure that the are conducted only with the written intoconsent of the client, parents (if the climinor) or legal guardian. This STANDARD is not met as evide Based on staff interview and clinical review, the facility staff failed to ensure was obtained prior to the implemental restrictive measure for one of 4 individual #1. Individual #1 was prescribed an antip behavioral management, without obtaiconsent from the individual's AR (authrepresentative). Findings include:		W 159.	33: 2	W263 1.) Address the corrective action taken for problem. a. An informed Neuroleptic consequence Risperdal will be obtained for Individual #1 from the Authoriz Representative by 4/1/17. 2. Address how the facility will identify similar occurrences of the problem. a. The Consent for Neuroleptics with modified to include side effects and benefits of any treatment. b. Neuroleptic Consents for individ with appointed substitute decis makers will be submitted for reapproval or refusal at the indivition annual meeting and anytime at neuroleptic is recommended. To consent will include the side efficient practices will not recapional. 3. Identify measures/systemic changes ensure deficient practices will not recapional. All consents for medications with reviewed by the RN monthly to ensure informed consent is curand has been obtained. 4. Indicate how facility will monitor its performance. a. All consents for medications with reviewed by the RN monthly to		4/1/17	
	During clinical record 03/14/17, Individual a reviewed. A consent Risperdal was review "Consent for the use	d review on 03/13/17 and # 1's clinical records were t for the medication, wed. The consent, titled, of a neuroleptic agent"			ensure informed consen- and has been obtained b. The Specially Constituted will review consents qua	l Committee		

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physician may prescribe various types of medication during the course of my treatment...

some of the side effects seen with this

Event ID:L6PQ11

Facility ID: VAICFMR40

If continuation sheet Page 7 of 10



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- T T T	I AND HU \ 1 SERVICES E & MEDICAID SERVICES	(RINTED: 03/15/201 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
	49G039	B. WING	03/14/2017

03/14/2017 STREET ADDRESS, CITY, STATE, ZIP CODE

3018 FOREST HILL CIRCLE

LYNCHBURG, VA 24501

(X4) ID PRÉFIX TAG

NAME

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ľD PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

W 263 Continued From page 7

PROVIDER OR SUPPLIER

FOREST HILLS GROUP HOME

medication... sleepiness... drying effects... dizziness... sunburn... muscle movements... I understand the above information, and I have been offered the opportunity for further discussion. with my physician about this drug and its side effects..." Just below this area was a signature and date line for the individual served or the AR and below that was an area for the physician to sign and date. This form was dated 07/22/16 and had an illegible mark in the individual's spot and the physician signed below.

Additionally another consent for the same medication (exactly as above) was reviewed and dated 10/25/16. This consent had a hand written entry in the individual's section to sign, that documented, "client can not write." The physician again signed and dated.

Further review of Individual #1's record revealed that the individual had an AR at the time that these consents were signed and/or presented to the individual.

The facility nurse and the administrator were made aware of concerns regarding this in a meeting with the survey team on 03/14/17 at approximately 2:30 p.m.

The facility staff were made aware that the individual would not be able to understand all the information (risk, benefits, side effects) in the consent and was curious why the information was not given to the individual's AR, instead of the individual. Both staff members agreed that the consent should have been for the AR to address, not the individual.

No further information and/or documentation was

W263

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:L6PQ11

Facility ID: VAICFMR40

If continuation sheet Page 8 of 10

RECEIVED MAR 28 2017 VDHIOLO

DEPAR CENTE	TMENT OF HEALTH	AND HUI SERVICES & MEDICAID SERVICES				F	TED: 03/15/201 ORMAPPROVE NO 0938-039	=		
STATEMENT DEFICIENCIES (X1) PROVIDERJSUPPLIERJCLIA IDENTIFICATION NUMBER:			(X2) MULTIF A BUILDING		DATE SURVEY					
		49G039	B. WING				03/14/2017			
NAME OF	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE			-		
FOREST	HILLS GROUP HOME		ı	3018 FOREST HILL CIRCLE LYNCHBURG, VA 24501						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	10 PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	OATE			
W 263	Continued From page	ge 8	W263	w:	362		4/15/17			
	presented prior to the 03/14/17.	ne exit conference on		1,)	Address the corrective action taken fo	r the				
W 362		REGIMEN REVIEW	W 362	2	problem. a. It is the expectation and plan that Pharmacy quarterlies will be	at all				
		put from the interdisciplinary			completed on time.		[
		e drug regimen of each client		2.)		milar				
		not met as evidenced by:			occurrences of the problem. a. All client records will be audited the QIDP quarterly to ensure the Pharmacy quarterlies are comple on time.	, 2				
	and facility documen ensure a quarterly d performed timely for	riew, clinical record review, t review, the facility failed to rug regimen review was 4 of four Individuals in the ridual's #'s 1 through 4.		3.)	ensure deficient practices will not rect a. The Pharmacy, with which we contract, to provide this service hired multiple Pharmacists to en they will provide a pharmacist to	ur. has sure				
	The Findings Include	e:		4.	complete the quarterlies on time Indicate how facility will monitor its	2.				
	performed for Individently that quarterly pharma	al record reviews were duals 3 and 4 and evidenced acy reviews were not tember, October, and			performance. a. The QIOP will complete quarterly audits of the Client Health record ensure Pharmacy review has been completed. b. Random Audits are completed by Lead R.N. to ensure all required documentation is completed.	to n				
	Individual's 1 and 2 a reviews for February until January 26, 201 June, July and Augus completed until Nove pharmacy reviews for the state of the st			4	ascanicitation is completed.					

On 3/14/17 at 1:30 p.m. the facility's operations manager (OM) was asked to provide evidence that the pharmacy had done a quarterly review for the Individuals in the survey sample for the

W 362 Continued From page 9

quarter beginning in September through November 2016.

On 3/14/17 at 2:00p.m. the OM presented a pharmacy review dated 1/26/17 and verbalized that was the review for September through November 2016. OM was asked why the review was over a month late. OM verbalized that the facility was having issues with the pharmacy doing their reviews on time and went onto verbalize that the previous quarter (June through August) was not done until October 2016 (documentation was evidence in the Individuals clinical record).

OM also verbalized that all individuals in the facility were reviewed at the same time and a new pharmacist was coming to the facility through the same pharmacy and was catching up on all the pharmacy reviews.

A policy was provided to the survey team titled "Clinical Services" Under section 13 subtitled Pharmacist, states"[...] Will complete a review of the drug regimen of each individual at least quarterly[...]"

No further information was provided prior to exit conference on 3/14/17.

W 362