STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G039	A. BUILDING---------- B. WING	03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS GROUP HOME	3018 FOREST HILL CIRCLE LYNCHBURG, VA 24501

(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	WOOO	W 120 1.) Address the corrective action taken for the problem. a. Staff at the day support at Lutheran Family Services will receive an in-service on the active treatment plan for Individual #1 by 4/15/17 if the ID Team feels the program can currently meet Individual #1's needs. b. Staff at the day support at the ARC will receive an in-service on the active treatment plan for Individual #4 by 4/15/17 if the ID Team feels the program can currently meet Individual #4's needs. 2.) Address how the facility will identify similar occurrences of the problem. a. All day support providers will receive an in-service on each individual's active treatment plans by 4/15/17. b. The in-services will be coordinated by the QIDP. They will consult/collaborate with utilize the other ID Team Members as their expertise is needed (nurses, OT, PT. ETC.) c. To keep the day support providers aware of all ongoing medical issues Horizon will continue to provide monthly nursing assessments. d. 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. b. 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. c. 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.	4/15/17

An unannounced Medicaid re-certification survey was conducted on 03/13/17 through 03/14/17. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIIID). No complaints were investigated during the survey.

The census in this 10 certified bed facility, was 10 at the time of the survey. The survey sample consisted of 4 current Individual reviews (Individual's #1 through 4).

W 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES — W 120

The facility must assure that outside services meet the needs of each client.

This STANDARD is not met as evidenced by:
Based on staff interview and clinical record review failed to ensure the Day Program implemented the Active Treatment Plan (ATP) for two of 4 Individuals in the survey sample, Individual's #4 and #1.

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

2. Individual #1's Active Treatment Plan (ATP) was not implemented for toileting at the day program.

The findings include:

1. Individual #4 was admitted to the facility on

MAR 28 2017 VDH/OLC

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

LON Program Manager 3/23/17

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	49G039	A. BUILDING _____ B. WING	03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 120	Continued From page 1	W 120	W 120 Continued	4/15/17

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 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 interviewed 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

4.) Indicate how facility will monitor its performance.

a. 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.

b. 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.

c. 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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W 120	Continued From page 2	W 120		

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.

2. 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

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	49G039	A. BUILDING _____ B. WING	03/14/2017

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W 120	Continued From page 3	W 120		

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

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W 120 Continued From page 4

unti110:00 a.m., but did not know why that would make a difference, as far as being on a different schedule (related to toileting).

No further information or documentation was presented prior to the exit conference on 03/14/17.

W 159 483.430(a) QIDP

Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the Qualified Intellectual Disabilities 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

W 120

W1S9

4/15/17

1.) Address the corrective action taken for the problem.
   a. Staff at the day support at Lutheran Family Services will receive an in-service on the active treatment plan for Individual #1 by 4/15/17 if the ID Team feels the program can currently meet Individual #1's needs.

W 159

2.) Address how the facility will identify similar occurrences of the problem.
   a. All day support providers will receive an in-service on each individual's active treatment plans by 4/15/17.
   b. The in-services will be coordinated by the QIDP. They will consult/collaborate with utilize the other ID Team Members as their expertise is needed (nurses, OT, PT. ETC.)
   c. To keep the day support providers aware of all ongoing medical issues. Horizon will continue to provide monthly nursing assessments.
   d. 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.
   b. 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.
   c. 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.

STATEMENT OF DEFICIENCIES AND PFAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS GROUP HOME	3018 FOREST HILL CIRCLE LYNCHBURG, VA 24501

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W 159	Continued From page 5	W 159	W159 Continued	4/15/17

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

4.) Indicate how facility will monitor its performance.

a. 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.
b. 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.
c. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 159	Continued From page 6 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.	W 159.		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure consent was obtained prior to the implementation of a restrictive measure for one of 4 individuals, Individual # 1. Individual # 1 was prescribed an antipsychotic for behavioral management, without obtaining consent from the individual's AR (authorized representative). Findings include: During clinical record review on 03/13/17 and 03/14/17, Individual # 1's clinical records were reviewed. A consent for the medication, Risperdal was reviewed. The consent, titled, "Consent for the use of a neuroleptic agent" documented, "...While I am being treated...my physician may prescribe various types of medication during the course of my treatment... some of the side effects seen with this	W263:	W263 1.) Address the corrective action taken for the problem. a. An informed Neuroleptic consent for Risperdal will be obtained for Individual #1 from the Authorized Representative by 4/1/17. 2. Address how the facility will identify similar occurrences of the problem. a. The Consent for Neuroleptics will be modified to include side effects, risks, and benefits of any treatment. b. Neuroleptic Consents for individuals with appointed substitute decision makers will be submitted for review, approval or refusal at the individual's annual meeting and anytime a new neuroleptic is recommended. The consent will include the side effects, risks, and benefits of any treatment. 3. Identify measures/systemic changes to ensure deficient practices will not recur. a. All consents for medications will be reviewed by the RN monthly to ensure informed consent is current and has been obtained. 4. Indicate how facility will monitor its performance. a. All consents for medications will be reviewed by the RN monthly to ensure informed consent is current and has been obtained b. The Specially Constituted Committee will review consents quarterly.	4/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

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W 263	Continued From page 8 presented prior to the exit conference on 03/14/17.	W263	W362 1.) Address the corrective action taken for the problem. a. It is the expectation and plan that all Pharmacy quarterlies will be completed on time. 2.) Address how the facility will identify similar occurrences of the problem. a. All client records will be audited by the QIDP quarterly to ensure the Pharmacy quarterlies are completed on time. 3.) Identify measures/systemic changes to ensure deficient practices will not recur. a. The Pharmacy, with which we contract, to provide this service has hired multiple Pharmacists to ensure they will provide a pharmacist to complete the quarterlies on time. 4. Indicate how facility will monitor its performance. a. The QIOP will complete quarterly audits of the Client Health record to ensure Pharmacy review has been completed. b. Random Audits are completed by the Lead R.N. to ensure all required documentation is completed.	4/15/17
W 362	483.4600)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility failed to ensure a quarterly drug regimen review was performed timely for 4 of four Individuals in the survey sample, Individual's #'s 1 through 4. The Findings Include: On 3/14/17 Individual record reviews were performed for Individuals 3 and 4 and evidenced that quarterly pharmacy reviews were not documented for September, October, and November 2016. Record reviews were also completed on Individual's 1 and 2 and evidenced that pharmacy reviews for February of 2016, were not completed until January 26, 2017; pharmacy reviews for June, July and August of 2016 were not completed until November of 2016, and pharmacy reviews for September, October and November of 2016 were not documented as being 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		

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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.