DEPARTMENT OF HEALTH AND H[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G071	A. BUILDING _____ B. WING _____	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLOWAY PLACE	6831 WAY LUCY CORR DRIVE CHESTERFIELD, VA 23832

(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	W 000		

An unannounced annual 56 Fundamental Medicaid Certification survey was conducted 12/12/17 through 12/13/17. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey.

The census in this 12 certified bed facility was 12 at the time of the survey. The survey sample consisted of 4 Individual reviews (Individuats #1 through #4).

W 255 PROGRAM MONITORING & CHANGE W 255
CFR(s): 483.440(f)(1)(i)

The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.
This STANDARD is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed for 1 Individual (Individual #4) of 4 Individuals in the survey sample to ensure an active treatment plan was in place for elopement behavior.

Individual #4 was found outside of the building on four occasions. No plan was in place to manage the elopement behavior.

The findings included:

Individual #4, a 23 year old, was admitted to the facility on 8/20/14. Her diagnoses included

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas C. Boucher	Service Supervisor	1/23/18

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 000	INITIAL COMMENTS An unannounced annual 55 Fundamental Medicaid Certification survey was conducted 12/12/17 through 12/13/17. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 12 certified bed facility was 12 at the time of the survey. The survey sample consisted of 4 Individual reviews (Individuals #1 through #4).	W 000		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed for 1 Individual (Individual #4) of 4 Individuals in the survey sample to ensure an active treatment plan was in place for elopement behavior. Individual #4 was found outside of the building on four occasions. No plan was in place to manage the elopement behavior. The findings included: Individual #4, a 23 year old, was admitted to the facility on 8/20/14. Her diagnoses included	W 255		

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W 255	Continued From page 1 Down's Syndrome, depression, Autistic disorder, hypothyroidism. The facility's Incidents and Accidents were reviewed. According to the documentation, Individual #4 was found by staff outside of the building without injury on the following occasions: 3/11/17 3/13/17 8/4/17 11/24/17 The Treatment Plan for Individual #4 was reviewed. The plan's effective date was 12/16/16. The plan did not address the elopements. On 12/12/17 at 5:05 p.m., an interview was conducted with Direct Services Associate A (DSA A). DSA A was supervising Individual #4 in Individual #4's bed room. When asked if she was working 1:1 with Individual #4, DSA A stated no, she was supervising two Individuals that night, but Individual #4 required more supervision. When asked if Individual #4 would go outside unattended, DSA A sated yes. DSA A stated that Individual #4 was aware when staff were not watching or helping other Individuals and would try to leave the building during those times. On 12/13/17 at 3:30 p.m., the Qualified Intellectual Disabilities Professional (QIDP) was asked if she ever revised a treatment plan in between the annual reviews. The QIDP stated yes, the plan would be revised if the need occurred. When asked why a plan had not been developed to manage the elopement behavior, the QIDP stated that the staff had discussed the need to watch Individual #4 closer but the	W 255	W255 1. The QIDP in conjunction with the interdisciplinary team will develop objectives within Individual #4's active treatment plan to address her risk for elopement. 2. Other residents of the facility will have their plans reviewed by the QIDP to ensure if they are an elopement risk and will address it in their active treatment plans accordingly. 3. At any time there is an elopement or attempted elopement, the QIDP will review the individual's active treatment plan to ensure the behavior is addressed and include necessary protocols to reduce the risk for elopement in the future. 4. The interdisciplinary team will review and discuss any elopement issues quarterly and ensure they are addressed within the treatment plan of the individual. All staff will be trained on elopement prevention for all individuals who are at risk for elopement. 5. To be completed by January 26, 2018.	

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W 255	Continued From page 2 treatment plan had not been updated. It was reviewed with the QIDP that Individual #4 continued to elope despite the staff discussions to watch her more closely. The QIDP stated that Individual #4's annual review had just taken place 12/13/17 (the date of the survey). The QIDP stated she had added elopement as part of the safety section in the treatment plan due to the elopement that occurred on 11/24/17. On 12/13/17 at 3:30 p.m. it was reviewed with the Administrator and QIDP that the current treatment plan did not include a plan to manage Individual #4's elopement behavior.	W 255		
W 261	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed for **1** individual (Individual #3) of 4 individuals in the survey sample to ensure the Specially Constituted Committee (SCC) met as a group to discuss the use of a seat belt and other care issues. Members of the SCC discussed Individual #3's	W 261		

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W 261	Continued From page 3	W 261		

care via telephone and not as a group. "Participation on the specially constituted committee(s) must be in real time allowing all membership to speak and discuss in an interactive mode." The quote was obtained from the guidance under W261.

The findings included:

Individual #3, a 64 year old, was admitted to the facility on 8/20/14. Her diagnoses included cerebral palsy, asthma, diverticular disease, and dysphagia.

The form titled "Specially Constituted Committee Consent Form" dated 12/14/16 was included in Individual #3's clinical record. The form documented the description, purpose and desired effects of medication, equipment, techniques and therapies to be used for Individual #3. The SCC was comprised of four members. The group did not meet face to face to discuss Individual #3. It was documented on the SCC form that two members were contacted separately via telephone by the Administrator to discuss Individual #3.

On 12/13/17 at 1:30 p.m. the Qualified Intellectual Disabilities Professional (QIDP) was asked if the SCC met as a group when discussing the Individual's care. She stated no.

On 12/13/17 at 3:10 p.m. the Administrator was asked if the SCC met as a group. He stated that it depended on the availability of the group members. He stated that sometimes he called the members of the group individually. He stated that the phone calls were documented on the back of the SCC form.

W261

1. The Specially Constituted Committee will meet face to face to address care methods and other items that could be viewed as restrictive for Individual #3.

2. The Specially Constituted Committee will meet face to face to address care methods and other items that could be viewed as restrictive for all residents.

3. All residents will have their plans, medications, medical orders, restraints, adaptive equipment, and special needs reviewed by the Specially Constituted Committee quarterly and or as needed during a face to face meeting. The QIDP will schedule the committee meetings and ensure the committee agrees to face to face meetings to review all necessary information.

4. Meetings will be scheduled on a routine basis by the QIDP. The Program Services Supervisor will monitor monthly to ensure meetings are occurring as needed.

5. To be completed by January 26, 2018.

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W 261	Continued From page 4 It was reviewed with the QIDP and the Administrator that the SCC should meet face to face when discussing an Individual.	W 261		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility failed for one individual (Individual #2) in a survey sample of 4 individuals, to follow up and treat an open area to the sacrum. Individual #2 developed an open area on the sacrum, which was not treated or monitored. The findings included: Individual #2 was admitted to the facility on 2/23/15 with the diagnoses of, but not limited to, moderate intellectual disability, cerebral palsy and paraplegia. On 12/13/17, Individual #2 was observed in his Day Program. He was seated in his electric wheelchair, which he can move, raise and lower with a joystick manipulated by his mouth. He remembered this surveyor by name. Review of the incident and accident reports revealed on 7/12/17, Individual #2 developed an "open area" on the Individual's sacrum which measured 5 mm (millimeters) in diameter with "	W 322	W322 1. The nurses will review individual #2 to ensure that all skin conditions are monitored and tracked to ensure proper medical care and follow up is being completed. Nursing notes will be completed. 2. All individuals will be assessed for any skin conditions requiring care and/or follow-up care. All will be noted in nursing notes. 3. The nurse supervisor has created an excel spreadsheet to monitor specifics of individualized care regarding the monitoring of skin conditions, tracking the condition, date condition noted, location of condition, treatments initiated, date resolved, and any comments regarding the individual, condition, treatment or needed follow-up care. Nurses will be retrained in ensuring follow up care for all individual needs. 4. The Program Services Supervisor and Nurse Supervisor will work together to ensure documentation and follow up is completed for all skin conditions. 5. To be completed by January 26, 2018.	

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W 322	Continued From page 5	W 322		

red around edges." The report included the following: "Continue to monitor and apply cream as necessary. Staff to notify MD (physician) if conditions worsens." Desitin ointment was ordered on an as needed basis and was applied. Review of the July, 2017, medication administration record revealed no further treatment was documented as given, nor was the area monitored.

On 12/13/17 at 2:50 PM, RN (registered nurse) A was interviewed. She stated, "We should have been monitoring and marking the treatment." The staff reported the resident had no skin breakdown at the present time. The resident was out at his Day Program and a skin assessment could not be performed.

On 12/13/17 at approximately 4:00 PM, the facility was informed of the above findings.