PRINTED: 07/25/2017 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		49G013	B. WING		and granter and another state of the state o	07/20/2017
	PROVIDER OR SUPPLIER Y HOUSE OF PORTSM	MOUTH INC REVISED COPY		STREET ADDRESS, 4211 COUNTY STR PORTSMOUTH,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOUL ERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
W 000	INITIAL COMMENT	rs	W O) 00.		;
	through 07/20/17. Compliance with 42 Regulations. The Li follow. The census in this 2	standard Medicaid ey was conducted on 07/18/17 Corrections are required for CFR Part 483 ICF/ID Federal fe Safety Code report will 28 bed facility at the time of The survey sample consisted				
W 262	of 8 Individual recor reviews (Individuals record review (Indiv	rds: 7 current individual #1 through #7) and 1 closed	W 2 (32		
	monitor individual pri inappropriate behav	uld review, approve, and rograms designed to manage rior and other programs that, committee, involve risks to I rights.		accomplindividual deficient The Faci	lity QIDP will present trostomy tube protectiv	sue(s), for those affected by the Individual #2's use the belt for the Special
to home.	Based on record re facility staff failed to Committee (SCC) to the use of a gastros	not met as evidenced by: view and staff interviews, the have the Special Constituted o review, approve and monitor tomy tube protective belt for in the survey sample of eight		monitor on July 3 Behavior playing v gastrosto Departm	ted Committee (SCC) to at an Emergency SCC of 31, 2017. The SCC will be Support Plan, which we with, pulling and/or distant the procession with use ent will follow with use tective belt for Individue	meeting scheduled I review the amended vill include slodging the dures that the Nursing ing the gastrostomy
	The findings include	d:			ion Date: July 31, 2017	i
;	with diagnoses which	ed to the facility on 9/1/2004 h included Intellectual levelopmentally delayed				
RORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN.	ATUDE		TI F	: IX6) OATE

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 is the second 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.

Continuation Sheet Page 1 of 9

July 28, 2017

Chief Adminsitrative Officer

PRINTED: 07/25/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILOI	PIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO
		49G013	B. WING	4,4	07/20/2017
	PROVIDER OR SUPPLIER Y HOUSE OF PORTS	MOUTH INC REVISED COPY		STREET AOORESS, CITY, STATE, ZIP COC 4211 COUNTY STREET PORTSMOUTH, VA 23707	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCEO TO THE AF OEFICIENCY)	HOULO BE COMPLETION
W 262	Continued From pa	=	W 2	Point #2: Address how the fa	acility will identify other
	medication adminis	•		individuals having the poten same deficient practice. The that any apparatus restricting themselves without assistance protective belt, orthotics, item listed on the Restrictive Autl	Facility QIDP will ensure g an Individual to remove the (gastrostomy tube ms with straps, etc.) is
	10/21/2011 read "I v get a G-tube protect	will fax the orders for her to to tor belt so they do not have to er around her abdomen".		Forms and presented to the S Constituted Committee for re Completion Date: August 24	eview and approval.
	A physician's order of Protector belt to be	dated 10/10/16 read: "G-Tube used as needed".		Point #3: Address what meast place or systemic changes medicient practice will not reconstruct the place of the place of the practice will not reconstruct the place of the place of the place.	sures will be put into nade to ensure that the
; ; ;	coverage and protect	protective belt provides ction from snagging, pulling, trostomy feeding tube button.		Administrative Officer has re Constituted Committee Police approval and monitoring the	cy regarding the review, use of any apparatus
	plan of care dated 8 which addressed the not address Client # guidance indicating belt, periods of remove the note of the playing with, pulling tube. The document inappropriate touching which addressed to the note of the n	al records revealed a nursing 8/31/16 through 8/31/2017 a gastrostomy tube but it did 2's G-Tube Protector belt with when to wear the protective eval or when to apply it. If the Behavioral plan list a chavior of Client #2 as or dislodging the gastrostomy ed behaviors were: Ing. property destruction, hair abbing and throwing items on		restricting an Individual to r assistance (gastrostomy tube orthotics, items with straps, of The Chief Administrative Of Specially Constituted Comm Facility QIDP's to ensure the are educated in the Specially Committee policies and proc Completion Date: July 24, 26	protective belt, etc.). fficer reviewed the uittee Policy with the at the Facility QIDP's Constituted edures.

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Event IO: IHO411

Facility IO: VAICFMR09

If continuation sheet Page 2 of 9



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	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO
		49G013	B. WING	}	07/20/2017
NAME OF PROVIDER OR SUPPLIER HOLIDAY HOUSE OF PORTSMOUTH INC REVISED COPY		-	STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES ' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		OULO BE COMPLETION
W 262	Intellectual Develop 7/20/17 at approxim stated the use of the not been reviewed, SCC. During the pre-exit i Administrator, Direct Licensed Practical approximately 5:15 they were so elated physical intervention administration they belt was a restraint.	inducted with the Qualified ment Professional (QIDP) on lately 3:30 p.m. The QIDP is G-Tube Protector belt had approved or monitored by the interview with the tor of Nursing and the lurse (LPN) on 7/20/17 at p.m., the Administrator stated they no longer had to use	W 2	Point #4: Indicate how the facil performance to make sure that a The Director of Nursing and the meet quarterly to discuss the inapparatus restricting an Individual without assistance (gastrostomy orthotics, items with straps, etc.) Director of Nursing and the Facany changes or additions to indicapparatus restricting an Individual without assistance (gastrostomy orthotics, items with straps, etc.) will review the Individual's Reforms to ensure that the use of an Individual to remove themse (gastrostomy tube protective be straps, etc.) are listed on the Reforms. The Facility QIDP will	colutions are sustained. The Facility QIDP will dividual's use of any use to remove themselves tube protective belt, The Facility QIDP will review viduals who uses any use to remove themselves tube protective belt, The Facility QIDP strictive Authorization any apparatus restricting elves without assistance lt, orthotics, items with strictive Authorization
	Committee" dated 1. Any program that util techniques must be the Special Constituimplementation. This to; restraints, drugs restrictions on commidenial of any right; o locations in the home 483.460(k)(1) DRUG. The system for drug that all drugs are additing the physician's order	nunity access, contingent restrictions of materials or e. ADMINISTRATION administration must assure ministered in compliance with	W 3	Authorizations to the Specially at the scheduled quarterly meet approval and monitoring. Completion Date: August 24, 2	ngs for review,

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Event IO: IHO411

Facility IO: VAICFMR09

If continuation sheet Page 3 of 9



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 OMB NO. 0938-0391

CLITIC	TO TOTALLE TO THE	A MEDIO/ ID OLI (VIOLO				OND 140. 0000-000
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		49G013	B. WING	i		07/20/2017
	PROVIDER OR SUPPLIER Y HOUSE OF PORTSI	MOUTH INC REVISED COPY		421	REET ADDRESS, CITY, STATE, ZIP CODE 1 COUNTY STREET RTSMOUTH, VA 23707	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	facility staff failed to administered in con order for one client sample of eight clie. The facility staff faile AcuDial to Client #2. The findings include Client #2 was admit with diagnoses which disability, profound everbally and a seizu. The clinical record record which reveale 7/15/17 at approxim 9:20 p.m. The client head, shoulder and sleeping. Again on 7 10:01 p.m., until 10: observed with seizur clinched and there we followed by reaction. The Nursing plan of 8/31/2017 contained Some of the interver activity, administer a ordered.	eview and staff interview, the ensure all medications were appliance with the physician's (client #2) in the survey ants. ed to administer Diastat as ordered by the physician. ed: ted to the facility on 9/1/2004 and included Intellectual developmentally delayed are disorder. evealed a seizure activity ed Client #2 had a seizure on ately 9:18 p.m., lasting until was observed salivating, with arm jerks followed by 7/15/17 at approximately 0.2 p.m., Client #2 was are activity, the fist were was mouth movement, to verbal stimulation. care dated 8/31/16 through a Seizure plan of care. Intions read; record all seizure inticonvulsant medications as	W	368	Point 1: Address how corrective ac accomplished to address the issue found to have been affected by the The Director of Nursing will meet a staff to review the current survey redepartment. At that time the staff and Nursing Management of Seizure, In Physician Orders for Diastat AcuDiaction to communicate seizure activity action to give a verbal report to include seizure activity length, frequency a were given to the oncoming shift. The acknowledge understanding by sign roster. Completion Date: August 24, 2017 Point 2 Address how the facility with individuals having the potential to same deficient practice. The Directon nursing staff to review all Individuals disorder. At that time the staff will the Nursing Management of Seizure Physician Orders regarding their seand the plan of action to communic on the 24 hour communication reprogress notes and to give a verbal not limited to seizure activity length medications were given to the oncommunications were given to the oncommunication of the training roster. Completion Date: August 24, 2017	s), for those individuals deficient practice. with the nursing sults for the vill be educated on the ndividual #2's ial and the plan of vities on the 24 hour g progress notes le but not limited to and if any medications. The nurses will hing off on the training off on the training li identify other be affected by the or will meet with the als who have a seizure be educated on e, all Individual's eizure medications ate seizure activities ort sheet, nursing report to include but the frequency and if any oming shift.
	The July 2017 physic	cian order summary revealed :				

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Event ID: IHO411

Facility ID: VAICFMR09

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		ŀ	NG	CON	(X3) DATE SURVEY COMPLETED	
	49G013	B. WING		07/	20/2017	
			STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION OATE	
an order dated 1/2/ System 20 milligram milligram delivery sy milligrams as neede minutes or two seize Diastat AcuDial gel of increased seizure	17, which read; Diazepam 2 in Kit for Diastat AcuDial 20 ystem. One rectally 12.5 ed for seizures longer than two ures within an hour.	W 3	or systemic changes made to practice will not recur. The Di amend the Nursing Managem the plan of action to communicatio progress notes and to give a v but not limited to seizure action and if any medications were	ensure that rector of Nur ent of Seizur nicate seizura report shee erbal report t vity length, fi	the deficient sing will e to include e activities t, nursing to include requency	
other seizure medic penzodiazepine. It v seizures.	ines. Diastat AcuDial gel is a works in the brain to decrease		Point #4: Indicate how the faci	lity plans to		
evealed the nurse o	did not administer the Diastat 📑		The Director of Nursing or Ch will have quarterly medication knowledge base practice and p administering in compliance w	ange will en testing to de roficiency of ith physician	sure nurses monstrate medication as orders.	
Idministrator, Directicensed Practical New pproximately 5:15 purse should have a biastat AcuDial as on formation was provided as 1470(b)(4)(iv) CL	tor of Nursing and the lurse (LPN) on 7/20/17 at o.m. The LPN stated the dministered the as needed rdered. No additional vided. IENT BEDROOMS	W 42	quarterly thereafter. The Direct bring a monthly Seizure Surve Risk Management Committee Surveillance Report will include whom had seizures throughout statement that ensures that meet as the physician ordered.	tor of Nursing Illance Report for review. It the individual the month a lications were	ng will rt to the The Seizure luals nd with a	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa an order dated 1/2/ System 20 milligram nilligram delivery sy nilligrams as neede ninutes or two seize Diastat AcuDial gel of increased seizure certain patients with other seizure medic penzodiazepine. It we certain patients with other seizure medic penzodiazepine. It we certain patients with other seizure medic penzodiazepine. It we certain patients with other seizure medic penzodiazepine. It we certain patients with other seizure medic penzodiazepine. It we certain patients with other seizure percalage percalage diastat AcuDial as ordered our. During the pre-exit in deministrator, Direct icensed Practical N pproximately 5:15 pures icensed Practical N	Summary STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 an order dated 1/2/17, which read; Diazepam 2 System 20 milligram Kit for Diastat AcuDial 20 milligram delivery system. One rectally 12.5 milligrams as needed for seizures longer than two minutes or two seizures within an hour. Diastat AcuDial gel is used for treating episodes of increased seizure activity (cluster seizures) in mertain patients with epilepsy who already take other seizure medicines. Diastat AcuDial gel is a menzodiazepine. It works in the brain to decrease menzodiazepine. It works	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 an order dated 1/2/17, which read; Diazepam 2 System 20 milligram Kit for Diastat AcuDial 20 milligram delivery system. One rectally 12.5 milligrams as needed for seizures longer than two minutes or two seizures within an hour. Diastat AcuDial gel is used for treating episodes of increased seizure activity (cluster seizures) in vertain patients with epilepsy who already take extensionable in the brain to decrease eizures. It works in the brain to decrease eizures. https://www.drugs.com/cdi/diastat-acudial-gel.ht ml) Review of the Medication administration record evealed the nurse did not administer the Diastat couDial as ordered for two seizures within an our. During the pre-exit interview with the deministrator, Director of Nursing and the icensed Practical Nurse (LPN) on 7/20/17 at pproximately 5:15 p.m. The LPN stated the urse should have administered the as needed diastat AcuDial as ordered. No additional information was provided. 83.470(b)(4)(iv) CLIENT BEDROOMS W 42 the facility must provide each client with unctional furniture, appropriate to the clients	AUSE OF PORTSMOUTH INC REVISED COPY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 an order dated 1/2/17, which read; Diazepam 2 System 20 milligram kit for Diastat AcuDial 20 milligrams as needed for seizures longer than two ninutes or two seizures within an hour. Diastat AcuDial gel is used for treating episodes of increased seizure activity (cluster seizures) in sertain patients with epilepsy who already take ther seizure medicines. Diastat AcuDial gel is a senzodiazepine. It works in the brain to decrease eizures. Interview of the Medication administration record evaled the nurse did not administration record evaled the nurse of Nursing and the icensed Practical Nurse (LPN) on 7/20/17 at proroximately 5:15 p.m. The LPN stated the urse should have administered the as needed liastat AcuDial as ordered. No additional formation was provided. 33.470(b)(4)(iv) CLIENT BEDROOMS 4211 COUNTY STREET PORTSMOUTH. A 210 SAN TAGE CORNETICE ACID SHAP TAGE CRACH CORRECTES AND CRACH CORRECTES TAGE CRACH C	AUSE OF PORTSMOUTH INC REVISED COPY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIGED BY FULL REGULATORY OR LSC IDENTIFY MC INFORMATION) Continued From page 4 an order dated 1/2/17, which read; Diazepam 2 System 20 milligram kit for Diastat AcuDial 20 milligram sa needed for seizures longer than two ninutes or two seizures within an hour. Diastat AcuDial gel is used for treating episodes of increased seizure activity (cluster seizures) in sertain patients with epilepsy who already take ther seizure medicines. Diastat AcuDial gel is a benzodiazepine. It works in the brain to decrease eizures. https://www.drugs.com/cdi/diastat-acudial-gel.ht nl) Review of the Medication administration record evealed the nurse did not administer the Diastat couDial as ordered for two seizures within an our. Review of the Medication administration record evealed the nurse did not administer the Diastat couDial as ordered for two seizures within an our. Review of the Medication administration record evealed the nurse did not administration record evealed the nurse did not administer the Diastat couDial as ordered for two seizures within an our. Review of the Medication administration record evealed the nurse did not administration record evealed the nurse did not administration frecord evealed the nurse did not administration record evealed the nur	

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Facility ID: VAICFMR09

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NAME OF PROVIDER OR SUPPLIES

STREET ADDRESS, Cirif, STATE, ZIP CODE

4211 COUNTY STREET PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

HOLIDAY HOUSE OF PORTSMOUTH INC REVISED COPY

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

(X5) COMPLETION DATE

W 420 Continued From page 5

This STANDARD is not met as evidenced by: Based on general observations of the facility, staff interviews and facility policy review, the furnishings on 2 of 3 living areas were in disrepair. On both the Right and Left Wing living rooms, the couch cushions were sunken in appearance.

The findings include:

On 7/18/17 at 3:00 p.m., during rounds on two individual living room areas, the sofa cushions the individuals sitting were sitting on were sunken. Upon a closer look on 7/20/17 at 9:45 along with the Maintenance Director and the Environmental Director, the cushions were unlocked and the covers removed which revealed broken rusted springs and stained worn shredded foam. The Environmental Director and assistant Environmental Director stated the cushion covers were removed for laundering and replaced by the Maintenance Director and they never put the cushion covers on or off, thus they did not know the springs were broken or the foam stained and worn. The Maintenance Director stated he made rounds weekly to identify necessary repairs and that he could repair the springs and replace the foam in the sofa cushions.

On 7/20/17 at 5:00 p.m., the Chief Executive Officer (CEO) and the Director of Nursing (DON) were informed of the condition of the sofa cushions. The CEO stated the facility may purchase new sofas for both wings.

The policy and procedure titled "Maintenance Services" (undated) indicated the primary purpose of the maintenance policies and procedures is to provide a uniform set of W 420

Point#1: Address how corrective action will be accomplished to address the issue(s), for those individuals found to have been affected by the deficient practice. The Environmental Services supervisor will purchase new furniture for the

Right and Left wings

Completion Date: August 24, 2017

Point #2: Address how the facility will identify other individuals having the potential to be affected by the same deficient practice. The Maintenance Supervisor will implement weekly checks for all furniture fixtures in the Right and Left wings to ensure all furniture is in good working condition. If repairs are needed, the Maintenance Department will repair in a timely manner. If the furniture cannot be repaired, the Environmental Services Supervisor will purchase a replacement.

Completion Date: August 24, 2017

Point #3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Maintenance Supervisor will complete a weekly walk through to check all furniture conditions to ensure that all furniture is in good condition. The Maintenance Supervisor will document on the weekly preventative maintenance inspection schedule regarding the furniture condition.

Completion Date: August 24, 2017

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	JD PLAN OF CORRECTION INDENTIFICATION NUMBER.		(X2) Mui A. Buill		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING	B. WING		07/20/2017
NAME OF PROVIDER OR SUPPLIER HOLIDAY HOUSE OF PORTSMOUTH INC REVISED COPY				421	REET ADDRESS, CITY, STATE, ZIP CODE 1 COUNTY STREET RTSMOUTH, VA 23707	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
	guidelines for all per that the facility is man sanitary manner, mequipment in a safe. The Weekly Prevenschedule dated 2/4. Left Wing were last problems identified the line items, special 483.470(i)(2)(iii) EV. The facility must file each evacuation drift acility documentation of the each evacuation drill. The findings include On 7/20/17 at approasked to review the details and evaluation of the endocation took place of the each evacuation of the endocation took place of the each evacuation and Disindicated the Alpha are sanitary manner.	rsonnel to follow in assuring aintained in a safe and aintain the facility and it's and operative manner. Intative Maintenance Inspection /14 indicated the Right and inspected on 7/14/17 with no to include furniture as one of ifically "sofas". ACUATION DRILLS In a report and evaluation on III. Is not met as evidenced by: ions, staff interviews and on, the facility staff failed to port and evaluation on each eximately 11:00 a.m., when yearly evacuation drill with on of the drill, the facility was report. The Chief Executive led evidence that the latire facility to an offsite 7/5/17 and stated he did not en report and evaluation of hould have had one.		147	Point #4: Indicate how the facility preformance to make sure that soluthed Maintenance Supervisor will preventive maintenance inspection to the Risk Management meeting for checks and inspections are complet Completion Date: August 24, 2017 Point 1: Address how corrective active accomplished to address the issue(s) Director of Recreation services created in the Director of recreation evacuation drill form regarding facility drill that was held on July 5, 2017. Completion Date: July 31, 2017 Point #2: Address how the facility windividuals having the potential to be the same deficient practice. All evacuation drills will be docume evacuation drill form. Completion Date: August 24, 2017 Point #3: Address what measures with or systemic changes made to ensure practice will not recur. The Director services created the evacuation drill The Director of Recreation will revidesignee regarding the completion of drill form. The Maintenance Superviand train his designee regarding come evacuation drills form evidenced by training roster. Completion Date: August 24, 2017	tions are sustained. esent the weekly schedule monthly or review to ensure ed. on will be , for those The tted an evacuation of completed the ity evacuation will identify other e affected by inted on the If the put into place that the deficient of Recreation form. ew and train her of the evacuation isor will review upletion of the

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Event ID:IHO411

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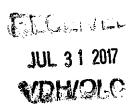
	10 1 011 11120.01 1112	T THE COUNTY OF				IND NO	<u>, 0330-039 i</u>	
	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G013	B. WING			07	/20/2017	
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
HOLIDA	Y HOUSE OF PORTS	MOUTH INC REVISED COPY			1 COUNTY STREET RTSMOUTH, VA 23707			
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			•			•	:	
W 447	Continued From pa	ge 7	W 4	147	Point #4: Indicate how the facility p	lane to n	: rionitor	
	relationship to the e	evacuation procedure. The	•		its performance to make sure that so			
		ch team member on the teams	! ;	ļ	sustained. The Annual evacuation de			
		ded. After the evacuation drill						
		ompleted and turned into the		•	be reviewed by the risk managemen			
		Manager. The report would be			annually. The CAO has emphasized			
		ality Improvement Committee.		1	with all staff the evacuation and disa	ation and disaster plan evidenced		
W 454)(1) INFECTION CONTROL		154	by signature on a training roster.		į	
			• • •	U T,			i	
	The facility must pro	ovide a sanitary environment			Point #1		:	
		d transmission of infections.		į	Address how corrective action will be			
				į	to address the issue (s), for those indi			
					to have been affected by the deficien			
	This STANDARD is	s not met as evidenced by:		,	The couches, chairs and sofa cushion			
	Based on general of	observations of the facility,		!	(left wing, right wing and recreation			
	staff interviews and	facility documentation, the			thoroughly cleaned on July 21, 2017	removin	ig any	
		3 living areas (Right and Left 🣑		ĺ	and all food and debris.			
	Wings) exhibited for	od and debris between the		;	The furniture was cleaned and sanitiz	ed unde	r	
	sofa cushions.	;		į	the direct supervision of the Environ	mental S	Services	
:				i	Supervisor and the Environmental Se	rvices A	ssistant.	
	The findings include):		- !	Completion Date: July 21, 2017			
					Point #2		!	
		p.m., during rounds on two			Address how the facility will identify	other in	ıdividuals	
		n areas, the sofas cushions		į	having the potential to be affected by	the sam	ie .	
		g were sitting were inspected			deficient practice. The Environmenta	al Servic	es	
		lebris between all cushions.		1	Supervisor and the Environmental Se	rvices		
		on 7/20/17 at 9:45 along with		į	Assistant has purchased two hand he	ld vacur	im	
		rector and the Environmental		;	cleaners on July 26, 2017.		:	
;		ns were unlocked and the		i	The hand held vacuum are equipped	with	: !	
	food and debris fell	•		į	attachments that allows staff to mane		mall	
•	Environmental Direct	1			places and crevices for cleaning; rem-		•	
į		ctor stated they needed a			food particles, crumbs and debris fr			
		n special attachments to			sofa, chair and cushions. All Environ		mmuuo,	
i.	enable deaning acc	ess between the cushions.		:	Technicians have been trained on the		ļ he	
	On 7/20/47 of 5:00 =	m the Chief Evenutive		-	hand held vacuums by the Environm			
1		o.m., the Chief Executive		ŗ				
		ne Director of Nursing (DON)			Supervisor. Evidenced by a signed tra	ruma to	ster.	
•		e food and debris in between			Completion Date: July 27, 2017			
,	the sora cushions. I	he CEO stated the facility		i		Ì		

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING		07/20/2017	
NAME OF PROVIDER OR SUPPLIER HOLIDAY HOUSE OF PORTSMOUTH INC REVISED COPY				421	REET ADDRESS, CITY, STATE, ZIP CODE 1 COUNTY STREET RTSMOUTH, VA 23707	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 454	wand attachments to parts of furniture to The facility's policy a "Housekeeping Sendaily cleaning schedinglemented to ass	se vacuum cleaners with o effectively reach between include sofa cushions. and procedures titled vices" (undated) indicated dules are developed and ure that each area of the I in a safe, clean, sanitary and	W	tities of the second of the se	Address what measures will be put into changes made to ensure that the deficie not recur. The Environmental Services created a deep cleaning weekly schedule the daily routine cleaning schedule that Environmental Technicians will use whe chnician cleaning the areas will check and sanitized, sign and date indicating tem(s) listed on the deep cleaning weeklecklist has been thoroughly cleaned. The Environmental Services Supervisor Maintenance Supervisor will coordinate of all sofa cushions for vacuuming, dee while noting any need of sofa or cushion completion Date: July 26, 2017 Point # 4 Indicate how the facility plans to monit to make sure that solutions are sustained environmental Services Supervisor or the Services Assistant checks, signs and dail areas as indicated on the deep clean schedule checklist by the assigned Environmental furniture, sofa, chair and cushions he horoughly cleaned, sanitized and is in addition the deep cleaning weekly schedule checklist of their review. Completion Date: August 4, 2017	ant practice will supervisor has ale in addition to the nen cleaning. The at the item cleaned that the area(s) or kly schedule r and e the unlocking p cleaning ion repair. or its performance ed. The the Environmental tes ensuring that ning weekly ironmental d. Ensuring that have been good repair. In edule will be

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