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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G051	A. BUILDING _____ B. WING _____	02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	154 CHARLOTTE AVENUE LA CROSSE, VA 23950

(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 An unannounced annual Medicaid Certification survey was conducted 01/31/2017 through 02/01/2017. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The Life Safety Code survey report will follow. No complaints were investigated. The census in this eight bed facility was six at the time of the survey. The survey sample consisted of four current Individual reviews, (Individuals #1 - #4).	W 000	1. The door to the laundry room will remain locked and closed at all times. Locks will be placed on the cabinets of the laundry room that contain laundry detergent, bleach, and fabric softener sheets. Keys to unlock the laundry door will be kept on a person or in a secured location at all times. No surface disinfectant will be left in bathrooms or anywhere in reach of residents throughout the facility.	2/15/17
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a safe environment in the facility. The door to the laundry room was not shut and was observed pushed all the way open and an object placed in front of the door to hold/prop it open. The key to the lock was observed in the lock. A gallon jug of laundry detergent was on top of the washing machine. A bathroom door in the hallway was also observed with the door pushed wide open. There were two cans of commercial strength surface disinfectant, a bottle of unopened hand soap, an opened bottle of hand soap and a bottle of opened hand sanitizer setting on a table inside the bathroom door.	W 104	2. Staff will be trained and reminded to keep the laundry room door closed at all times along with keeping the cabinets in the laundry room locked. The facility does not purchase commercial cleaning products and will not purchase them in the future. 3. All staff will receive training on 2/9/17 on where the keys are to be kept in the facility, keeping the laundry room door closed, and keeping surface disinfectant secured away from residents at all times. All staff will receive monthly reminders during staff	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana J Mills — TITLE: Facility Administrator — (X6) DATE: 2/8/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1	W 104		

Findings were:

On 02/01/2017 at approximately 7:15 a.m., the door to the laundry room was observed. A sign was posted on the door, "Keep Door Locked at All times, Employees Only". The door was pushed back against the wall as far as it would go. A blue rectangular plastic tub was in front of the door to hold/prop it open and preventing the door from closing. Observed in the lock of the door was a set of keys with a long lanyard hanging down. Inside of the laundry room a gallon jug of "Sunbright Laundry Detergent" was observed sitting on top of one of the machines. The jug was full, but had been opened. The lid was in place.

Across the hall from the laundry room was a bathroom. The door to the bathroom was pushed back against the wall leaving the room open. Observed sitting inside the door on a table were: two cans of commercial strength surface disinfectant, a bottle of unopened hand soap, an opened bottle of hand soap and a bottle of opened hand sanitizer.

One of the residential techs (Other staff #2) was in the dining area. She was asked who used the bathroom in the hallway. She stated, "Whoever wants to use it." She was asked if the individuals residing at the facility had access to that bathroom. She stated, "Yes."

No facility staff were in the hallway or in eyesight of either of the opened rooms.

At approximately 7:40 a.m., a residential tech (Other staff #1) entered the laundry room. She

meetings and every month thereafter. New staff will be trained upon hire and monthly thereafter as well.

4. The facility administrator and/or designee will make unannounced visits to the facility at least twice monthly on each shift to ensure policy is being followed as it pertains to the laundry room being locked and all surface disinfectant spray is properly secured.
5. All staff will receive training on the aforementioned policy on 2/9/17. The locks will be placed on the laundry room cabinets by 2/15/17. All surface disinfectant spray has been secured as of 2/2/17.

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W 104	Continued From page 2 was asked about the door being propped and left open. She stated, "We do that in the morning while they (individuals residing in the facility) are eating breakfast and we are getting everybody up...we are coming in and out bringing linens that need to be washed." As she left the room she removed the items propping the door open and shut it completely. The key to the door was left in the lock. At approximately 8:30 a.m. LPN (licensed practical nurse) #1 was shown the keys in the lock to the laundry room. She removed the keys and stated, "They shouldn't be in the door." At approximately 10:50 a.m., the administrator was told of the above information including the items in the bathroom. She stated, "They all know those doors are to be shut and the laundry room is to be locked at all times...They failed to execute the procedures we have in place. All those doors are to be shut and locked." No further information was obtained prior to the exit conference on 02/01/2017.	W 104		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on clinical record review, staff interview and facility document review, facility staff failed to	W 153	1. The findings of the investigation from incident report 3/2/16	2/10/17

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implement policies and procedures for investigating an injury of unknown source for one of four individuals in the survey sample, Individual #4.

Facility staff did not implement policies and procedures for investigating a facial cut that occurred 03/02/2016 for Individual #4.

Findings included:

Individual #4 was admitted to the facility on 03/24/2006 with diagnoses including, but not limited to: Profound MR (mental retardation), Autism Spectrum Disorder, esophageal reflux, hypothyroidism and intellectual disability.

During the review of incident/accident reports on 01/31/2017 at approximately 3:00 p.m., it was identified that on 03/02/2016 during his morning self-care with a RT (resident tech), Individual #4 was noted to have a facial "...cut about 1 1/2 inches long on the right side of his hairline. The cut was not bleeding but appeared deep enough to require stitches...I called 911 at 8:20 a.m. and took (Name) Individual #4's vital signs while waiting for EMS (emergency medical services) to arrive...EMS arrived at 8:33 a.m. (Name) LPN (licensed practical nurse) also arrived at 8:33 a.m. and was briefed of the situation. (Name) Individual #4 was transported by ambulance to (Name) Emergency Room. (Name), LPN followed the ambulance in the agency van." Also included in the incident report, "Was an internal investigation initiated by supervisor?: N (no)...Was the situation resolved?: Yes (how was it resolved?) (Name) Individual #4 was transported by ambulance to the ER..."

W 153

involving Individual #4 will be recorded on Exhibit 2005f2. Prevention measures for reoccurrence of the incident was recorded in Individual #4's chart on Exhibit 5004a dated 3/10/16 (see attached), which included adding a video monitor in Individual#4's room to be used overnight while sleeping to ensure Individual#4 does not get out of bed unassisted. There have been no injuries since this prevention has been in place. The completed investigation report will be forwarded to the residential manager by 2/10/17.

2. All injuries of unknown origin will be investigated by the facility administrator. Findings will be presented to the residential manager regardless of the outcome of the initial investigation for further review. Any findings of abuse or neglect will be forwarded to the local Human Rights advocate and escalated as policy dictates.

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W 153	Continued From page 4 Facility policy for "Reporting Incidents Involving Residents" was reviewed on 01/31/2017 at approximately 3:30 p.m. The policy included the following: "1. (Facility Name) shall respond appropriately and document significant medical and behavioral incidents involving residents. a. A significant medical incident is defined as an incident that occurs involving the resident which requires the implementation of first aid training by staff, the immediate care of a medical professional, or has the potential to cause medical care in the near future and requires monitoring by staff...2. When a significant medical incident occurs, the primary responsibility of staff is to provide immediate care to the resident to assure their health and safety. a. Examples of significant medical incidents include but are not limited to: falls, cuts, burns, bruising, etc...3. Once the immediate medical needs of the resident are met by staff or medical professionals, staff will assure appropriate documentation of the incident. a. Staff will complete incident reporting form...b. This form includes but is not limited to the inclusion of the following: ...supervision at the time of incident, a diagram depicting the injury, witnesses, how the incident occurred, what factors could contribute to the incident...recommendations to prevent future incidents, and supervisor's review and recommendations." The Administrator was interviewed on 01/31/2017 at approximately 4:00 p.m. regarding the above incident. She stated, "[Individual #4] has had injury to this same area before and has a scar there that contributes to the same area opening back up whenever [Individual #4] rubs or bangs his head in this same area. [Individual #4] gets out of bed on his own sometimes without	W 153	3. The residential manager will review all incident reports for an injury of unknown origin. The residential manager will review and sign off on the investigation report of each incident of unknown origin, regardless of the initial findings by the facility administrator. The investigation report will be edited to add a place for the residential manager's comments and signature. 4. The facility administrator will review all incident reports as they are written and again on a monthly basis to ensure policies are followed. All findings of abuse or neglect will be forwarded to the local human rights advocate and escalated as policy dictates. 5. The investigation report from incident 3/2/16 Individual#4 will be completed by 2/10/17 and forwarded to the residential manager. The investigation report will be updated by 2/10/17.	

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assistance and goes to the bathroom. All residents are on Q15 [every 15] minute checks throughout the night, but he will sometimes get up in between checks. The tech found him in the bathroom on that day." When asked if he received stitches the Administrator stated, "No stitches, I believe they used Dermabond. He wouldn't leave stitches alone, so skin glue was used." When asked where any of this information was documented the Administrator stated, "Corporate has told us not to include information on the report that is speculation. There should be a progress note in his record that documents the incident and any follow-up care from the emergency room visit. I will look and see if there is anything in his record and get that for you."

A progress note was received from the Administrator dated "3/2/2016 11:30 AM to 11:45 AM" that included a synopsis of his ER visit written by the LPN. No progress note was written by the RT regarding the incident. No diagram of the injury, witnesses, what could have contributed to the incident, or prevention measures were located in the clinical record.

No further information was received by the survey team prior to the exit conference on 02/01/2017.

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W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS

The facility must have evidence that all alleged violations are thoroughly investigated.

This STANDARD is not met as evidenced by:
Based on clinical record review and staff interview, facility staff failed to thoroughly

W 154

1. The findings of the investigation from incident report 3/2/16 2/10/17

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W 154	Continued From page 6 investigate an injury of unknown source for one of four individuals in the survey sample, Individual #4. Facility staff did not thoroughly investigate a facial cut that occurred 03/02/2016 for Individual #4. Findings included: Individual #4 was admitted to the facility on 03/24/2006 with diagnoses including, but not limited to: Profound MR (mental retardation), Autism Spectrum Disorder, esophageal reflux, hypothyroidism and intellectual disability. During the review of incident/accident reports on 01/31/2017 at approximately 3:00 p.m., it was identified that on 03/02/2016 during his morning self-care with a RT (resident tech), Individual #4 was noted to have a facial "...cut about 1 1/2 inches long on the right side of his hairline. The cut was not bleeding but appeared deep enough to require stitches...I called 911 at 8:20 a.m. and took (Name) Individual #4's vital signs while waiting for EMS (emergency medical services) to arrive...EMS arrived at 8:33 a.m. (Name) LPN (licensed practical nurse) also arrived at 8:33 a.m. and was briefed of the situation. (Name) Individual #4 was transported by ambulance to (Name) Emergency Room. (Name), LPN followed the ambulance in the agency van." Also included in the incident report, "Was an internal investigation initiated by supervisor?: N (no)...Was the situation resolved?: Yes (how was it resolved?) (Name) Individual #4 was transported by ambulance to the ER..." Facility policy for "Reporting Incidents Involving Residents" was reviewed on 01/31/2017 at	W 154	involving Individual #4 will be recorded on Exhibit 2005f2. Prevention measures for reoccurrence of the incident was recorded on Exhibit 5004a dated 3/10/16 which included adding a video monitor in Individual#4's room to be used overnight while sleeping to ensure Individual#4 does not get out of bed unassisted. There have been no injuries since this prevention has been in place. 2. All injuries of unknown origin will be investigated by the facility administrator. Findings will be presented to the residential manager regardless of the outcome of the initial investigation for further review. 3. The residential manager will review all incident reports for an injury of unknown origin. The residentiat manager will review and sign off on the investigation report of each incident of unknown origin, regardless of the initial findings by the facility administrator. The investigation	

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approximately 3:30 p.m. The policy included the following: "1. (Facility Name) shall respond appropriately and document significant medical and behavioral incidents involving residents. a. A significant medical incident is defined as an incident that occurs involving the resident which requires the implementation of first aid training by staff, the immediate care of a medical professional, or has the potential to cause medical care in the near future and requires monitoring by staff...2. When a significant medical incident occurs, the primary responsibility of staff is to provide immediate care to the resident to assure their health and safety. a. Examples of significant medical incidents include but are not limited to: falls, cuts, burns, bruising, etc...3. Once the immediate medical needs of the resident are met by staff or medical professionals, staff will assure appropriate documentation of the incident. a. Staff will complete incident reporting form...b. This form includes but is not limited to the inclusion of the following: ...supervision at the time of incident, a diagram depicting the injury, witnesses, how the incident occurred, what factors could contribute to the incident...recommendations to prevent future incidents, and supervisor's review and recommendations."

The Administrator was interviewed on 01/31/2017 at approximately 4:00 p.m. regarding the above incident. She stated, "[Individual #4] has had injury to this same area before and has a scar there that contributes to the same area opening back up whenever [Individual #4] rubs or bangs his head in this same area. [Individual #4] gets out of bed on his own sometimes without assistance and goes to the bathroom. All residents are on Q15 [every 15] minute checks

W 154

report will be edited to add a place for the residential manager's comments and signature.

4. The facility administrator will review all incident reports on a monthly basis to ensure policy is followed.
5. The investigation report from incident 3/2/16 Individual#4 will be completed by 2/10/17. The investigation report will be updated by 2/10/17.

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W 154	Continued From page 8 throughout the night, but he will sometimes get up in between checks. The tech found him in the bathroom on that day." When asked if he received stitches the Administrator stated, "No stitches, I believe they used Dermabond. He wouldn't leave stitches alone, so skin glue was used." When asked where any of this information was documented the Administrator stated, "Corporate has told us not to include information on the report that is speculation. There should be a progress note in his record that documents the incident and any follow-up care from the emergency room visit. I will look and see if there is anything in his record and get that for you." A progress note was received from the Administrator dated "3/2/2016 11:30 AM to 11:45 AM" that included a synopsis of his ER visit written by the LPN. No progress note was written by the RT regarding the incident. No diagram of the injury, witnesses, what could have contributed to the incident, or prevention measures were located in the clinical record. No further information was received by the survey team prior to the exit conference on 02/01/2017.	W 154		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure all medications and	W 382	1. The door to the medication room will remain locked and closed at all	2/9/17

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biologicals were locked when not being prepared for administration.

The door to the medication room was observed pushed all the way open. No staff members were in the room. After medication administration, Other Staff #2 left the room with one of the individuals and left all of that resident's medication cards lying on the counter unattended and out of her eyesight.

Findings were:

On 02/01/2017 at approximately 7:15 a.m., the door to medication room was observed to be open and pushed back against the wall as far as it would go. The lights were out in the room. A fan was sitting on the far side of the room and was on. There was a large whirlpool tub in the room (no water was in the tub), a large bottle of hand sanitizer was on a prep table in the room. No staff members were in the room or within eyesight of the room.

At approximately 7:40 a.m., a residential tech (Other staff #2) went to the medication room to administer medications. This surveyor accompanied her and observed the medication pass and pour. After the medications were prepared and administered, the residential tech accompanied the individual out of the medication room. She left the medication cards and a bottle for the medications administered on the counter in the medication room (Risperidone, Colace, Celexa, Zantac, Divalproex and a bottle of Lactulose). She left the room and assisted the individual to another area. She then assisted another individual to the medication room.

W 382

times. Keys to unlock the medication room along with the cabinets containing medications and biologicals will be kept on the person assigned to administer medications during the shift or in a secured location at all times.

2. All staff will be trained and reminded to keep the medication room door closed at all times along with keeping the cabinets in the medication room locked and the key to these areas in a secure place at all times.
3. All staff will receive training on 2/9/17 on where the medication room keys are to be kept at all times while in the facility and keeping the medication room door closed, All staff will receive monthly reminders during staff meetings every month thereafter. New staff will be trained upon hire and monthly thereafter as well.
4. The facility administrator and/or designee will make unannounced visits to the facility at least twice monthly on each shift to ensure

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W 382	Continued From page 10 Other staff #2 was interviewed at approximately 8:00 a.m. aboul the medication room door being lefl open and leaving the medications on the counter. She stated that she did not have a key to the medication room on her key chain and that the key was located in the desk at the nurse's station. She stated it was easier to just leave the door open. She also stated that she normally stays in the medication room in the mornings but had gone out to help with breakfast that morning (02/01/2017). She was asked about the medications being left on the counter post administration. She stated, "I know, I saw them when I went back in there...I should have put them away." The administrator was notified of the above information on 02/01/2017 at approximately 10:50 a.m. She stated the medication room door should have been locked. She also stated, "They failed to execute the procedures we have in place. All those doors are to be shut and locked." No further information was obtained prior to the exit conference on 02/01/2017.	W 382	policy is being followed as it pertains to the medications and biologicals being locked. 5. All staff will receive training on the aforementioned policy on 2/9/17. The medication room door and medication cabinets have been locked since 2/2/17.	