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
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 Fundamental Medicaid re-certification survey was conducted 02/16/16 through 02/17/16. 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 15 certified bed facility was 15 at the time of the survey. The survey sample consisted of 4 Individual reviews (Individuals one through four).	W 000		Completion date: 3/15/16
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure the day programs implemented the active treatment plan/ISP (Individual Support Plan) for one of 4 individuals in the survey sample, Individual # 2. Findings included: Individual # 2 was observed at lunch at the day program on 02/17/16 between 10:55 a.m. and 11:45 a.m. The individual's food was placed in front of him in an aluminum pan with a cardboard type lid. Three drinks, each in it's own nosey cup were also placed in front of him.	W 120	In response to W120 483.410(a) (3), Harrison ICF -IID (the facility) will ensure outside sources meet the specific needs for each individual according to program plans and /or professional protocols. This will be done as follows: The QIDP for the facility will provide documentation of any specialized needs or treatments to the Day Program Coordinator, and will review the documentation with her. Before the procedures are implemented, all support staff will be trained and observed on the correct procedures by the QIDP or his/her designee. All training will be thoroughly documented and this documentation will be maintained both at the Day Program site and within the personnel files. Each new hire shall receive specific training as part of the orientation process.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	QIDP	3-15-16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 120	Continued From page 1 At 11:15 a.m., the individual's food was uncovered. At 11:20 a.m., the individual's spoon was placed in the food in front of him. At 11:25 a.m., DSP # 3 started to feed the individual. The DSP did not sit down beside the resident, the DSP stood by the individual's side the entire time. At approximately 11:30 a.m., DSP # 3 was observed standing on the individual's right side, the DSP had his left arm wrapped around the back of the individual's neck with his left hand holding the individual's jaw and tilting the individual's head backward, while pouring the drink in with the right hand. At approximately 11:35 a.m., DSP # 3 was interviewed regarding the above observation. The DSP voiced that this was part of Individual # 2's program. The individual's program plan was retrieved and DSP # 3 was asked to show where this was part of the plan. DSP # 3 pointed to the individual's plan that read, "...the palm of one hand rests on chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip..." The DSP was asked if anyone instructed him on this technique. The DSP voiced, no and went on to say that he (DSP) just read it from the program. Individual # 2's clinical record was reviewed on 02/17/16 at approximately 1:30 p.m. The current physician's orders were reviewed and	W 120	The Day Program and the team leaders will continually monitor for compliance with protocols, and will provide correction, retraining, and documentation as necessary. The QIDP for the facility shall continue to complete observations and random spot checks of the services provided to individuals in the outside services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 120	Continued From page 2 documented: "...Help him with 1st bite or two of food, give him the spoon to feed himself, after 20 minutes feed him the rest of his meal..." A document was reviewed titled, "FEEDING TECHNIQUES" dated February 7, 2001. The documented read, "...maximum feeding time 40 minutes--allow 20 minutes to feed himself, if he has not finished his plate, then a staff member will feed him for the next 20 minutes...position of the feeder for solids...sitting down...position of the feeder for liquids...standing...palm of one hand rests on chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip. The hand that is resting on the chin pushes the head backward into a mild extension to reduce spilling...minimal touching of individual's head and face during the feeding..." The QIDP (Qualified Intellectual Disability Professional) was interviewed on 02/17/16 at approximately 2:10 p.m. regarding the 'feeding techniques' for individual # 2. The QIDP voiced that everyone is trained on how to do it (feed) and went on to say that 'we' (facility staff) go to the day program to observe, but further added that she (QIDP) had not observed the individual during lunch at the day program. The QIDP voiced that the day program staff and house staff meet regularly and that they (day program) know what they are suppose to be doing. No further information or documentation was presented prior to the exit conference on 02/17/16 at 3:30 p.m.	W 120		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 155	Continued From page 3 The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review; the facility staff failed to ensure a direct staff person (DSP) was removed from employment after an allegation of abuse, while the investigation was underway for one (1) of 4 Individuals, Individual #1. Individual #1 was suspected of being abused by a DSP on 10/2/15; an investigation was conducted on 10/2/15 and completed on 10/6/15, the DSP worked an eight (8) hour shift on 10/3/15 through 10/5/15, while the investigation was being conducted. The findings include: On 2/16/16 at approximately 3:00 p.m., the executive director presented to the Surveyors an Investigation for "Suspected Abuse." The form was reviewed to include the following: "Alleged Abuse Date: 10/2/15...[Individual named]...Specific Site: Bedroom...Relation: Abuse Alleged, "Physical" was marked on the form...Description: Staff reported that they heard a noise coming out of an individual's bedroom. This individual has a history of smacking people but they assumed the person that was changing him had smacked him...Description of Medical Treatment Provided & Finding: There were no marks or bruising on individual and he is has limited verbal interactions and as not able to indicate if he has pain (sic)...Investigation Begin Date: 10/2/15...Date Investigation Final Report: 10/6/15..." Further review of "Witness	W 155	As a corrective action for W155 483.420 (d) (3) Staff Treatment of Clients, the facility shall continue to follow the agency's (Pleasant View, Inc) Human Rights Policy regarding abuse and neglect, as approved by the Department of Behavioral Health and Development Services, the local Human Rights Advocate, and the local Human Rights Committee. Full documentation of any abuse allegations and the resulting investigations will be maintained per agency policy. To ensure this, the following procedures will be followed: - All new staff will have a through training in Human Rights policies, with an emphasis on the State Human Rights Regulations (the Blue Book). This training will be updated for every employee, and as the need may arise. - For any individual(s) found to be affected by any breach of rights, the following steps shall be enacted: * The identified staff member shall be immediately removed from contact with any individual served within PV,Inc. program, pending completion of the investigation. * Per timelines established within the agency's policies, the incident will be reported to all appropriate agencies.	Completion Date: 3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 155	Continued From page 4	W 155		

Statements," from the DSP's that overheard the "smack" and reported the allegation, which were written by the facility's Social Workers revealed that the DSP accused of "smacking" the Individual also made the following statement "..."he's a spoiled [f...ing, explicit language] brat, I'll take care of him..."

On 2/16/16 at approximately 4:30 p.m., the program coordinator and the director of residential services / Qualified Intellectual Disabilities Professional (QIDP) was interviewed regarding the DSP employment at the facility and if she was still working, the QIDP stated, "Yes, she is working tonight." The QIDP was interviewed regarding statement made by the DSP and of the findings being "Unsubstantiated," the QIDP stated, "The social worker and the Human Rights person said as long as it didn't happen in front of the resident or others it wasn't considered abuse..."
On 2/17/16 at approximately 8:00 a.m., the Social Worker (SW) was interviewed regarding the statement made by the DSP and the findings of abuse being "Unsubstantiated." The SW stated, "The people that were involved were agency staff persons and [person named] did not hear anything she was just going off of what [person named] told her and [person accused of abused named] said they didn't like her..." When interviewed regarding the statement made by the DSP, accused of abuse, the SW stated, "When it's done around staff it is not considered abuse, they can vent to each other."

On 2/17/16 at approximately 8:30 a.m., the DSP, accused of the abuse allegation and will be identified as DSP #1 hence forward, was interviewed regarding the accusation of abuse.

* The Social Work Department will begin the investigation within the prescribed time frame. At this time, any other individuals who may have been affected by the incident will be identified, and included in the investigation as needed.
* The investigation of the alleged incident will be completed promptly, and all data collected will be recorded and maintained in closed files per PV, Inc's policies. The agency will develop a clear interview form as well as a tracking form for use during the investigation in order to ensure clear documentation of the investigation is attained. The documentation shall include concise dates and times of all reports.
* If the incident is founded, the staff member will be subject to the findings of the investigation. if termination occurs, the staff member will be prohibited from access to any of Pleasant View, Inc's properties or individuals. if the staff person is found to be retrainable, the staff member will undergo a through Human Rights retraining with the Social Worker and work closely observed with the Program Coordinator for a specified period of time.
-The Program Coordinator and the Program Director/QIDP shall continually observe and monitor staff behavior and interactions with the individuals residing within the facility, and correction with documentation will occur as necessary to prevent any further breaches of human rights.

Completion Date
3/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 155	Continued From page 5	W 155		

DSP #1 stated, "I was in the room with [Individual named] when [Individual named] tried to hit me and I put my hand up to block it and [DSP named] from agency] heard the noise and thought I hit [Individual named]." When interviewed regarding the statement documented on the "Witness Statements" regarding the Individual being a "spoiled [explicit language] brat," DSP #1 stated, "I would never say that about anybody." I know when it happened, [Program Coordinator named] came in and made me aware of what was going on and told me to leave, I left and went home. It happened on a Thursday night and I was off Friday. I was scheduled to work on Saturday night and they called me and told me everything was okay and come to work on Saturday night." DSP #1 was interviewed and asked if she had worked with the Individual after the allegation, DSP #1 stated, "Oh yeah, we don't have assignments on the night shift, we do everything together. We work and help each other out."

On 2/17/16 at approximately 9:00 a.m., a copy of the Employee's Time sheet was requested and received; the Timesheet evidenced that DSP #1 worked on 10/3/15, 10/4/15 and 10/5/15 for eight (8) hours, while the investigation was still being conducted.

On 2/17/16 at approximately 9:45 a.m., a copy of the facility's abuse policy was reviewed to include the following:

"Subject: Dignity...It is the policy of the agency to ensure that all individuals will be treated fairly and will not be abused, neglected, or exploited in any manner...Individual abuse or mistreatment is defined as follows:...d. Statements or actions which would humiliate, demean, or exploit an individual; or condoning, or permitting the abuse of an individual...Any staff person having knowledge of such abuse or mistreatment or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 155	Continued From page 6 having reasonable cause to believe abuse is taking place will: 1. Immediately report an allegation of abuse to his or her supervisor who will immediately take necessary steps to protect the individual until an investigation is complete..." On 2/17/16 at approximately 10:30 a.m., the QIDP stated to this Surveyor, "I know the policy was not followed, she [DSP #1] shouldn't have been allowed to return to work until after the investigation was completed (sic)." No further information was provided during the course of the survey pertaining to the DSP returning to work prior to the completion of an investigation regarding the allegation of abuse.	W 155	Completion Date: 3/15/16 Pursuant to W159 438.430 (a), the facility QIDP shall ensure that all agency policies involving protection of the individuals are followed. Individual #1 will be protected as follows:	
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, clinical record review and facility document review; the QIDP (Qualified Intellectual Disability Professional failed to 1) ensure the policies and procedures were implemented for abuse investigations and 2) failed to ensure the Active Treatment Plan (ATP) was implemented regarding feeding for one (1) of 4 Individuals in the survey sample, Individual #2. 1. Individual #1 was suspected of being abused by a DSP on 10/2/15; an investigation was conducted on 10/2/15 and completed on 10/6/15, the DSP worked an eight (8) hour shift on 10/3/15 through 10/5/15, while the investigation was being conducted. 2. Individual #2's Active Treatment Plan (ATP) was not implemented for feeding.	W 159	the facility shall continue to follow the agency's (Pleasant View, Inc) Human Rights Policy regarding abuse and neglect, as approved by the Department of Behavioral Health and Development Services, the local Human Rights Advocate, and the local Human Rights Committee. Full documentation of any abuse allegations and the resulting investigations will be maintained per agency policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 159	Continued From page 7	W 159		

The findings include:

1. On 2/16/16 at approximately 3:00 p.m., the executive director presented to the Surveyors an Investigation for "Suspected Abuse." The form was reviewed to include the following: "Alleged Abuse Date: 10/2/15...[Individual named]...Specific Site: Bedroom...Relation: Abuse Alleged, "Physical" was marked on the form...Description: Staff reported that they heard a noise coming out of an individual's bedroom. This individual has a history of smacking people but they assumed the person that was changing him had smacked him...Description of Medical Treatment Provided & Finding: There were no marks or bruising on individual and he is has limited verbal interactions and as not able to indicate if he has pain (sic)...Investigation Begin Date: 10/2/15...Date Investigation Final Report: 10/6/15..." Further review of "Witness Statements," from the DSP's that overheard the "smack" and reported the allegation, which were written by the facility's Social Workers revealed that the DSP accused of "smacking" the Individual also made the following statement "..."he's a spoiled [f...ing, explicit language] brat, I'll take care of him..."

On 2/16/16 at approximately 4:30 p.m., the program coordinator and the director of residential services / QIDP (Qualified Intellectual Disability Professional) was interviewed regarding the DSP employment at the facility and if she was still working, the QIDP stated, "Yes, she is working tonight." The QIDP was interviewed regarding statement made by the DSP and of the findings being "Unsubstantiated," the QIDP stated, "The social worker and the Human Rights

For Individual # 2, feeding protocol will be done as follows:
The QIDP for the facility will provide documentation of any specialized needs or treatments to the Day Program Coordinator, and will review the documentation with her. Before the procedures are implemented, all support staff will be trained and observed on the correct procedures by the QIDP or his/her designee.

All training will be thoroughly documented and this documentation will be maintained both at the Day Program site and within the personnel files.
Each new hire shall receive specific training as part of the orientation process.
The Day Program and the team leaders will continually monitor for compliance with protocols, and will provide correction, retraining, and documentation as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 159	Continued From page 8	W 159		

person said as long as it didn't happen in front of the resident or others it wasn't considered abuse..."
On 2/17/16 at approximately 8:00 a.m., the Social Worker (SW) was interviewed regarding the statement made by the DSP and the findings of abuse being "Unsubstantiated." The SW stated, "The people that were involved were agency staff persons and [person named] did not hear anything she was just going off of what [person named] told her and [person accused of abused named] said they didn't like her..." When interviewed regarding the statement made by the DSP, accused of abuse, the SW stated, "When it's done around staff it is not considered abuse, they can vent to each other."

On 2/17/16 at approximately 8:30 a.m., the DSP, accused of the abuse allegation and will be identified as DSP #1 hence forward, was interviewed regarding the accusation of abuse. DSP #1 stated, "I was in the room with [Individual named] when [Individual named] tried to hit me and I put my hand up to block it and [DSP named] from agency] heard the noise and thought I hit [Individual named]." When interviewed regarding the statement documented on the "Witness Statements" regarding the Individual being a "spoiled [explicit language] brat," DSP #1 stated, "I would never say that about anybody." I know when it happened, [Program Coordinator named] came in and made me aware of what was going on and told me to leave, I left and went home. It happened on a Thursday night and I was off Friday. I was scheduled to work on Saturday night and they called me and told me everything was okay and come to work on Saturday night." DSP #1 was interviewed and asked if she had worked with the Individual after the allegation, DSP #1

The QIDP of the facility shall continue to complete observations and random spot checks of the services provided to individuals in the outside services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 159	Continued From page 9	W 159		

stated, "Oh yeah, we don't have assignments on the night shift, we do everything together. We work and help each other out."
On 2/17/16 at approximately 9:00 a.m., a copy of the Employee's Time sheet was requested and received; the Timesheet evidenced that DSP #1 worked on 10/3/15, 10/4/15 and 10/5/15 for eight (8) hours, while the investigation was still being conducted.
On 2/17/16 at approximately 9:45 a.m., a copy of the facility's abuse policy was reviewed to include the following:
"Subject: Dignity...It is the policy of the agency to ensure that all individuals will be treated fairly and will not be abused, neglected, or exploited in any manner...Individual abuse or mistreatment is defined as follows:...d. Statements or actions which would humiliate, demean, or exploit an individual; or condoning, or permitting the abuse of an individual...Any staff person having knowledge of such abuse or mistreatment or having reasonable cause to believe abuse is taking place will: 1. Immediately report an allegation of abuse to his or her supervisor who will immediately take necessary steps to protect the individual until an investigation is complete..."
On 2/17/16 at approximately 10:30 a.m., the QIDP stated to this Surveyor, "I know the policy was not followed, she [DSP #1] shouldn't have been allowed to return to work until after the investigation was completed (sic)."
No further information was provided during the course of the survey pertaining to the DSP returning to work prior to the completion of an investigation regarding the allegation of abuse.

2. The facility staff failed to ensure the active

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 159	Continued From page 10	W 159		

treatment plan was integrated, coordinated and monitored by the QIDP (qualified intellectual disability professional) for individual # 2 related to feeding.

Findings included:

The facility QIDP (Qualified Intellectual Disability Professional) failed to ensure a plan for 'feeding techniques' for Individual # 2 was integrated, coordinated and monitored between the individual's home and day program.

Individual # 2 was observed eating breakfast at home on 02/17/16, between 7:30 a.m. and 8:10 a.m. The individual was observed to be left alone for approximately 20 minutes with his food tray and three separate beverages in front of him. At approximately 7:55 a.m., DSP (direct staff person) # 2 approached the individual and assisted with feeding. DSP # 2 sat down beside the individual and fed the individual all of contents on the food tray and two of three beverages on the table. The DSP spooned the pureed food in with a special spoon and gave the individual drinks of the beverages via 'nosey cup', DSP # 2 positioned her hand under the individual's chin, put the nosey cup up to the individual's lip and the individual would drink. No other special positioning was performed or required to feed the individual.

At approximately 9:00 a.m., DSP # 2 was interviewed regarding the above observation. DSP # 2 voiced that the individual is set up for meals and is left alone for 20 minutes per the individual's plan to allow the individual opportunity to feed himself. The DSP voiced that the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 159	Continued From page 11	W 159		

rarely will feed himself and that he most always waits for staff to assist him.

Individual # 2 was observed at lunch at the day program on 02/17/16 between 10:55 a.m. and 11:45 a.m. The individual's food was placed in front of him in an aluminum pan with a cardboard type lid. Three drinks, each in it's own nosey cup were also placed in front of him.

At 11:15 a.m., the individual's food was uncovered.

At 11:20 a.m., the individual's spoon was placed in the food in front of him.

At 11:25 a.m., DSP # 3 started to feed the individual. The DSP did not sit down beside the resident, the DSP stood by the individual's side the entire time.

At approximately 11:30 a.m., DSP # 3 was observed standing on the individual's right side, the DSP had his left arm wrapped around the back of the individual's neck with his left hand holding the individual's jaw and tilting the individual's head backward, while pouring the drink in with the right hand.

At approximately 11:35 a.m., DSP # 3 was interviewed regarding the above observation. The DSP voiced that this was part of Individual # 2's program.

The individual's program plan was retrieved and DSP # 3 was asked to show where this was part of the plan. DSP # 3 pointed to the individual's plan that read, "...the palm of one hand rests on chin pushing his lower lip upward to form a seal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 159	Continued From page 12	W 159		

with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip..." The DSP was asked if anyone instructed him on this technique. The DSP voiced, no and went on to say that he (DSP) just read it from the program.

Individual # 2's clinical record was reviewed on 02/17/16 at approximately 1:30 p.m. The current physician's orders were reviewed and documented: "...Help him with 1st bite or two of food, give him the spoon to feed himself, after 20 minutes feed him the rest of his meal..."

A document was reviewed titled, "FEEDING TECHNIQUES" dated February 7, 2001. The documented read, "...maximum feeding time 40 minutes--allow 20 minutes to feed himself, if he has not finished his plate, then a staff member will feed him for the next 20 minutes...position of the feeder for solids...sitting down...position of the feeder for liquids...standing...palm of one hand rests on chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip. The hand that is resting on the chin pushes the head backward into a mild extension to reduce spilling...minimal touching of individual's head and face during the feeding..."

The QIDP (Qualified Intellectual Disability Professional) was interviewed on 02/17/16 at approximately 2:10 p.m. regarding the 'feeding techniques' for individual # 2. The QIDP voiced that everyone is trained on how to do it (feed) and went on to say that 'we' (facility staff) go to the day program to observe, but further added that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 159	Continued From page 13 she (QIDP) had not observed the individual during lunch at the day program. The QIDP voiced that the day program staff and house staff meet regularly and that they (day program) know what they are suppose to be doing. The QIDP further voiced that the individual had an appointment to be evaluated again in March (2016) by the doctor for swallowing, but this was only due to the individual's mother's preferences, not because the individual was having any type of problems or concerns related to the individual's swallowing. The QIDP voiced that nothing had changed with the individual swallowing and no problems or concerns had been identified. No further information or documentation was presented prior to the exit conference on 02/17/16 at 3:30 p.m.	W 159		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to implement the active treatment plan/ISP (Individual Support Plan) for one of 4 individuals in the survey sample, Individual # 2.	W 249	To ensure that the regulation W249 483.400 (d) (1), Program Implementation is met, the appointed QIDP for the facility shall ensure that all program plans providing active treatment for the individuals are followed as written. Individual #2 feeding procedures will be ensured as follows; The QIDP for the facility will provide documentation of any specialized needs or treatments to Day Program Coordinators, and will review the documentation with her.	Completion Date: 3/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 249	Continued From page 14	W 249		

The facility staff failed to ensure the active treatment plan was integrated, coordinated and monitored by the QIDP (qualified intellectual disability professional) for individual # 2 related to feeding.

Findings included:

The facility staff failed to ensure a plan for 'feeding techniques' for Individual # 2 was integrated, coordinated and monitored by the QDIP (Qualified Intellectual Disability Professional).

Individual # 2 was observed eating breakfast at home on 02/17/16, between 7:30 a.m. and 8:10 a.m. The individual was observed to be left alone for approximately 20 minutes with his food tray and three separate beverages in front of him. At approximately 7:55 a.m., DSP (direct staff person) # 2 approached the individual and assisted with feeding. DSP # 2 sat down beside the individual and fed the individual all of contents on the food tray and two of three beverages on the table. The DSP spooned the pureed food in with a special spoon and gave the individual drinks of the beverages via 'nosey cup', DSP # 2 positioned her hand under the individual's chin, put the nosey cup up to the individual's lip and the individual would drink. No other special positioning was performed or required to feed the individual.

At approximately 9:00 a.m., DSP # 2 was interviewed regarding the above observation. DSP # 2 voiced that the individual is set up for meals and is left alone for 20 minutes per the individual's plan to allow the individual opportunity

Before the procedures are implemented,all support staff will be trained and observed on the correct procedure by the QIDP or his/her designee. All training will be thoroughly documented and this documentation will be maintained both at the Day

Program site and within the personnel files. Each new hire shall receive specific training as part of the orientation process. The Day Program Coordinator and the team leaders will continually monitor for compliance with protocols and will provide correction, retraining, and documentation as necessary. The QIDP for the facility shall continue to complete observations and random spot checks of the services provided to individuals in the outside services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 249	Continued From page 15	W 249		

to feed himself. The DSP voiced that the resident rarely will feed himself and that he most always waits for staff to assist him.

Individual # 2 was observed at lunch at the day program on 02/17/16 between 10:55 a.m. and 11:45 a.m. The individual's food was placed in front of him in an aluminum pan with a cardboard type lid. Three drinks, each in it's own nosey cup were also placed in front of him.

At 11:15 a.m., the individual's food was uncovered.

At 11:20 a.m., the individual's spoon was placed in the food in front of him.

At 11:25 a.m., DSP # 3 started to feed the individual. The DSP did not sit down beside the resident, the DSP stood by the individual's side the entire time.

At approximately 11:30 a.m., DSP # 3 was observed standing on the individual's right side, the DSP had his left arm wrapped around the back of the individual's neck with his left hand holding the individual's jaw and tilting the individual's head backward, while pouring the drink in with the right hand.

At approximately 11:35 a.m., DSP # 3 was interviewed regarding the above observation. The DSP voiced that this was part of Individual # 2's program.

The individual's program plan was retrieved and DSP # 3 was asked to show where this was part of the plan. DSP # 3 pointed to the individual's plan that read, "...the palm of one hand rests on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 249	Continued From page 16	W 249		

chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip..." The DSP was asked if anyone instructed him on this technique. The DSP voiced, no and went on to say that he (DSP) just read it from the program.

Individual # 2's clinical record was reviewed on 02/17/16 at approximately 1:30 p.m. The current physician's orders were reviewed and documented: "...Help him with 1st bite or two of food, give him the spoon to feed himself, after 20 minutes feed him the rest of his meal..."

A document was reviewed titled, "FEEDING TECHNIQUES" dated February 7, 2001. The documented read, "...maximum feeding time 40 minutes--allow 20 minutes to feed himself, if he has not finished his plate, then a staff member will feed him for the next 20 minutes...position of the feeder for solids...sitting down...position of the feeder for liquids...standing...palm of one hand rests on chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip. The hand that is resting on the chin pushes the head backward into a mild extension to reduce spilling...minimal touching of individual's head and face during the feeding..."

The QIDP (Qualified Intellectual Disability Professional) was interviewed on 02/17/16 at approximately 2:10 p.m. regarding the 'feeding techniques' for individual # 2. The QIDP voiced that everyone is trained on how to do it (feed) and went on to say that 'we' (facility staff) go to the day program to observe, but further added that she (QIDP) had not observed the individual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 249	Continued From page 17 during lunch at the day program. The QIDP voiced that the day program staff and house staff meet regularly and that they (day program) know what they are suppose to be doing. No further information or documentation was presented prior to the exit conference on 02/17/16 at 3:30 p.m.	W 249		