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 _____	05/23/2018

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/22/18 through 05/23/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 05/22/18 through 05/23/18. 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 3 Individual reviews (Individuals 1 through 3).	W 000		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to complete a CFA (comprehensive functional assessment) within 30 days of admission for one of three	W 210	W 210 INDIVIDUAL PROGRAM PLAN CFR(S): 483.440(C)(3) In response to W 210 CFR(s):483.440(c)(3), Harrison ICF/IID (Facility) will ensure a completed CFA (Comprehensive Functional Assessment). 1. For Individual #2 a completed CFA will be completed by July 7, 2018. The facility will conduct a CFA that will provide assessments and reassessments that include any specialized needs or treatments; Medical reports, Psychological reports, evaluations, speech, and therapy assessments, activities, cognition, continence, mobility, and social and/or physical supports. 2. Any current Individual who resides in the facility will have an annual meeting, the interdisciplinary team along will the QIDP, Program Coordinator and facility nurse will meet and discuss to ensure all individuals who currently reside in the facility receive a completed CFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn A Dean	Program Coordinator	6/11/2018

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 _____	05/23/2018

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 210	Continued From page 1 individuals in the survey sample, Individual # 1. Individual # 1 was admitted to the facility on 12/14/17, the facility failed to complete a CFA for the resident within 30 day and at the time of the survey, the CFA had still not been completed. Findings include: Individual # 1 was admitted to the facility on 12/14/18. Diagnoses for the individual included, but were not limited to: Coffin-Lowry syndrome (genetic disorder) with severe mental retardation, epilepsy (seizure disorder), hypothyroidism, and VNS (vagus nerve stimulator). During the entrance conference on 05/22/18 at approximately 10:15 a.m., the administrative assistant was asked for a complete list of individuals residing in the facility, including any new admissions in the last 6 months. The administrative assistant presented a list of individuals with requested information, including one new admission (Individual # 1) on 12/14/17. At approximately 10:50 a.m., the director was interviewed and stated that Individual # 1 was admitted to the hospital earlier that morning for peg tube displacement and should return to the facility, but was unsure of the estimated return time. Individual # 1 was added to the sample. A copy of the individual's IPP (individual program plan) was requested at this time. At approximately 3:00 p.m., Individual # 1 had not yet returned to the facility.	W 210	Continued The new CFA (Comprehensive Functional Assessment) will replace the old adaptive behavior checklist that facility was using prior to the new CFA being put in place. 3. CFS be added to facilities admissions protocols/procedures and will be monitored by facilities quality assurance department to ensure all new 30 day admission CFA documentation is completed. 4. Quality Assurance department will monitor to ensure all new admissions within the 30 days time frame are receiving a completed CFA and documentation is completed and accurate per facility policy and protocols, as well as over see that all annual CFAs are being completed for residing individuals within 30 days of the annual Interdisciplinary meeting. 5. Comprehensive Functional Assessment for #2 resident will be completed by July 7, 2018.	

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 _____	05/23/2018

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 210	Continued From page 2 On 05/23/18 at approximately 7:30 a.m., the director and program coordinator were asked for a copy of Individual # 1's CFA. Individual # 1 was observed on 05/23/18 approximately 8:15 a.m. at the facility preparing for day programming. At approximately 8:45 a.m., the PC (program coordinator) presented an "Adaptive Behavior Checklist" and stated that this was the CFA. The information presented was reviewed and did not identify skills, abilities, and/or training needs, or specialized adaptive equipment. Individual # 1 was observed at the day program site on 05/23/18 from approximately 9:30 a.m. with observations through 11:00 a.m. On 05/23/18 at approximately 11:15 a.m., the director and the PC were asked for the individual's CFA, both staff members stated that this 'adaptive behavior checklist' was the CFA. The director and the PC were made aware that the checklist did not identify the individual's strengths, skill deficits, needed supports, per the CFA requirements and did evidence that the interdisciplinary team was involved. The checklist provided was completed by the PC. The director stated that this is how 'the facility has always done it' and further stated that the local behavioral services department is responsible for completing an admission assessment for the facility and the that the facility had not received a copy of that assessment yet. The director and PC were made aware that a	W 210		

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 _____	05/23/2018

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 210	Continued From page 3 CFA is to be completed by facility staff within 30 days of admission to the facility. No further information and or documentation was presented prior to the exit conference.	W 210		
W 321	PHYSICIAN SERVICES CFR(s): 483.460(a)(2) The medical care plan of treatment must be integrated in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to follow physician orders for one of 3 Individuals in the survey sample, Individual #2, and failed to ensure two of 3 Individual's medical care plan was utilized in the development of the Individual Service Plan (ISP). 1. The facility did not use a physician ordered gait belt while ambulating Individual #2, and did not integrate the gait belt correctly onto the ISP. 2. The facility staff failed to integrate the medical care plan for peg tube care and treatment into Individual # 1's ISP. The findings includes: 1. Individual #2 was admitted to the facility on 4/1/1988 with an intellectual development of profound and a medical diagnoses of unsteady gait. On 5/22/18 at 12:50 P.M. Individual #2 was observed at the day program standing alone against a wall holding onto a rail that ran the	W 321	W321-PHYSICIAN SERVICES CFR(s): 483.460(a)(2) In response to W 321 CFR 483.460(a)(2) Harrison ICF/IID (facility). 1. Physicians orders for use of gait belt/adaptive equipment for individual #2 will be reviewed with staff for individuals ambulatory or walking programs and or/outings. Support staff will receive adequate training on the use of individual #2 gait belt use. The QIDP, program coordinator or team lead will ensure said physicians orders are being followed for compliance and will provide corrections, retraining, and documentation as necessary. Individual service plan will be revised and physicians orders for gait belt will integrated into individual #2 ISP. Revised ISP will be reviewed with all support staff. Individual #1- individual service plan will be revised and include peg tube care and treatment. Physicians orders will be reviewed by facility nurse. Nurse will train support staff for proper maintenance and care of peg tube to ensure compliance. Staff will be trained on cleaning of and around the peg tube, flushes, instruction on accidental tube removal. An initial 6 hour training course on peg tubes is giving to all untrained staff, an 1 hour refresher training course on peg tubes is giving every six months that include 3 checks by the nurse hands on within that six months. 2. Care plans and ISP for current individuals with peg tubes will have physicians orders reviewed by the nurse and and revised ISP with integrated per facility protocols. Observations and retraining/training will be conducted as needed. 3. Peg Tube protocol will be implemented for said facility. protocol will be reviewed by facility quality assurance department to ensure individual is properly receiving fluids,medications and feedings. 4.Quality Assurance department will monitor to ensure all peg tube protocols, trainings/retrainings, performance	

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 _____	05/23/2018

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 321	Continued From page 4 length of the wall. After 10 minutes of observation a direct staff person (DSP) approached Individual #2 and prompted Individual #2 to ambulate throughout the day programs common area. Indivisual #2 was lead by the DSP holding onto Individual #2's hands while the DSP walked backward. After the ambulation activity was complete, the DSP sat Individual #2 in a reclining chair. A review of Resident #2's ISP (Individual Service Plan) was conducted at the time of the observation and documented under section titled "Adaptive Equipment" that Individual #2 used a gait belt. On 5/23/18 at 9:00 A.M. the above information was presented to the facility Director. This surveyor asked the Director when should the gait belt be placed on Individual #2. The Director verbalized that Individual #2 should have a gait belt on during ambulation. This surveyor asked for clarity, as the ISP indicated that the gait belt was to be used when getting on and off the bus. The Director verbalized that any adaptive equipment has to have a physician's order and the order is then placed onto the ISP. A current copy of Individual #2's physician order set (signed on 4/26/18 and current through 5/31/18) was obtained. A physician's order documented "Gait belt should be used during walking programs to prevent injuries from falls." On 5/23/18 at 9:45 A.M. the DSP team leader was interviewed concerning the above finding. The team leader reviewed Individual #2's	W 321	Continued management. Quality Assurance will monitor and review documentation quarterly for any evaluation performance and provide solutions. Random monitoring will be performed. 5. Care plan and ISP revisions and gait belt training for resident #1 will be completed by July 7, 2018 Care plan, ISP revisions and Peg tube training for resident #2 will be completed by July 7, 2018	

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 _____	05/23/2018

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 321	Continued From page 5	W 321		

physician's orders and verbalized that he had mis-read the physician order.

No other information was presented prior to exit conference on 5/23/18.

2. Individual # 1 was admitted to the facility on 12/14/18. Diagnoses for the individual included, but were not limited to: Coffin-Lowry syndrome (genetic disorder) with severe mental retardation, severe dysphagia, peg tube placement, epilepsy (seizure disorder), hypothyroidism, and VNS (vagus nerve stimulator).

During the entrance conference on 05/22/18 at approximately 10:15 a.m., the administrative assistant was asked for a complete list of individuals residing in the facility, including any new admissions in the last 6 months. The administrative assistant presented the list, which included Individual # 1 as a new admission on 12/14/17.

At approximately 10:50 a.m., the director was interviewed and stated that Individual # 1 was admitted to the hospital earlier that morning for peg tube displacement and should return to the facility, but was unsure of the estimated return time.

Individual # 1 was added to the sample. A copy of the individual's ISP (individual service plan) was requested at this time.

On 05/23/18 at approximately 7:30 a.m., the director and program coordinator (PC) stated that the resident returned to the facility at approximately 5:30 p.m. on 05/22/18.

Individual # 1 was observed on 05/23/18

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 _____	05/23/2018

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 321	Continued From page 6	W 321		

approximately 8:15 a.m. at the facility preparing for day programming. The individual had tube feeding running at that time.

At approximately 8:45 a.m., the PC was made aware that the resident's ISP did not include any information regarding the peg tube care/treatment. The PC was asked for the CFA (comprehensive functional assessment) at this time. The PC presented an "Adaptive Behavior Checklist" and stated that this was the CFA.

The information presented was reviewed and did not identify skills, abilities, and/or training needs, specialized adaptive equipment, and/or pertinent medical information. The PC was again asked for the CFA.

Individual # 1 was observed at the day program site on 05/23/18 from approximately 9:30 a.m. with observations through 11:00 a.m. The individual had tube feeding running during that time.

On 05/23/18 at approximately 11:15 a.m., the director and the PC were made aware that the adaptive behavior checklist was not the individual's CFA. The PC and director were made aware that the CFA includes, but is not limited to identification of the individual's strengths, skill deficits, needed supports, identification of needed or adaptive equipment, and pertinent medical information and that this is an interdisciplinary team effort with various disciplines involved. The director stated, "That is all we have."

The director and PC were made aware that the individual's ISP did not include any information regarding the peg tube care/treatment. The PC

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 _____	05/23/2018

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 321	Continued From page 7 stated, "Maybe you want the medical care plan." The medical care plan was presented and did not include any information regarding the individual's peg tube. The PC and director were made aware that the individual's medical care plan information should be considered and included in the individual's ISP resulting from the completion of the CFA within 30 days of admission. No further information and or documentation was presented prior to the exit conference to evidence that the facility staff integrated pertinent medical care plan information into the ISP.	W 321		
W 329	PHYSICIAN PARTICIPATION IN THE IPP CFR(s): 483.460(b)(1) A physician must participate in the establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure physician participation for one of 3 individuals in the survey sample, Individual # 1. The facility failed to ensure physician participation for a newly admitted client, Individual # 1. The facility staff were using a 'belly band' to prevent the resident from pulling/dislodging his peg tube without a physician's order. This information was not included on the physician's orders and was not included in the individuals ISP (Individual Service Plan).	W 329	W329-PHYSICIAN PARTICIPATION IN THE IPP CFR(S): 483.460(b)(1) In response to W 329CFR(s): 483.460(b)(1). Harrison ICF/IID (Facility) will ensure 1.Individual #1 the facility nurse will obtain physicians orders for abdominal binder for feeding tube to prevent resident from pulling feeding tube out. The information from the physicians orders will be included into the residence ISP(Individual Service Plan).Program Coordinator and nurse will review the physicians orders for accuracy and incorporate abdominal band order into ISP(Individual Service Plan). All supports staff will be trained and observed on correct procedures/protocols. Each employee shall receive specific training, program coordinators and team leads will monitor for compliance with said physicians orders and provide correction, retraining and documentation as necessary. Observations and services provided by staff to ensure proper use of the abdominal band. The facility nurse/program Coordinator will review physicians order each month when received to ensure accuracy and any possible changes to orders. If any changes are noted, facility nurse will call physicians office to verify changes 2. Interdisciplinary team will evaluate and discuss at individuals quarterly/annual meeting of seeking a physicians evaluation and order for belly band use. Individual will follow up with his/her primary care physician in order to be evaluated for a possible belly band order	

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 _____	05/23/2018

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 329	Continued From page 8 The individual's clinical record did not evidence the physician had identified and/or assessed the individual's medical needs for the use of a belly band for the prevention of dislodging the individual's peg tube. Findings include: Individual # 1 was admitted to the facility on 12/14/18. Diagnoses for the individual included, but were not limited to: Coffin-Lowry syndrome (genetic disorder) with severe mental retardation, dysphagia with peg tube placement in 2016, epilepsy (seizure disorder), hypothyroidism, and VNS (vagus nerve stimulator). During the entrance conference on 05/22/18 at approximately 10:15 a.m., the administrative assistant was asked for a complete list of individuals residing in the facility, including any new admissions in the last 6 months. The administrative assistant presented a list, including one new admission (Individual # 1) on 12/14/17. At approximately 10:50 a.m., the director was interviewed and stated that Individual # 1 was admitted to the hospital earlier that morning for peg tube displacement and should return to the facility, but was unsure of the estimated return time. Individual # 1 was added to the sample. A copy of the individual's ISP (individual service plan) was requested at this time. The ISP was presented and reviewed and did not have any information regarding the individual's peg tube care and/or maintenance.	W 329	Continued If physician orders a belly band the order will be reviewed and integrated into individuals care plan and ISP will be revised. 3. Adaptive Equipment (Abdominal band)protocol will be put into place. Protocol will be reviewed by quality assurance department and support staff will be trained per protocol. 4. Physicians orders will be monitored and reviewed by facility nurse and program coordinator to ensure accuracy once received from the pharmacy. Physicians orders are received on a monthly basis. Any changes noted by the nurse will be addressed with the ordering physician before any changes are made 5.Physicians orders for adaptive equipment (abdominal band) for #1 resident will be completed by July 7, 2018.	

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 _____	05/23/2018

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 329	Continued From page 9 On 05/23/18 at approximately 7:30 a.m., the director and program coordinator were asked for information regarding the individual's CFA (comprehensive functional assessment) and/or information where the physician was involved in assessment and planning of the individual's ISP. Individual # 1 was observed on 05/23/18 approximately 8:15 a.m. at the facility preparing for day programming, the individual had tube feeding running at this time. At approximately 8:45 a.m., the PC (program coordinator) presented an "Adaptive Behavior Checklist" and stated that this was the CFA. The information presented was reviewed and did not identify skills, abilities, training needs, specialized adaptive equipment, or any medical information The director and PC were made aware that no information could be located on the ISP or the adaptive behavior checklist regarding the individual's peg tube care and/or treatment. The director stated that the individual wore a 'belly band' to prevent the individual from pulling or accidentally disobliging his peg tube. The director was made aware that the 'belly band' was not on the individual's physician's orders and no information could be found on the individual's ISP regarding the peg tube or care thereof. The director stated that the individual had only dislodged his peg tube once since admission in December. The director was made aware that the nursing notes documented that the individual had a dislodged peg tube in April and had to have it replaced at the hospital.	W 329		

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 _____	05/23/2018

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 329	Continued From page 10	W 329		

The PC stated, "Maybe you are looking for the medical care plan."

The medical care plan was presented and reviewed and did not evidence any information regarding the peg tube and/or care.

Individual # 1 was observed at the day program site on 05/23/18 from approximately 9:30 a.m. with observations through 11:00 a.m.

A program staff member #1 was interviewed regarding the care of the individual's peg tube. The staff member presented a book (ISP) for care of the individual and no information regarding the peg tube was listed. The staff member stated that the day program has a nurse available for any concerns regarding the individual's peg tube.

On 05/23/18 at approximately 11:15 a.m., the director and the PC were asked for the individual's CFA, that listed the specific, identified areas of concern for this individual. The director stated that 'we don't have anything else.'

The director and the PC were made aware that the checklist did not identify specific information regarding individual, physically and or psychologically.

The director and PC were made aware of concerns that no evidence could be found that the physician had assessed and/or identified pertinent medical information for collaboration with the interdisciplinary team for inclusion into the individual's ISP and/or physician's orders.

The director and PC were made aware that a

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 _____	05/23/2018

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 329	Continued From page 11 CFA should have been completed by the interdisciplinary team, including physician participation within 30 days of admission to ensure physician's order/treatments and to ensure an accurate ISP was developed for the individual. No further information and or documentation was presented prior to the exit conference.	W 329		