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

STATEMENT OF DEFICIENCIES AND PLAN OFCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G005	A. BUILDING _____ B. WING _____	C 05/04/2017

NAME OFPROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN VIRGINIA TRAINING	2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320

(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 SHULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	The unannounced annual 55 Fundamental Medicaid survey for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) was conducted on 05/02/17 through 05/04/17. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities. (ICF/ID) Federal Regulations. One complaint was investigated during this survey. The Life Safety Code report will follow. The census in this 75 bed facility at the time of the survey was 69. The survey sample consisted of 7 current Individual records (Individual #1 through #7).	W 000		
W249	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 observations, clinical record review, individual and staff interviews, the facility staff failed to ensure the objectives of the program plan were followed for 2 out of 7 individuals (I #4 and I #5) in the survey sample. 1. The facility staff failed to consistently provide 1:1 supervision for Individual #4 which resulted in	W 249	483.440(d)(1) POC Individual #4: 1. The Direct Support Professional (DSP) who failed to implement Individual #4 program plan was disciplined in accordance with established Standards of Conduct on 3.17.17. The DSP received retraining on Individual #4 supervision level and the importance of adhering to the individual's program plan by the Residential Manager on 3.21.17. The toilets in Home 305 where Individual #4 lives were modified to secure the lid to the tank and deter removal on 3.6.17. Residential Managers and Behavior Specialists will in-service all DSP staff assigned to Home 305 on Individual #4 program plan, supervision (cont. p2)	5.22.17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Facility Director	5-17-17

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 249	Continued From page 1 injuries for the Individual. 2. The facility staff failed to consistently provide supervision for Individual #5 to prevent elopement. The findings include: 1. Individual #4 was admitted to an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) on 3/5/01 with diagnoses that included Moderate ID level, Autism, an abnormal desire to eat substances (such as chalk or ashes) not normally eaten (PICA) behavior, aggressive behavior and Schizophrenia. Individual #4's Quarterly program plan dated 12/17/16 to 2/9/17 identified behaviors that included deceleration of property destruction and that there were 5 occurrences during the quarterly summary period. One of his most destructive behaviors included breaking of the tank top of the toilet bowl. His treatment plan called for reinforcement of replacement behaviors, environmental management and 1:1 supervision at all times within arms reach of the individual. Individual #4 remained fully ambulatory. Individual #4's Annual program plan dated 11/9/16 identified the same type of behaviors and that the individual required continuous 1:1 within arm's reach support for psychiatric symptom/behavioral management. Individual #4 was fully ambulatory. Individual #4 had a Behavioral Treatment Plan dated 5/20/13 and updated 4/26/17 for property destruction, physical aggression, self-injurious	W 249	483.440(d)(1) (continued from p1): requirements and Behavior Support Plan by 5.22.17. Training Records will be maintained in the Person-Centered Supports Department. 2. Residential Managers will review all SEVTC individuals' program plans to determine which individuals have program plans with 1:1 supervision by 5.20.17. Residential Managers and Behavior Specialists will in-service DSP staff on all individuals who have Behavior Support Plans with 1:1 supervision supports as part of their program plan and will emphasize the importance of implementing individual program plans as written by 6.1.17. Training Records will be maintained in the PCS Department. 3. Director, Person-Centered Supports (DPCS) will ensure all Person-Centered Supports' (PCS) staff have been in-serviced on the Supervision of Individuals and Groups Guideline by 6.1.17. All PCS staff will be required to review the Supervision of Individuals and Groups Guideline as required reading annually by 6.1.17. All DSP staff will be required to complete a Training Alert with competency quiz regarding individual supervision by 6.12.17. The Director of Person-Centered Supports will ensure all training is complete for DSPs and update annual training requirements for the PCS Department by 6.12.17. Training Records will be maintained in the PCS Department. (cont. p3)	5.22.17 6.1.17 6.12.17

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W 249	Continued From page 2 behaviors and behavior/cyclical vomiting. The property destruction included entering bathrooms and breaking of the tops of toilet tanks. The plan included keeping the individual on 1:1 supervision with staff remaining within the resident's room within arms reach to be alert to his behaviors in order to intervene immediately if he should attempt aggressive or destructive behaviors or self injurious behavior to ensure his safety and safety of others. Out of the 5 aforementioned occurrences, one of them dated 3/5/17, Individual #4 sustained injury that required medical intervention. The investigator's investigation summary dated 3/10/17 concluded a Direct Support Staff Professional (DSP) was neglectful due to leaving the resident in his room to retrieve charting books. The report indicated the DSP thought Individual #4 was asleep because he heard snoring, at which time he went to retrieve the books. After a minute, the DSP ran back because she heard noise coming from the bathroom. Upon entering the bathroom, Individual #4 had broken the top of the toilet tank. The Individual was sent to the local hospital Emergency Room where he was treated for injuries that resulted in lacerations to his right index finger requiring sutures. Bilateral splints and mittens were ordered for his safety during the healing process. On 5/3/17 at 3:25 P.M., an interview was conducted with Individual #4's Residential Services Coordinator and the assigned Qualified Intellectual Disability Professional (QIDP). They both recounted the same details of the event that occurred 3/5/17. They stated Individual #4 was an opportunist and would seek out all bathrooms to destroy the toilet tank covers. They stated he	W 249	483.440(d)(1) (continued from p2): 4a. PCS Shift Supervisors will monitor during rounds each shift to ensure that program plans (including 1:1 supervision) are being implemented by DSP staff as written by 6.1.17. 4b. Qualified Intellectual Disability Professionals (QIDP) will monitor program plan implementation (including 1:1 supervision) during active treatment observations monthly by 6.1.17. 4c. DPCS will provide a quarterly report to the Quality Council identifying issues and corrective action plans developed during PCS shift supervisor rounds and QIDP active treatment observations regarding program plan implementation by 6.1.17.	6.1.17 6.1.17 6.1.17

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W 249	Continued From page 3 required constant supervision at all times even if it was thought by the staff he was asleep. They showed this surveyor where all toilet tanks had a wooden encased shelf that prohibited Individual #4 from removing the tank tops. Individual #4 was observed on 5/2/17 in a TV room with a staff member supervising him. He was moving about on the couch with fingers in his mouth. The staff in the home stated the individual had to constantly be watched to ensure his and other's safety, otherwise he will find something to get into. The facility's policy and procedure titled 'Guidelines for Resident Program Planning' (RPP) dated 2/2008 indicated an interdisciplinary approach in resident assessment and program planning, implementation and monitoring; the IF team is responsible for the development and implementation of the RPP. The facility's policy and procedure titled 'Guidelines for the Supervision of Individuals and Groups' dated 1/18/17 indicated "Individuals and groups were to receive staff supervision and support consistent with the individual needs and within parameters determined by the individual support team (ISP). One to One/Arms Reach Supervision included constant, uninterrupted, focused, visual observation of an individual by at least one staff member who is not performing any other duties, has no other assignments, and is within arm's reach of the person." 2. Client #5 was admitted to the facility on 9/9/16	W 249	483.440(d)(1) (continued): POC Individual #5 (cont.p5)	

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W 249	Continued From page 4 with diagnoses which included: Autism spectrum disorder, bipolar disorder, sleep disturbances, and Intellectual Disability; profound. The Behavior Support Plan dated 9/9/16 revealed the client has a history of self-injurious behavior, refusing to wear clothes in public and leaving the supervision of support staff. The client's Behavior Support Plan dated 9/9/16 further stated targeted behaviors included; "leaving without supervision: wanders or run away more than 10 -20 feet from support staff when outside and unable to redirect verbally back to close proximity". The Behavior Support Plan dated 9/9/16 read under, When Challenging Behaviors occur, #10 stated; Strategies for Leaving Supervised Area: Staff will ensure (name of client) is with staff when he is outside of the home. In the event that he attempts to leave the area, staff will state the following: a. (a nick name), and please come back inside, I don't have keys, it is not time to go yet. b. If need be, staff can call for additional assistance. On 5/2/17 at approximately 4:50 p.m., Client #5 was observed standing at the front exit door looking out until staff redirected the client to the dinner table at approximately 5:50 p.m. While standing at the exit door the client was easily redirected when someone was entering or exiting the building.	W 249	483.440(d)(1) (continued from p4): 1. The Direct Support Professional (DSP) who failed to implement Individual #5 program plan was disciplined in accordance with established procedures on 4.4.17. The DSP received retraining on Individual #5 supervision level, risk for elopement, and the importance of adhering to the individual's program plan by the Residential Manager on 4.5.17. All DSP staff were required to complete a Training Alert with competency quiz regarding 'individual door safety' by 5.7.17. Residential Managers and Behavior Specialists will in-service all DSP staff assigned to Home 202 on Individual #5 program plan, supervision requirements, and Behavior Treatment Plan by 5.22.17. Training Records will be maintained in the Person-Centered Supports Department. 2. Residential Managers will review all SEVTC individuals' program plans to determine which individuals have risks for Elopement by 5.20.17. Residential Managers and Behavior Specialists will in-service DSP staff on all individuals who have BSPs with Elopement and related supervision requirements as part of their program plan and emphasize the importance of implementing individual program plans as written by 6.1.17. (cont. p6)	5.22.17 6.1.17

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W 249	Continued From page 5 An interview was conducted with Direct Support Professional # 7 on 5/2/17 at approximately 5:00 p.m. The Direct Support staff stated, Client #5 did not speak but was capable of following directions most of the time. The client walked independently and required consistent supervision, as well as checks every 15 minutes while awake and every 30 minutes when asleep. An Investigators Summary dated 3/27/17 read; on March 26 at 5:12 p.m., nursing staff located (name of client) by Building 28, unsupervised and notified reception while keeping the client in sight. Nursing and Day Support personnel assisted (name of client) into building #28. The Shift supervisor and security responded and re-directed (name of client) back to his home without further incident or injury. The Investigators Summary dated 3/27/17 at 12:30 p.m., read; an interview was conducted with the Direct Support Professional assigned to Client #5 on 3/26/17. The Direct Support Professional stated, after returning from a community outing individuals were escorted inside the home. Client #5 was escorted into the home and the Direct Support Professional began assisting with another client, when he was alerted Client #5 was attempting to elope. The assigned Direct Support Professional stopped Client #5 from leaving the home and then proceeded to another area in the home to check on another assigned client whose supervision level required continuous in-sight supervision. This resulted in Client #5 not having any supervision.	W 249	483.440(d)(1) (continued from p5): Training Records will be maintained in the PCS Department. 3. Director, Person-Centered Supports (DPCS) will ensure all Person-Centered Supports' (PCS) staff have been in-serviced on the Supervision of Individuals and Groups Guideline by 6.1.17. All PCS staff will be required to review the Supervision of Individuals and Groups Guideline as required reading annually by 6.1.17. Training Alert with competency quiz regarding Guidelines for Elopement will be required by all DSP by 6.12.17. The Director of Person-Centered Supports will ensure all training is complete for DSPs and update annual training requirements for the PCS Department by 6.12.17. Training Records will be maintained in the PCS Department. 4a. PCS Shift Supervisors will monitor during rounds each shift to ensure that program plans (including elopement precautions and supervision) are being implemented by DSP staff as written by 6.1.17. 4b. Qualified Intellectual Disability Professionals (QIDP) will monitor program plan implementation (including elopement precautions and supervision) during active treatment observations monthly by 6.1.17. (cont. p7)	6.1.17 6.12.17 6.1.17 6.1.17

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W 249	Continued From page 6 A witness account revealed during an interview on 3/29/17 at 2:35 p.m., that Client #5 was observed on 3/26/17 during unloading of the van after an outing turning to go behind the van. The witness stated he got out the van and "saw him to the door The investigators review of the video footage of the incident revealed the following information regarding Client #5: At 5:08:58 p.m., Client #5 came up the walkway to the front door, 5:09:04 p.m., staff opens the front door, At 5:09:15 p.m., Client #5 enters the home, At 5:10:12 p.m., Client #5 exits the home through the front door and was redirected back to the house by his assigned Direct Support Professional. At 5:10:30 p.m., Client #5 enters the home with his assigned Direct Support Professional. At 5:10:53 p.m., Client #5 exits the home through the front door as it was closing. At 5:26:27 p.m., the shift supervisor and security officer returns Client #5 to the home. The facility's Program Guidelines No. 48, section 5 dated 1/18/17 reads; All staff members must exercise good judgment in the provision of individual and group supervision and increase monitoring as warranted by changes in health or mental status and risk involved in particular activities. On 05/4/16 at approximately 2:00 p.m., the Compliance Director and Medical Director was informed of the above findings during the pre-exit meeting	W 249	483.440(d)(1) (continued from p6): 4c. DPCS will provide a quarterly report to the Quality Council identifying issues and corrective action plans developed during PCS shift supervisor rounds and QIDP Active Treatment observations regarding program plan implementation by 6.1.17.	6.1.17

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W 440 W 440	Continued From page 7 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to hold evacuation drills at least quarterly for each shift. The findings included: The facility staff failed to hold fire drills on each shift at least quarterly. A review of the facility's evacuation drill log indicated the following: The first shift was designated as 6:00 A.M. until 2:00 P.M. The second shift was designated as 2:00 P.M. until 10:00 P.M. The third shift was designated as 10:00 P.M. until 6:00 A.M. Fire Drills were held on the following shifts: During the month of April 2016 from 4/14/16 until 4/27/16 fire drills were held on the 2-10 shift. During the month of May 20116 on 5/22/16 a partial listing of home had fire drills on the 2-10 shift. During the month of June 2016 on 6/2/16 until 6/4/16 fire drills were held on the 6-2 shift. During the month of July 2016 on 7/12 until 7/17/16 fire drills were held on the 2-10 shift. During the month of August 2016 on 8/9/16 until 8/30/16 a partial listing of homes had fire drills on the 10-6 shift	W 440 W 440	483.470(i)(1) 1. The Safety Director/Fire Marshall will in-service designated Security staff that assist with evacuation drills regarding the importance of following the drill schedule, due dates for submission, and review the requirements and expectations of the fire drill exercises by 6.1.17. Training Records will be maintained in the Risk Management Department. 2. The Safety Director/Fire Marshall will review all Fire Drills conducted during the past two quarters, identify homes or shifts that did not receive a fire drill, develop a corrective action plan to prevent reoccurrence, and submit to the Director, Risk Management (DRM) by 5.20.17. The Safety Director/Fire Marshall will review the current Fire Drill Schedule to ensure drills are scheduled quarterly for each location and shift by 5.20.17. Any locations that have not had a drill each shift in the current quarter will be completed by 5.29.17. 3. The DRM will revise Fire Safety Instruction 9004 to include scheduled drill results to be turned in to the Safety Director/Fire Marshall by the 25th of each month for review to ensure compliance with the monthly drill schedule by 5.20.17. Fire drills are not conducted via telephone; however the Instruction will also emphasize approved drill practices such as conducting drills face to face with staff via verbal simulations or through actual full evacuations. All Security staff (cont. p9)	6.1.17 5.29.17 6.12.17

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W 440	Continued From page 8 During the month of September 2016 on 9/17/16 until 9/18/16 fire drills were held on the 6-2 shift. During the month of October 2016 on 10/28/16 until 10/31/16 fire drills were held on the 2-10 shift. During the month of October 2016 on 10/25/16 a partial listing of homes had fire drills on the 6-2 shift. During the month of November 2016 on 11/18/16 until 11/19/16 a partial listing of homes had fire drills on the 10-6 shift. During the month of December 2016 on 12/02/16 until 12/19/16 a partial listing of homes had fire drills on the 6-2 shift. During the month of January 2017 on 01/25/17 until 01/31/17 a partial listing of homes had fire drills on the 2-10 shift. During the month of February 2017 on 02/13/17 until 02/19/17 a partial listing of homes had fire drills on the 10-6 shift. During the month of March 2017 on 03/11/17 until 03/19/17 fire drills were held on the 6-2 shift. During the month of April 2017 on 04/08/17 until 04/29/17 a partial listing of homes had fire drills on the 2-10 shift. A Fire Safety and Fire Training Policy indicated: Section 10-C "Fire drills are considered to be a part of the Facility's safety training program. Once per Quarter, each shift of each home will	W 440	483.470(i)(1) (continued from p8): designated to conduct evacuation drills at SEVTC will be in-serviced on the updated Instruction 9004 by 6.12.17. Training Records will be maintained in the Risk Management Department. 4a. Safety Director/Fire Marshall will monitor to ensure the completion of each fire drill as scheduled monthly and develop corrective action plans for any identified issues by 6.1.17. 4b. Safety Director/Fire Marshall will report fire drill results and corrective actions to the Patient Safety/Risk Management Committee monthly by 6.1.17.	6.12.17 6.1.17 6.1.17

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W 440	Continued From page9 participate in a simulated fire. Evaluation of the drill is based on staff response to the simulation. Training is conducted by the safety Manager or his designee after the drill to discuss the participants responses. The safety Manager will maintain detailed records and the original reports of fire drills and the evaluations. Results of the drill and a copy of the report will be provided to the Team Leader and the Director. A copy of the most current drill should be maintained in each residential location. During an interview at 1:45 P.M. on 5/4/17 with the Safety Manager he stated, some of the drills were "Call Out's" where a phone call is made to the building rather than an actual drill. When asked why the drills were not provided on each shift of each home and building. There was no response The facility staff failed to provide a Fire Drill at least quarterly for each shift of personnel.			