versability resources

WHERE ABILITY MEETS OPPORTUNITY

February 4, 2016

Elizabeth Hudnall, LTC Supervisor
Division of Long Term Care Services
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

RE: VersAbility Resources Cloverleaf House
898 Cloverleaf Lane
Newport News, VA. 23601
ICF/ID: 49-G053

Dear Ms. Hudnall:

Enclosed is the Plan of Correction for Cloverleaf House including the completed form CMS-2567 which was received on January 26, 2016. Also enclosed are Attachments 1-5 referenced in the completed CMS-2567.

Please contact me at (757) 896-8431 if you have any questions.

Sincerely,

Linda R. Kerns

Linda R. Kerns, LCSW
Director of Community Living

cc: Kasia Grzelkowski, President CEO
Courtney Pollard, Chief Financial Officer
Joyce Cofield, Assistant Director Community Living
Karla Ricks, Manager
Sharon McClinton, QA Manager

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G053	A. BUILDING _____ B. WING _____	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES CLOVERLEAF HOUSE	898 CLOVERLEAF LANE NEWPORT NEWS, VA 23601

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W 000	INITIAL COMMENTS The unannounced Annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted on 01/12/16 through 01/14/16. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities. (ICF/ID) Federal Regulations. The Life Safety Code report will follow. The census in this 5 bed facility at the time of the survey was 4. The survey sample consisted of 1 current Individual record and one closed record (Individual #1 through #2).	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the staff failed to thoroughly investigate an allegation of abuse incident involving one Individual (Individual #1) in the survey sample of 2 individuals. The findings included: Individual #1 was admitted to the facility on October 2011 with diagnoses of seizures, osteopenia, cerebral palsy, and scoliosis. The facility staff failed to thoroughly investigate an allegation of abuse involving Individual #1's care and services. Individual #1 was assessed as requiring	W 154	W 154 Staff failed to thoroughly investigate an allegation of abuse incident involving one individual (Individual #1) in the survey sample of 2 individuals 1 & 2. All allegations of abuse, neglect, exploitation or criminal activity subject to Individual #1 or any other ICF-IID resident will be thoroughly investigated via an internal review by the Director of Program and Quality Services, an investigation committee or assignment of an external investigation. This will include using all available information (e.g. reviewing written reports, relevant program records, interviewing victims, witnesses, administrative and direct care staff). 3. The Director of Program and Quality Services and the new Chief Human Resources Officer reviewed the revised Abuse, Neglect and Exploitation policy on 1/15/16 to ensure consistent application and understanding for future investigations. (Reference Attachment # 1, VersAbility Resources Abuse, Neglect and Exploitation Policy, Policy # 1.00.000.07) The revised Abuse, Neglect and Exploitation policy will be reviewed with Cloverleaf staff by the CL Director during their monthly QIDP/Staff Meeting on 2/11/16. All other ICF-IID facilities will also review the policy at their QIDP/Staff Meetings in February 2016.	1/15/16 1/15/16 2/11/16 2/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda K. Kerns, LCSW — TITLE: Director of Community Living — (X6) DATE: 2-3-16

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.

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W 154	Continued From page 1 assistance with personal hygiene. A Program Plan indicated: "Change Individual #1 every two hours for incontinence care." Individual #1 was assessed as being four feet tall and weighing 89.4 pounds. An Incident Report dated 9/11/15 indicated: "On the evening of 9/5/15 an incident was reported to the Community Living Manager by Direct Support Professional (DSP #1). DSP #1 came into the room of Individual #1 and observed DSP #2 changing Individual #1 improperly, with her legs in the air and that Individual #1 was crying. DSP #1 took over changing Individual #1 and later reported this incident to the on-call supervisor. The concern at that time was that Individual was being changed in an inappropriate position and DSP #2 was not responding to Individual #1's crying and saying she was hurting." "Investigation - DSP #2 said she was working directly with Individual #1 and that they had been to the (name of store) and purchased a (soda) and (snack food). Individual had dinner and then was eating her snack and threw it up. She was cleaned up then DSP #2 assisted her in cleaning up and getting into bed. DSP #2 sat with her beside her bed and she began throwing up again. She called the nurse again and the Manager. She remains in the back with Individual #1 because she would rather not interact with co-workers and "didn't need extra problems". She then went towards the office area, wrote the incident reports for what had already happened, and went back to check on Individual #1. She repositioned her and Individual #1 vomited again. She noticed when she touched her that she may have been choking, and turned her towards the left side,	W 154	4. There will be a second level review conducted by the Chief Human Resources Officer following any abuse or other investigations conducted by the Director of Program and Quality Services. This review will assist in overview of the outcome of the investigations, as well as, determining appropriate disciplinary actions to ensure the safety of each resident.	1/15/16

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bringing her towards her so she would throw up on the floor and not on herself or the bed, which already had throw up on it. She continued coughing and DSP #2 yelled for help. She saw water in Individual #1's eyes, and a lot of vomit was coming on, much like projectile. She had her rolled towards her and was trying to move the sheets by rolling them up so the soiled area was contained.

She put a clean tuck under Individual #1's (sic) back, though she didn't have any gloves. DSP #1 came in and asked if she needed the A&D ointment, and she said she didn't right then, what she needed was towels and wipes. She lifted her legs up behind her knees to remove the soiled linens and Individual said her legs hurt. DSP #2 lay her back on the bed. DSP #1 took over from there and DSP #2 went and called the nurse on call, and when she walked back in the room. Individual #1 was sitting supported up in bed with her feet dangling off the bed, and DSP #3 and DSP #4 were all in the room when she arrived. Someone asked Individual #1 if her stomach hurt, and while DSP #2 was talking to (CLM) Community Living Manager, DSP #1 asked to speak with the (CLM)."

DSP #2 followed nurses orders and gave her PRN (as needed) for nausea and gave her small sips of water. Individual #1 told her, "Thank you honey, thank you honey". DSP #2 said when she came back up in the main area of the house, the three staff were in the medication room, and were talking loud enough that she could hear them say/plot, What am I going to write on this report (SIC) " or something along those lines. DSP #2 explained that staff members were mad at her because she has reported them in the past,

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including sending in a video a few weeks ago. She feels this group of staff are friends and "gaining up on me and gearing up against me". There have been a few complaints she has had to file recently and feels this is related to her being called in today. She determined that the group of ladies figured an abuse allegation was a way "to get her out of here."

DSP #2 says she wasn't changing Individual #1 at the time DSP #1 entered the room. We reviewed the changing of her depends and current procedures for that. DSP #2 said they were trained to changed her from side to side and not lift her legs up. After she was changed, they got her up and brought Individual #1 into the living room areas until the end of the shift.

DSP #2 made it a point to say a few times in discussion that she had not changed Individual #1 and she was working with her while she was throwing up. In her written statement, she discusses changing her depend, which when talking with her, she seemed to strongly present that she hadn't changed her, that she was previously and recently found dry and was trying to get help cleaning her up from throw up.

It is important to note that I have met with DSP #2 regarding allegations previously, and that she was the alleged person in a serious abuse allegation regarding being very rough with an individual in pushing on her head in her wheelchair. This was unfounded. In this investigation, as in the first one, DSP #2 was assertive and very direct. Her eyes darted around and she seemed to be working hard to remain calm as she carefully gave the details of her story."

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Investigation: DSP #1- "DSP #1 said Individual #1 ate dinner and they wen out to the (name of store). Individual #1 did purchase the (soda) and (snack food) and ate them once home. DSP #1 said it was unusual that she (DSP#2) had Individual #1 in the back room/office area for her snack and came out to report that Individual #2 threw up her snack. The nurse was contacted. Individual #1 is to be changed every two hours, and DSP #1 asked DSP #2 about changing her. DSP #1 as the med person is responsible for the A & D ointment, and so has to monitor that everyone is changed every two hours. DSP #2 said she would change her after she finished writing something, she checked her and she was dry, around 9:30 PM, and she sat with her back in the for about 15 minutes. DSP #1 went to provide the ointment, and she found DSP #2 had rolled to the side of the bed with throw up over the floor. She heard Individual #1 saying, "It hurts, honey hurt me". Individual #1 rarely cries and doesn't say 'hurt me hurt me' very often. DSP #2 was trying to clean her up, and was lifting her legs up in the air towards her head. DSP #1 told (DSP #2) to stop, that she was hurting her, and told her she was not supposed to change her that way, and that she was hurting her, and that she has told her in the past as it can fracture her bones. She yelled, "Well how am I supposed to changed her then" and DSP #1 told her to change her the normal way. Individual #1 doesn't weigh very much and fractures easily and DSP #2 is rough in all of her movements. DSP #1 said said she is rough in all of her care of the individuals, very assertive and demonstrated on a few items around the office. Individual is "tiny, crying saying it hurts, and I yelled at her and took over."She cleaned Individual #1 up and changed her

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nightgown, and Individual #1 hugged her and said, "Thank you, thank you".

Staffing Issues: The staffing ratio at the time of the occurrence was appropriate.

Findings: There is not enough information and detail to substantiate a finding of abuse at this time, however, there is a clear pattern of rough handling of our individuals on the part of DSP #2. The former investigation from 5/1/14 also detailed reports of rough handling of the individuals although in the end it was unfounded for abuse. Three staff members have come forward to report rough behavior, and they appear genuine and believable."

During an interview on 1/14/16 at 9:15 A.M. with the Director of Program and Quality Services (DPQS) she was asked why abuse was not founded. The DPQS stated she did not find enough evidence for abuse. "While there was rough handling of the client" I did not have enough to go on and find abuse." When asked if rough handling of an individual was considered abuse, the DPQS stated, Yes. When asked if Individual #1's Incontinent program plan was implemented appropriately she stated, "No." When asked if the appropriate Program Plan had been reviewed to ensure more restrictive services were not being applied the DPQS stated, "She did not look at how Individual #1's program plan should have been implemented."

A revised Abuse, neglect and Exploitation Policy dated 10/14/15 indicated: "Purpose- to protect the health, welfare and safety of persons served.

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W 154	Continued From page 6 Definition (S): Abuse is any act or failure to act by an employee, or other person responsible for the care of an individual, that was performed or was failed to be preformed knowingly, recklessly or intentionally and that caused or might have caused physical or psychological harm, injury or death to a person receiving services for the (Facility Staff)." General Policy: "Examples of abuse, mistreatment, exploitation, neglect and criminal activity include, but are not limited to, the following: #6. Use of more restrictive or intensive services, denial of services or use of services that are not consistent with his or her individualized services plan to punish the individual. Internal Investigation Report: #9. Corrective Action Plan, if applicable." A review of the Investigation indicated: DSP #2 was terminated effective September 15, 2015. A review of the Individualized Program Plan for Individual #1 was not implemented with the appropriate care and services. The facility staff failed to thoroughly investigate an allegation of abuse.	W 154		
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	W 249		

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W 249	Continued From page 7 plan. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the staff failed to implement the Program Plans for one Individual (Individual #1) in the survey sample of 2 individuals. The findings included: Individual #1 was admitted to the facility on October 2011 with diagnoses of seizures, osteopenia, cerebral palsy, and scoliosis. The facility staff failed to implement Individual #1's Program Plans and thoroughly investigate an allegation of abuse involving Individual #1's care and services. Individual #1 was assessed as requiring assistance with personal hygiene. A Program Plan indicated: "Change Individual #1 every two hours for incontinence care." Individual #1 was assessed as being four feet tall and weighing 89.4 pounds. An Incident Report dated 9/11/15 indicated: " On the evening of 9/5/15 an incident was reported to the Community Living Manager by Direct Support Professional (DSP #1). DSP #1 came into the room of Individual #1 and observed DSP #2 changing Individual #1 improperly, with her legs in the air and that Individual #1 was crying. DSP #1 took over changing Individual #1 and later	W 249	W249 Staff failed to implement the Program Plans for one individual (Individual #1) in the survey sample of 2 individuals. 1. The procedures outlined in Policy #63-4: Adult Undergarments were reviewed with Cloverleaf staff at their monthly staff meeting on 1/14/16 by the CL Nurse and a Patient Care Simulator was used to demonstrate proper procedures for how to change undergarments for Individual #1. Cloverleaf staff were able to demonstrate procedures outlined in the policy. These procedures will be followed when changing Individual #1 undergarments per the ISP/Nursing Care Plan. (Reference Attachment #2: Policy #63-4 Adult Undergarments) 2. Cloverleaf ICF-IID facility staff will follow procedures outlined in Policy #63-4: Adult Undergarments, which were were reviewed and demonstrated during their staff meeting on 1/14/16, unless otherwise noted in the individual's ISP/Nursing Care Plan. 3. Cloverleaf ICF-IID staff were trained by the CL Nurse on the proper procedures for changing adult undergarments on 1/14/16. The CL Nurse and CNA demonstrated how to change the undergarments using a Patient Care Simulator. Staff were able to demonstrate the procedure as well. Staff at all other ICF-IID facilities operated by VersAbility Resources will also participate in formal training by the CL Nurses during their monthly Staff Meetings in February 2016. They will also demonstrate their knowledge of the procedures using a Patient Care Simulator. This training also will be provided to new employees during Orientation.	1/14/16 1/14/16 1/14/16 2/15/16

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W 249	Continued From page 8 reported this incident to the on-call supervisor. The concern at that time was that Individual was being changed in an inappropriate position and DSP #2 was not responding to Individual #1's crying and saying she was hurting." Investigation: DSP #1- "DSP #1 said Individual #1 ate dinner and they went out to the (name of store). Individual #1 did purchase the (soda) and (snack food) and ate them once home. DSP #1 said it was unusual that she (DSP#2) had Individual #1 in the back room/office area for her snack and came out to report that Individual #2 threw up her snack. The nurse was contacted. Individual #1 is to be changed every two hours, and DSP #1 asked DSP #2 about changing her. DSP #1 as the med person is responsible for the A & D ointment, and so has to monitor that everyone is changed every two hours. DSP #2 said she would change her after she finished writing something, she checked her and she was dry, around 9:30 PM, and she sat with her back in the for about 15 minutes. DSP #1 went to provide the ointment, and she found DSP #2 had rolled to the side of the bed with throw up over the floor. She heard Individual #1 saying, "It hurts, honey hurt me". Individual #1 rarely cries and doesn't say 'hurt me hurt me' very often. DSP #2 was trying to clean her up, and was lifting her legs up in the air towards her head. DSP #1 told (DSP #2) to stop, that she was hurting her, and told her she was not supposed to changed her that way, and that she was hurting her, and that she has told her in the past as it can fracture her bones. She yelled, "Well how am I supposed to change her then" and DSP #1 told her to change her the normal way. Individual #1 doesn't weigh very much and fractures easily and DSP #2 is rough in	W 249	4. The CL Manager will conduct monthly staff observations at random. These observations will include staff demonstrating (per outlined in the ISP/Nursing Plan of Care) procedures for changing adult undergarments.	1/15/16

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all of her movements. DSP #1 said she is rough in all of her care of the individuals, very assertive and demonstrated on a few items around the office. Individual is "tiny, crying saying it hurts, and I yelled at her and took over."She cleaned Individual #1 up and changed her nightgown, and Individual #1 hugged her and said, "Thank you, thank you".

During an interview on 1/14/16 at 10:05 A.M. with the House Nurse, she was asked to present a copy of how Individual #1 should have been changed per facility policy and professional practice. A "Changing an Adult Undergarment policy was presented: " 1. Gather all supplies: Disposable washcloths- Gloves- Clean Undergarment. 2. Put on gloves. 3. Undo tape on both sides of undergarment. 4. Turn the individual to one side (facing away from you) and bend upper knee toward his/her chest. 5. Wrap brief over itself to cover the soiled area inside. 6. Wipe between the individual's legs and buttocks with disposable washcloths. If the person is female always wipe from front to back. 7. Check skin for redness, tearing or sores. 8. Open the new undergarment. 9. Tuck half of the clean undergarment as far as possible under the individual. 10. Roll the person to the other side. 11. Remove dirty undergarment. 12. Spread the other half of the clean brief so that it is flat on the bed. 13. Roll the individual on his back pull the front of the brief between the individual's legs and fasten the tape on both sides of undergarment. 14. Place dirty undergarment in bag and throw away. 15. Remove gloves and throw away. Wash Hands.

When you should contact the nurse:

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W 249	Continued From page 10 1. You see new sores. 2. You see a red rash or pimple-like bumps. 3. You see redness and dryness that is spreading. 4. You have question or concerns about the individual's condition or care. 5. ANY CHANGE IN CONDITION" The Nurse was asked during an interview on 1/14/16 at 10:15 A.M. had Individual #1 been provided with the appropriate care and services for incontinence care, and she stated, "No, the staff should not have lifted her legs over her head and the Individual should not have been in pain due to the techniques used to change her." The facility staff failed to implement Individual #1's incontinence program in accordance with her Individual Program Plan.	W 249	W378 Facility Staff failed to maintain the medication refrigerator at the proper temperature. 1. and 2. A new refrigerator was purchased for Cloverleaf ICF-IID facility on 1/15/16 to store medications that require refrigeration. Policy#78 : Medication Administration was revised to include documentation of refrigerator temperature on the Medication Refrigerator Log. (Reference Attachment #3: Medication Refrigerator Temperature Log). The Medication Administration policy was also updated to include staff contacting the CL Nurse if refrigerator temperatures are below 33 degrees or above 42 degrees. (Reference Attachment #4: Policy #78 Medication Administration, updated 1/2016)	1/15/16 1/22/16 1/22/16
W 378	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of temperature. This STANDARD is not met as evidenced by: Based on observations and facility records, the facility staff failed to maintain the medication refrigerator at the proper temperature. The findings included: During the medication observation on 1/14/16 at 6:45 A.M. the Medication Refrigerator was observed to have temperatures which exceeded 42 degrees Fahrenheit.	W 378	3. CL Nurses checked all refrigerators housing medication at all ICF-IID facilities operated by VersAbility Resources to ensure proper reading and recording of temperatures and they were found to be within expected degree range. The Medication Audit Checklist was revised to include review of medication refrigerator temperature logs. (Reference Attachment #5: Medication Audit Checklist form) The revision to Policy #78: Medication Administration and Medication Refrigerator Log form will be reviewed with Cloverleaf ICF-IID staff and Envisions Day Program during their monthly Staff Meetings in February, 2016.	1/14/16 1/22/16 2/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G053	A. BUILDING _____ B. WING _____	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES CLOVERLEAF HOUSE	898 CLOVERLEAF LANE NEWPORT NEWS, VA 23601

(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 378	Continued From page 11 A review of the Medication Refrigerator Temperature Chart for the month of January 2016 indicated the following: January 1, Temperature-59 January 2, Temperature-60 January 5, Temperature-59 January 6, Temperature-59 January 7, Temperature-60 January 8, Temperature-60 January 11, Temperature-59 January 12, Temperature-60 January 13, Temperature-59 January 14 Temperature- 59 During observations of the medication refrigerator on 1/14/16 at 6:30 A.M. the temperature was 60 degrees. A review of the Medication Refrigerator Temperature Chart for the month of December 2015 recorded temperatures between 58 degrees and 61 degrees. The Medication Refrigerator Temperature Chart recorded temperatures between 48 degrees and 61 degrees for the month of November 2015. The Medication Refrigerator Temperature Chart recorded temperatures between 50 degrees and	W 378	4. The CL Manager will ensure daily documentation of medication refrigerator temperature by Cloverleaf Staff. The QA Manager will also conduct periodic review of the Refrigerator Temperature logs during unannounced audits of Cloverleaf, as well as all other ICF-IID facilities. The CL Manager and/or QA Manager will also notify the CL Nurse if refrigerator temperatures are not within expected degree range. The CL Nurses will conduct monthly audits of the medication room and complete the "Medication Audit Checklist (which includes review of the refrigerator temperature logs).	1/15/16 1/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G053	A. BUILDING _____ B. WING _____	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES CLOVERLEAF HOUSE	898 CLOVERLEAF LANE NEWPORT NEWS, VA 23601

(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 378	Continued From page 12 62 degrees for the month of October 2015. A review of the facility policy to maintain medication refrigerator temperatures was requested. The Community Living Manager did not provide one during the survey. During an interview on 1/14/16 at 10:40 A.M. with assigned nurse, she stated, "the refrigerator temperatures were not being maintained properly." The facility failed to maintain the Medication Refrigerator at the proper temperature.	W 378		

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WHERE ABILITY MEETS OPPORTUNITY

ATTACHMENT #1

Policy #1.00.000.07

Abuse, Neglect and Exploitation

Policy Title: **Abuse, Neglect and Exploitation Policy**		***Policy #:*** **1.00.000.07**
Approval Date: 19 Oct 2015	***Effective Date:*** 19 Oct 2015	***Date(s) Revised:*** **April 28, 2006; December 15 2008; March 7, 2011; August 9, 2011; July 16, 2012; October 19, 2015**
Scope: **All VersAbility Employees**		***Version:*** **2**
Policy Owner: **Director of Program and Quality Services**	***Approved by:***	

1.0 Purpose

To protect the health, welfare and safety of persons served.

2.0 Policy

SECTION I. GENERAL POLICY

VersAbility Resources treats individuals with developmental, intellectual and other disabilities with dignity and respect. VersAbility Resources fully supports, endorses and enforces the rights of individuals and requires all employees to make reasonable efforts to protect individuals from harm, abuse, exploitation and injury. Mistreatment, abuse, neglect, exploitation and criminal activity is strictly prohibited. Staff will not cause or allow individuals to suffer any form of physical or mental abuse, neglect, exploitation, unnecessary restraint or other similar acts while under the care of VersAbility Resources. Failure to comply with this policy is a serious employment issue and may result in disciplinary action, up to and including, termination of employment.

Examples of abuse, mistreatment, exploitation, neglect and criminal activity include, but are not limited to, the following:

1. Rape, sexual assault or other criminal sexual behavior
2. Assault or battery
3. Use of language that demeans, threatens, intimidates or humiliates the individual
4. Misuse or misappropriation of the individuals assets, goods or property
5. Use of physical restraint that is not in compliance with federal and state laws, regulations and policies, professionally accepted standards of practice, or the individual's individualized service plan as approved by the Local Human Rights Committee
6. Use of more restrictive or intensive services, denial of services or use of services that are not consistent with his or her individualized services plan to punish the individual
7. Failure to administer medications correctly

8. Injuries of unknown origin

SECTION II. STAFF RESPONSIBILITIES

The Commonwealth of Virginia mandates that all staff who, through his or her professional capacity, has knowledge of, or reason to believe that a person is being abused, neglected or exploited, or that a crime has been committed must report such suspicion to the proper authorities. Failure to report is punishable by law and will subject the staff member to immediate termination. Any staff suspecting abuse, neglect, exploitation, mistreatment, medication error or criminal activity will immediately take steps to stop the activity and report the incident. Staff will not wait to confirm the suspected activity to intervene and report it to his or her supervisor.

SECTION III. REPORTING

Once notified of the suspicion of abuse, neglect, exploitation, injuries of unknown origin, or criminal activity, the supervisor will contact the legal guardian or authorized representative of the involved individual(s) immediately. Serious incidents will also be reported to the President/CEO or designee. An incident report will be completed by the reporting staff in accordance with established procedures. Staff will report the incident by the close of the following business day to the appropriate entities, which may include:

1. The local Adult Protective Services or Child Protective Services office of the Virginia Department of Human Services
2. The Regional Advocate (through the Comprehensive Human Rights Information System (CHRIS)
3. The Department of Behavioral Health and Developmental Services (DBHDS) – Department of Licensure (through the CHRIS system)
4. The local police department
5. The Virginia Department of Health (VDH)

SECTION IV. INVESTIGATIONS

Any individual who is the subject of an abuse, neglect, exploitation, criminal activity or other serious allegation will be protected from the accused perpetrator. Depending upon the severity of the allegation, the employee accused of abuse or other serious actions will immediately be removed from contact with the subject individual(s) during the investigation in one of the following ways:

1. Directed to have no contact with the subject individual(s)
2. Transferred to duties without contact with the subject individual(s)
3. Transferred to duties without contact with any individuals
4. Placed on administrative leave with written notification to follow

The accused employee will be asked to complete an Incident/Injury Report for the time period or action in question. The employee will be given a copy of this policy and related procedures and will remain available to be contacted during the investigation process.

To investigate allegations of abuse, neglect, exploitation or criminal activity, the President/CEO or Senior Vice President will have the sole authority to authorize an internal review, investigation committee or assignment of an external investigation.

1. The President/CEO and/or Senior Vice President will authorize an internal staff review for minor occurrences or incidents where it is clear that no one is in immediate risk of further abuse or injury.
2. For allegations of a serious nature, the President/CEO and/or Senior Vice President may appoint a multiple-person internal investigation committee as appropriate, which may include non-staff or others with skills, knowledge or abilities useful to the investigation. No member of the committee will have any direct involvement with the incident or be an employee in the program in which the allegation occurred. As soon as the investigation committee is formed, any other internal investigations or review related to the allegation will cease unless otherwise directed by the President/CEO or designee. No staff member will interfere with the work of the committee in any way.
3. The President/CEO and/or Senior Vice Presient may elect to have the investigation conducted by an external source, when appropriate.
4. The persons(s) or committee conducting the investigation will be responsible for considering all available information in researching any allegations, including but not limited to requesting and reviewing written reports and relevant program records, as well as interviewing the victim(s), witnesses and administrative and direct care staff. Individuals and staff will not be interviewed by anyone other than the committee, a member of the committee, or a representative of the committee nor will they be coached in any manner. The interviews will take place in an environment and manner that is comfortable to the interviewee.
5. Staff from the Department of Human Services, DBHDS and/or VDH will be permitted and encouraged to participate and attend the investigation committee meetings and deliberations.
6. All staff will fully cooperate with any investigation of abuse, neglect, exploitation, criminal activity and/or injury of unknown origin. Failure to cooperate with an investigation or giving false or misleading information may result in immediate dismissal.
7. The results of the administrative review or internal investigation will be recorded on an Internal Investigation Report, or a similar report for external investigations, and submitted to the President/CEO and/or Senior Vice President within four business days of the incident so that the results can be reported to public officials within ten days, or five days if the incident occurred in an ICF/IID setting. Copies of the results of the investigation and actions taken will be filed with the same agencies with which notification was given. Results will also be shared with the involved employee(s). The Senior Vice President and/or program manager(s), in consultation with the President/CEO and Director of Human Resources

when appropriate, will develop a plan of action based on the report submitted by the committee.

8. The investigation committee will maintain the confidentiality of the incident and the parties involved by discussing the matter behind closed doors and only informing additional parties if necessary.
9. In the event an allegation is made against the President/CEO, the Board Chair will coordinate the investigation.
10. Employees will be paid for time missed from Administrative leave at his/her regular rate of pay

SECTION V. INTERNAL INVESTIGATION REPORT

The results of all administrative reviews, internal investigations or external investigations will be recorded on an Internal Investigation Report. The report will contain:

1. Description of the incident
2. Date, time, location of incident
3. Individuals involved
4. Nature of injuries including treatment required and received
5. Staffing levels at the time of the incident
6. Names and job titles of the appointed investigation committee members
7. Other contacts and notifications of the incident
8. Summary of actions taken or planned
9. Corrective Action Plan, if applicable
10. Type of abuse, if any
11. Conclusions/findings of the investigation

SECTION VI. CORRECTIVE ACTION PLAN

The results of the investigation may indicate a need for a plan of correction or the public agencies may require a plan of correction. In such cases, a written plan of correction will be completed and forwarded to the agency requiring the plan in accordance with their requirements. Documentation will be made verifying that the plan has been submitted. Any copy of the plan of corrections will be included in the corporate files, as described below, and provided to persons responsible for taking the action(s) contained therein.

SECTION VII. ADDENDUM

After the completion of an investigation, if significant information is discovered or a critical update is deemed appropriate with regards to the original investigation, an addendum to the report will be completed outlining the new information and sent to each of the public officials who were originally notified of the incident.

SECTION VIII. RECORDKEEPING

Records of any internal or external investigation committee will be kept in a confidential chronological file under the control of the Chair of the Incident Review Committee, including the original Incident/Injury Report(s) or exact copies of them. Investigation and Incident/Injury Reports will not be filed in the confidential binders maintained by each program on each individual so as to protect the confidentiality of all parties involved.

Each incident requiring an investigation will have a separate file. Each file will contain the following elements:

1. All Incident/Injury Reports, as well as other documentation related to the incident such as notes of a staff's personal account of the incident
2. Documentation of the notifications made
3. Copies of reports made to outside agencies
4. VersAbility Resources Internal Investigation Report
5. Any other documentation or correspondence related to the incident, such as communications with the Virginia Department of Human Services, corrective action plans and personnel action(s) taken

3.0 Procedure

None

4.0 Definitions

Abuse - is any act or failure to act by an employee, or other person responsible for the care of an individual, that was performed or was failed to be performed knowingly, recklessly or intentionally and that caused or might have caused physical or psychological harm, injury or death to a person receiving services from VersAbility Resources.

Exploitation - is the misuse or misappropriation of an individual's assets, goods or property, including the use of a position of authority to extract personal gain from an individual.

Individual - means a person who is receiving services. This term includes the terms "consumer," "patient," "resident," "recipient," and "client."

Mandated Reporter - means an individual who is required by Virginia law to report situations immediately in which they suspect a child or an adult may have been abused, neglected or exploited, or is at risk of being abused, neglected or exploited.

Neglect - is a failure by a person, program or facility responsible for providing services to do so, including nourishment, treatment, care, goods or services necessary to the health, safety or welfare of an individual receiving services from VersAbility Resources.

5.0 References

CARF Standards, Employment and Community Services

Centers for Medicaid & Medicare Services

Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, Chapter 105

6.0 Policy History

April 28, 2006; December 15 2008; March 7, 2011; August 9, 2011; July 16, 2012

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WHERE ABILITY MEETS OPPORTUNITY

ATTACHMENT #2

Policy #63-4

Adult Undergarments

Division: Community Living	Category: Health Care Services
Subject: Adult Undergarments	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: **Adult undergarments**

NUMBER: **64-4**

POLICY: It is the policy of Versability Resources to ensure that all individuals that are incontinent of urine and/or bowel will remain clean and dry at all times and maintain good skin integrity in the perineum area.

PROCEDURES:

1. Gather all supplies:
   Disposable washcloths, Gloves, Clean Undergarment
2. Put on gloves.
3. Undo tape on both sides of undergarment.
4. Turn the individual to one side (facing away from you) and bend knee up toward his/her chest.
5. Wrap brief over itself to cover the soiled area inside.
6. Wipe between the individual's legs and buttocks with disposable washcloths. If the person if female always wipe from front to back.
7. Check skin for redness, tearing or sores.
8. Open the new undergarment.
9. Tuck half of the clean undergarment as far as possible under the individual.
10. Roll the person to the other side.
11. Remove dirty undergarment.
12. Spread the other half of the clean brief so that it is flat on the bed.
13. Roll the individual on his/her back and pull the front of the brief between the individual's legs and fasten the tape on both sides of undergarment.
14. Place dirty undergarment in bag and throw away.
15. Remove gloves and throw away.
16. Wash hands.

When you should contact the nurse:

You see new sores.
You see a red rash or pimple-like bumps.
You see redness and dryness that is spreading.
You have question or concerns about the individual's condition or care.
ANY CHANGE IN CONDITION.

References:

Drugs.com. 2015. How to Change Disposable Brief. [ONLINE] Available at: http://www.drugs.com/cg/how-tochange-disposable-briefs.html. [Accessed 13 January 16]

	W 339
DATES	**SIGNATURE**
Issued Date: 1/16	
Reviewed Date: 2/1	Linda R. Kerns
Revised Date:	Linda Kerns, LCSW Director of Community Living Versability Resources

versability resources

WHERE ABILITY MEETS OPPORTUNITY

ATTACHMENT #3

Medication Refrigerator Temperature Log

Versability Resources

Medication Refrigerator

Temperature Log

Date	Time	Temperature	Initials

**If temperature is below 33 degrees or above 42 degrees please notify nurse.

versability resources

WHERE ABILITY MEETS OPPORTUNITY

ATTACHMENT #4

Policy #78

Medication Administration Policy

Pg. 1 & 4

Division: Community Living	Category: Health Care Services
Subject: Medication Administration	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: **Medication Administration**

NUMBER: **78**

POLICY: It is the policy of Cloverleaf House to ensure that prescribed medications are handled, stored, and administered safely, securely, and accurately.

PROCEDURES:

A. Within Versability Resources Cloverleaf House, medications are administered only by licensed health care professionals, or by Direct Support Professional staff who are currently certified in Medication Administration and have successfully completed/passed the Medication Management For Agents Authorized Under the Drug Control Act approved medication administration course. It is the responsibility of staff who are medication administration certified to ensure that all prescribed medications are properly received, recorded, safeguarded, stored, filled, refilled, administered, and disposed of in accordance with State and Federal regulations. While under the care and supervision of Cloverleaf House staff, individuals maintain the right to refuse the administration of medication.

B. Receiving/Recording procedures

1. Prior to an individual's actual admission into the Cloverleaf House, it will be the responsibility of the Admissions/ Discharge Committee and Interdisciplinary Team (IDT) to review the individual's medical record (including current medications).

2. Once an individual is admitted into the program all new or refilled prescribed medication orders are to be recorded into that specific individual's Medication Administration Record (**MAR**) by the Community Living Nurse, Community Living Manager or by any designated medication administration certified staff.

3. Medications received for an individual will be documented on the Checklist for Medication Received.

C. Documentation

1. **Picture Identification:** Individual photographs will be used to identify all individuals currently receiving medication. The photographs will be displayed in the individual-specific Medication Administration Record.

2. **Medication Administration Record (MAR):** This form is used to document a medication's administration in conformance with a physician's instructions. It shall be maintained to document the administration of medication, whether self-administered, administered with staff assistance, or totally administered by certified staff. The administrations of medications that are prescribed as well as over-the-counter medications are to be documented on the Medication Administration Record. Documentation is to state the individual's name, name of medication, dosage, route, time of administration, and indicate the certified staff that witnessed, assisted, or administered the medication. Staff are responsible for writing their own initials or signatures when documenting on forms requiring initials or signature. Allergies should be clearly noted. All entries are to be made in **black ink. Corrections will be made by placing a single ink line through an incorrect entry with NO OBLITERATIONS.**

b. Medication requiring refrigeration will be kept in a refrigerator with a thermometer in the medication room/area (33 to 42 degrees). Staff will document the refrigerator temperature on the Medication Refrigerator Temperature Log. Staff will report to the house nurse if the refrigerator temperature is below or above the recommended temperature.

c. Medications requiring refrigeration must be kept in a locked container that is placed in a medication only refrigerator. If locked area is available medication requiring refrigeration should be in medication only refrigerator in the locked area.

d. Controlled substances requiring refrigeration will be contained in a locked container within a locked container in a designated medication only refrigerator.

3. Light:
   a. The pharmacy dispenses medication in containers approved by federal guidelines for light.
   b. Medication will be stored in the medication room/area away from direct sunlight.

4. Humidity:
   a. Medication will be stored in containers in the medication room/area, away from excessive moisture.

5. Keys to the medication room/cabinet are to be accounted for at all times and must be carried or available to a designated medication administration certified staff during each shift. If or when the medication storage keys are not carried by such a staff person they must be kept in a locked and secure area at all times.

4. Internal and external medications must be separated.

7. Medication is not to be stored in a container other than that in which it was received from the pharmacy. When a container is empty, it is to be disposed of immediately after obliterating or removing the label. It is not to be reused for any other medication or for any other purpose.

8. All medication packaged and labeled by the issuing pharmacy as a "Controlled Substance" must be kept in a secure double-locked storage area or container(s). Double-locked storage is defined as a locked container kept within another locked container, each having a different key or combination. Controlled medications are kept in a combination locked box which is kept in a locked medication room/area.

9. Discontinued, outdated, dropped or otherwise contaminated medications (including "Controlled Substances") will be safely disposed of (disposal in a manner in which the medication is not recoverable) by Community Living Nurse, RN Consultant, Community Living Manager, or Medication Administration Certified staff. The Certified staff member must have the Community Living Nurse or RN Consultant or Community Living Manager to witness the destruction of medication. A medication destruction form will be completed and signed by both staff involved in the destruction. This form must be maintained in the medication room or medication area.

10. No medication is to be used after its expiration date. Prescription medication should have an expiration date printed on the label. Repackaged medication (medication placed by the pharmacist in a pharmacy-provided bottle/bubble pack) is to be discarded no longer than one (1) year after the date of issue. Over the counter medication is to be discarded no longer than one (1) year after the date of issue or the expiration date stamped by the manufacturer on the bottle (container), which ever date expires first.

11. The Pharmacist will prepare medications for individuals who receive medication at their Day Support Site, Vocational or Work Site. The medication certified staff will transport the medication to the appropriate site. A medication transportation form will be completed and signed by the staff transporting the medications and the medication certified staff receiving the medication.

12. Sample medications/ study drug medication received from a physician must be clearly labeled with the following information: name of individual and ordering physician, name of medication, route, schedule of administration, and the date. All samples must also have written medication orders signed and dated by the physician that matches the information on the label. Samples should be stored in the same manner as all other medications.

E. General Information/ Information Sharing

A current reference manual of medications is kept in the medication cabinet or closet at each residence. The

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WHERE ABILITY MEETS OPPORTUNITY

ATTACHMENT #5

Medication Audit Checklist

Versability Resources
Cloverleaf ICF/IID House
MEDICATION AUDIT CHECKLIST

DATE OF AUDIT: _____

AUDIT CONDUCTED BY: _____

Reviewed with nurse: _____

	YES	NO	N/A	COMMENTS
MEDICATION STORAGE				
Medications locked				
Needles/syringes locked				
Medication keys secure				
Medication refrigeration				
Labeled				
Locked				
Contains medications only				
Thermometer present				
Temperature log completed				
Discontinued/expired meds on site				
Physician's order for all medications				
Medication reference text on site				
Medications stored in original pharmacy containers				
Legible/intact pharmacy labels on medication containers				
All medications labeled with individual's name and filled date				
Medication storage area neat and dry				
Sharps container on site				
MEDICATION INVENTORY				
Medications reviewed for re-ordering				
Medication inventory log on site				
Controlled-substance count on site				
Controlled substance sheet contains double signatures/is accurate and complete				
Sample medication on site				
Sample medication in original pharmaceutical company container				
Sample medications labeled				
MEDICATION DISPOSAL				
Medication disposal log on site				
Disposal log contains double signatures				

MEDICATION AUDIT CHECKLIST

	YES	NO	N/A	COMMENTS
MEDICATION ADMINISTRATION				
Medication administration identified by staff initials				
Medication administration support activities(i.e. blood pressure, glucose testing, etc.) completed per physicians orders				
MEDICATION DOCUMENTATION REVIEW				
Medication administration record completed on each individual				
PRN Record completed on each individual				
MAR and PRN matches physician order				
Staff initials identified with signatures				
Adverse reactions are reported and documented				
When medication is not administered, the reason is documented				
* Medication Errors				
Completed MAR and PRN records are placed in individual's record monthly				
Medical Records complete and orderly				

Medication Errors – If any medication errors have occurred within the 30 day audit period, place the individual's initials and date of the error, and name of medication in the comment section of the box.

_____ _____

Completed by **Date**

_____ _____

Reviewed with **Date**