COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

February 28, 2018

Linda Kerns, Director
Versability Resources Cloverleaf House
898 Cloverleaf Lane
Newport News, VA 23601

RE: Versability Resources Cloverleaf House
Newport News, Virginia
ICF/ID: 49G053

Dear Ms Kerns:

An unannounced Medicaid survey, ending February 8, 2018 was conducted, by the VDH Office of Licensure and Certification staff. All references to regulatory requirements are found in Title 42, Code of Federal Regulations

Survey Results and Plan of Correction

Enclosed is the CMS-2567, Statement of Deficiencies, for the Fundamental Health Survey. This document contains a listing of the deficiencies found at the time of this inspection. [Any deficiencies found as a result of a Life Safety Code inspection will be mailed separately from the office of the State Fire Marshall.]

You are required to file a plan for correcting these deficiencies. Your statements shall reflect the specific detailed actions you will take to correct deficiencies, prevent a recurrence of the deficiencies, and measures implemented to maintain compliance. You must also give the specific calendar date on which correction for each deficiency is expected to be completed. The response "Corrected" is not an acceptable response. That kind of response does not fulfill the requirement to provide information on preventing recurrence or maintaining compliance. The response "will train staff" is not an acceptable response unless specific information is given on the plan for frequency and methods to evaluate results.

Correction/completion dates must be within forty-five (45) days from the day of the inspection. If you have been cited for physical plant or Life Safety Code deficiencies that will require more than 45 days to correct and you intend to request an exception, you must provide a specific reason for the request and the expected completion date.

After signing and dating your Plan of Correction, retain one copy of the Report for your files and return the original to this office within ten (10) calendar days from receiving the report. You will be notified if your Plan of Correction is not acceptable.

Failure to return your Plan of Correction within the time frame specified above can result in a loss of Medicaid reimbursement.

A copy of the completed form (CMS-2567) will be kept on file in this office and will be available for public review. This Division is required to make copies of this report available to other Federal and State regulatory or reimbursement agencies upon request.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions, please call me at (804) 367-2100.

Sincerely,

Nicole Keeney

Nicole Keeney , LTC Supervisor
Division of Long Term Care Services

Enclosures

cc: Bertha Ventura, Department of Medical Assistance Services (Sent Electronically)
Susan Elmore, Department of Behavioral Health and Developmental Services

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G053	A. BUILDING _____ B. WING _____	02/08/2018

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 02/5/18 through 02/8/18. Corrections are required for compliance with CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Disabilities (ICF/ID). The Life Safety Code report will follow. The census in this 5 bed facility at the time of the survey was 5. The survey sample consisted of 2 current Individual records (Individual #1 and #2).	E 000	EO15 Facility staff failed to develop policies and procedures and emergency plans to provide for sewage and waste disposal. 1. Facility did not include in Emergency Plan or policy and procedures a policy related to disposal of sewage and waste. Policy was updated to indicate procedure for disposing of sewage and waste in the event of a disaster or emergency situation. (Reference Attachment #1: Policy 85: Physical Environment; and Attachment #2: ICF-IID Emergency and Continuity of Operations Plan, pg. 16). Servepro has been contracted by VersAbility Resources, Inc. to repair sewage, clean-up and/or dispose of waste, as warranted. ServePro will respond immediately, and no later than 24 hrs. following notification.	3/9/18
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm	E 015	2. All ICF-IID facilities operated by VersAbility Resources, Inc. are affected by this deficient practice. 3. Updated Policy #85 (Physical Environment) will be reviewed with Cloverleaf Staff, as well as, all VersAbility's ICF-IID facility staff during the QIDP/Staff Meetings in March, 2018.	3/9/18 3/16/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Linda R. Kerns LCSW | Chief Community Living Officer | 03/14/2018

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.

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

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E 015	Continued From page 1 systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop policies and procedures and emergency plans to provide for sewage and waste disposal. The findings included: During the Emergency Preparedness Review on 2/7/18 the Community Living Manager stated, there were no policies and procedures for sewage and waste disposal. During an interview on 2/8/18 at 10:15 A.M. with the Maintenance Director, he stated, there were no policies and procedures for sewage and waste disposal.	E 015	4. VersAbility's Facility Dept. will be responsible for assuring sewage and waste disposal have been addressed appropriately by ServePro, and meet all required regulatory standards. They will consult with the CL Manager, or designee, to evaluate whether or not the needs of each ICF-IID facility are met in this area immediately after services have been rendered. They will also follow-up with ServePro immediately to address any concerns related to disposal of waste and/or a sewage related crisis/event. Also, Policy #85 (Physical Environment) will be reviewed and updated at least annually, along with the Emergency Preparedness Plan. It may be revised, as warranted, throughout the year.	3/9/18

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E 015 Continued From page 2

The facility staff failed to develop policy and procedures and emergency plans for sewage and waste disposal.

E 025 Arrangement with Other Facilities
CFR(s): 483.475(b)(7)

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.

*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.

*[For RNHCIs at §403.748(b):] Policies and

E 015 E025

Facility failed to have an agreement with other facilities to receive individuals in an emergency.

E 025

1. Cloverleaf ICF-IID facility did not have an agreement with other facilities to receive individuals in the event of an emergency. An agreement was initiated with H-NN CSB, however, had not been finalized prior to this survey. Since the survey, a second agreement has been developed with Holiday House in Portsmouth, VA. and signed on March 08, 2018. H-NN CSB agreement is expected to be signed by March 22, 2018. 03/22/18

2. All residents of VersAbility Resources, Inc. ICF-IID Facilities are affected by this deficient practice. 3/9/18

3. Once the agreements have been signed, all VersAbility Resources, Inc. ICF-IID Facilities will have sheltering in event of the facility's limitation or cessation of operations during/following a disaster or crisis situation. Cloverleaf staff will be notified of this agreement, as well as, other VersAbility Resources, Inc. ICF-IID facility staff. The individuals (residents) and family (or Guardian/Substitute Decision Maker) will be informed of the agreements also. 03/22/18

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E 025 Continued From page 3

procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.
This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have an agreement with other facilities to receive individuals in an emergency.

The findings included:

On 2/7/18, a review of the facilities Emergency Preparedness Plan revealed there was no agreement with other facilities to receive individuals in the event the facility is not able to care for them in an emergency.

During an Interview on 2/8/18 with the Community Living Manager (CLM) she stated the facility did not have an agreement with another facility to receive individuals in the event the facility was not able to care for them in an emergency.

E 025

4. The Chief Officer of Community Living will coordinate all agreements with external facilities and will maintain copies of the agreements on file. The agreements will be reviewed at least annually, or updated as needed, with the Emergency Preparedness Plan. 03/22/18

E 032 Primary/Alternate Means for Communication
CFR(s): 483.475(c)(3)

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(3) Primary and alternate means for communicating with the following:
(i) [Facility] staff.

E 032

E 032
The facility failed to have a communication plan that included primary and alternate means of communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies.

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E 032 Continued From page 4

(ii) Federal, State, tribal, regional, and local emergency management agencies.

*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.
This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have a communication plan that included primary and alternate means of communicating with facility staff, Federal, State tribal, regional and local emergency management agencies.

The findings included;

During the Emergency Preparedness Plan review on 2/7/18, facility staff were asked to see the communication equipment listed in the communications systems plan. The facility staff were not able to produce the equipment.

During an interview with the Community Living Manager on 2/6/18 at 4:45 P.M. she stated, we do not have all of the alternate equipment for communicating during an emergency.

E 033 Methods for Sharing Information
CFR(s): 483.475(c)(4)-(6)

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(4) A method for sharing information and medical

E 032 1. The ICF-IID Emergency and Continuity Operations Plan for Cloverleaf was updated to reflect alternate means of communicating to facility staff, Federal, State, tribal, regional and local emergency management agencies. Currently AMG alerts, cell phones (texting), landline phones, VersAbility Resources website, news stations, etc. The contact lists were updated to reflect agency/staff contact numbers, numbers to state and local facilities, Federal organizations, etc. This information is easily accessible for the CL Manager and Cloverleaf Staff and housed in Cloverleaf's Emergency Preparedness Binder. (Reference Attachment #2: ICF-IID Emergency and Continuity of Operations Plan, pgs. 9-11). 3/9/18

2. All ICF-IID Facilities operated by VersAbility Resources are affected by this deficiency. 3/9/18

3. Since the survey occurred, hand-held Emergency Weather Radios have been purchased (2 per house) for all the ICF-IID Facilities. The weather radio's also have cell phone chargers attached. Cloverleaf staff (and all VersAbility's ICF-IID facility staff) will receive training on how to operate the Emergency Weather radios by 3/16/18. 3/16/18

E 033

4. The CL Managers will be responsible for assuring staff have adequate training on the location, use and maintenance of communication equipment and devices. The 3/16/18

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E 033	Continued From page 5	E 033		

documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]

(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.

*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).
This STANDARD is not met as evidenced by:
Based on record review and staff interview the facility staff failed to develop policies and procedures that address the means the facility will use to release individual information to include the general condition and location of individuals.

The findings included:

E 033

Community Living's Quality Assurance/Support Coordinator will conduct an audit at least quarterly to assure communication devices are on hand and are operable.

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E 033	Continued From page 6 During the Emergency Preparedness Plan review on 2/7/18, the communication plan did not include a method for sharing information with other health providers, nor did it include a means for providing information about the general condition of individuals. During the Emergency Preparedness Plan review with the (CLM) Community Living Manager she stated, there was no documentation that the communication plan included methods of sharing information with other health providers or maintaining the continuity of care to include the general condition and location of individuals.	E 033	E035 Facility failed to develop policies and procedures that address the means the facility will use to release individual information to include the general condition and location of individuals. 1. Policy #18 (Communication) was revised. Reference Attachment # 3: Policy #18--Communication). This policy was updated to reflect communicating information related to the individual's about their general condition and location of individuals with their families, Guardians, and/or Substitute Decision Makers in event of a crisis or emergency situation. Update also included need to share communication plan with the Individual. (Reference Attachment #2: ICF/IID Emergency and Continuity of Operations Plan, page 10). Also, Policy #6 (Authorization to Release Protected Health Information) was updated to reflect obtaining consent in order to share information with medical personnel, volunteers, etc. during a crisis/emergency and example of type of information to be shared. (Reference Attachment # 4: Policy #6--Authorization to Release Protected Health Information). The Consent to Exchange Information form was	3/8/18
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to ensure that the communication plan had been shared with Individuals. The findings included: During the Emergency Preparedness Plan review on 2/7/18, the facility staff were not able to			

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E 035 Continued From page 7

provide documentation that Emergency Preparedness Plan had been shared with the individuals.

During an interview on 2/8/18 at 10:15 A.M. with the (CLM) Community Living Manager she stated the the Emergency Preparedness Plan had not been shared with the individuals.

W 000 INITIAL COMMENTS

An unannounced Fundamental Medicaid survey survey was conducted on 02/05/18 through 02/08/18. 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 5. The survey sample consisted of 2 current Individual records (Individual #1 through #2).

W 149 STAFF TREATMENT OF CLIENTS
CFR(s): 483.420(d)(1)

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

This STANDARD is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility staff failed to implement written policies and procedures to prohibit neglect for one Individual (Individual #2) in the survey sample of 2 individuals.

The findings included:

E 035 also updated to include sharing information in event of an emergency/crisis. (Reference Attachment #5: Consent to Exchange Information)

3/8/18

2. All residents of VersAbility's ICF-IID are affected by this deficient practice.

W 000 3. Policy #18: (Communication) and Policy #6 (Authorization to Release Protected Health Information), and revised Consent to Exchange Information form which will be reviewed with Cloverleaf staff, as well as, other VersAbility ICF-IID staff during their monthly QIDP/Staff Meetings in March, 2018. 3/16/18

Also, the Emergency Plan Notification form was revised to include a signature space for the Individual and will be used by all ICF-IID facilities. 3/8/18

4. The ICF-IID Emergency and Continuity of Operations Plan will be reviewed annually, and update as needed throughout the year. This will include all policies and procedures related to Emergency Preparedness. The CL Manager will assure all staff are informed/trained on updated policies/procedures. Staff signatures will be obtained and kept on file also.

W 149 The Services Coordinator will obtain Consent to Exchange Information in event of emergencies from the Individual, Guardian, or 3/9/18

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W 149	Continued From page 8	W 149	Authorized Representative (Substitute Decision Maker) upon admission, annually or as needed. (Reference Attachment #4 : Policy #6--Authorization to Release Protected Health Information and Attachment #5: Consent to Exchange Information)	

Individual #2 was admitted to facility with diagnoses which included profound intellectual disability, left hemiplegia, cerebral palsy, status post hysterectomy, history of H pylori, tenea pedis, dysphasia, osteopenia and osteoporosis secondary to immobility and anticonvulsant therapy, constipation with functional vomiting likely secondary to intestinal dysmotility, hiatal hernia with reflux, erosive esophagitis and esophageal stricture, exotropia OD, bladder and bowel incontinence prognosis. Individual #2 incurred a fractured left knee.

A physician's order dared 2/14/17 indicated: "May have wheelchair postural support harness during meals, table activities and when being transported. Wheelchair safety straps on the positioning equipment to reduce the risk of falls from equipment."

An Orthopaedies examination dated 8/4/17 indicated: "Reason for Appointment: Left Fractured Patella. Impressions: Nondisplaced transverse fracture of left patella, subsequent encounter for closed fracture with routine healing. Plan:1. Nondisplaced transverse fracture of left patella, subsequent encounter for closed fracture with routine healing.
Imaging: X-Ray: Knee, left 2 views - Notes: Osteoporotic bone. Patella fracture healing well, Arthritic changes are chronic. Notes: Follow up if experiencing any pain otherwise fracture should continue to heal on its own. 2. Others: Continue Vitamin D Tablet, 1000 Unit, 1 tablet, Orally, Once a day. General Examination: Skin: skin is warm and intact, Small abrasion over patella laterally but no signs of infections. Small callus present. Extremities: ROM: Knee held in flexion

W149
Facility failed to implement written policies and procedures to prohibit neglect for one individual (Individual #2) in the survey.

1. VersAbility Resources' Abuse, Neglect, and Exploitation Policy states mistreatment, abuse, neglect, exploitation, unnecessary restraint, or other similar acts while under the care of VersAbilty Resources. This would include an injury of unknown origin as well. Policy indicates also that any suspicion of abuse, neglect, exploitation, mistreatment, medication error or criminal activity should be reported immediately and steps taken to stop the activity. However, Cloverleaf staff failed to implement policy and procedures to prohibit neglect for Individual #2 in this survey. (Reference Attachment # 6: VersAbility Resources Policy #7-- Abuse, Neglect and Exploitation Policy) Although it was suspected that their was improper use of wheelchair by staff, there was no documentation of training provided. 3/9/18

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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

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contracture. Pt tenderness to palpation Knee is stable to varus and valgus stress. Unable to test Lachman's. Unable to test McMurray's. Negative Homan's, Negative Thompson's.

X-rays of the left knee from ER on 6/30 show a transverse fracture of the inferior pole of the patella, .2 cm of displacement and possibly subacute in age."

Merriam-Webster Medical Dictionary defines subacute as The care of acute (and recurring acute) injuries is often divided into 3 stages with general time frames acute (0-4 days), subacute (5-14 days), and post - acute (after 14 days).

1. A Medical Incident Report dated 7/3/17 indicated: Investigation- "On 6/30/17, Direct Support Professional (DSP #1) reported that she found a dime-size abrasion on Individual #2's left knee while she was providing ADL care at 1:00 AM the previous night. She described the area as not fresh and in the healing process. She described the outer area of the small abrasion as scabbing and the center area as white in color and not draining. She reported her finding around 6:30 AM to Licence Practical Nurse (LPN) #1. Individual #2 was taken to hospital ER and found to have a transverse patellar fracture (break in the little round bone-kneecap)."

According to the hospital information package, "a Patellar Fracture, (adult) is a break in the little round bone (kneecap) that is the bump on the front of your knee. A direct blow to the knee, or a fall is usually the cause of a broken patella. Sometimes, a very hard and strong bending of the knee (like jumping events in sports) can cause a fracture. Usually the knee is tender and

W 149 Staff Training and Orientation policy indicated signatures would be obtained for all staff training. (Reference Attachment #7: Policy #23--Staff Training and Orientation) 3/9/18

2. Individual #2 was determined to be the only individual affected by this deficient practice. Upon review, no other residents were affected. 3/9/18

3. The Physical Therapy Consultant was contacted to conduct a assessment of Individual #2 and provided recommendations specific to the care/support required for Individual #2. (Reference Attachment #8: Physical Therapy Consultant Progress Notes dated 3/8/18, 2 pages) 3/8/18
Cloverleaf staff will be trained on these recommendations at their March 8, 2018 QIDP/Staff Mtg. and were included in the ISP and Nursing Care Plan for Individual #2. (Reference Attachment #9: Individual #2 Plan for Supports; and Attachment #10: Nursing Care Plan for Individual #2) 3/8/18

VersAbility's Physical Therapy Consultant also provided general information on the following to all the VersAbility Resources ICF-IID Facilities:
(a) Wheelchair Maintenance Checklist, (b) Wheelchair Operational Instructions, (c) Instructions for the Use of a Shoulder/Chest (d) Protocol for Cleaning Wheelchairs, and (e) Instructions for Proper Sitting Posture in a Wheelchair which the Physical Therapy 3/19/18

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W 149	Continued From page 10 swollen and has pain with motion, especially trying to straighten out the leg. There may be difficulty walking or putting weight on the affected side. These fractures generally heal in about 4 to 6 weeks." "During our investigation to determine the etiology of this fracture, we found that Individual #2 had a bruise noted on her left knee on 6/25/17. The abrasion found on 6/30/17 that led Individual #2 to the ER. Individual #2 uses a wheelchair for mobility and two staff members are required with a Hoyer Lift to transfer her in and out of her wheelchair, so a fall of any kind is highly unlikely. Individual #2 has recently been wheeling her chair around on her own, though she cannot make it very far. Some staff members suggested that she may have had her knee bumped into the dining room table, causing the injury. This appears the most likely cause of the injury. It is noteworthy that Individual #2 has recently received a new wheelchair. The transverse nature of the break and apparent scraping across the knee cap might indicate that her knee has, on at least two occasions, come in contact with a supporting wood piece under the table. Because a fracture was the result of injury, we are completing an investigation into the cause of the injury." (2). Incident Report details of DSP #2 - "On June 25, 2017 DSP #2 was getting Individual #2 ready for her shower and noticed that Individual #2 left knee appeared to be swollen. The nurse on call (LPN #1) was notified and came to the house to do a complete assessment for Individual #2 leg. After the assessment, LPN #1 reports, "The nurse came to the conclusion that Individual #2's knee was fine. Individual #2 did not appear to be	W 149	Consultant will use to train all VersAbility Resources ICF-IID Facility staff by March 30, 2018 and annually thereafter. Also, Policy #82-11 (Individual Wheelchair Usage) was updated and will be reviewed with all ICF-IID facilities at their March 2018 QIDP/Staff Meeting. (Reference Attachment #11: Policy 82-1--Individual Wheelchair Usage. 3/19/18 The Staff Training and Orientation policy will be reviewed with Cloverleaf Staff, as well as, all ICF-IID Facility staff to reiterate the need to obtain signatures from all staff whenever training occurs to ensure continuity of care. (Reference Attachment # 7: Policy #23--Staff Training and Orientation.) 3/19/18 4. The CL Manager will be responsible, or designee, for assuring staff comply with policy and procedures related to Abuse, Neglect and Exploitation. Also, VersAbility's Incident Review Committee will review Incident Reports and identify trends, where applicable and recommend additional follow-up/review as warranted. 3/9/18	

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W 149	Continued From page 11	W 149	The QIDP/Support Coordinator will monitor implementation of procedures for Individual #2 Physical Therapy recommendations ongoing as part of the Active Treatment Plan. The ISP and Nursing Care Plans were revised to include recommendations from the PT. (Reference Attachment # 9: Informal Supports summary or Individual #2 from the ISP; and Attachment # 10: Nursing Care Plan)	3/8/18

in any pain before, during or after the assessment.

On June 30, 2017 (No time given) DSP #2 reports that when she got back to the facility from picking up the Individuals from Day Support Program, her and LPN #1 had a verbal exchange in the office regarding in (sic) LPN #1 told DSP #2 to write or not write an incident report on the 25th of June. DSP #2 says that LPN #1 told her it was not necessary to write an incident report because Individual #2's leg as (sic) as a result of her assessment. LPN #1 told her on the 30th that she should have written an Incident Report on the 25th."

(3). LPN #1 report- "On 6/30/17 LPN #1 provided an in-service for staff on shift with Individual #2 on how to transfer her safely. (Community Living Manager #1) was there and she will be the one to continue to train other staff on this.

* (Of note when LPN #1 was asked on 2/7/18 at 11:15 AM, whether staff had been trained and to show documentation and program development. LPN #1 was unable to provide any information).

LPN #1 reported to Community Living Manager #1 that upon seeing the area on Individual #2's knee on the morning of the 30th, that the area looked like it could have been from her wheelchair being pushed underneath a table and hitting/scraping her knee.

When interviewed (No date or time given) LPN #1 indicated that she had observed Individual #2's new wheelchair being tilted back when Individual #2 was brought to the dinning room table. The knee abrasion and wound appear to be the same

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Staff attendance will be tracked annually for the Wheelchair Training conducted by the Physical Therapist via VersAbility's Relias Training database.

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height as the wooden support under the table when the wheelchair is brought up to table. LPN #1 states that the two injuries are in her opinion, separate and distinct."

(4). DSP #3 report- "DSP #3 was changing Individual #2 depends at the beginning of her shift, (No date or time is given) and noted an "appearance of a health open skin area on Individual #2's left knee. No fluid or swelling noted, nor appearance of distress." She asked the prior shift if the incident was reported and staff said that it was, and the nurse visited Individual #2.

(5). DSP #4 report- "On 6/30/17 DSP #4 was getting Individual #2 undressed for her shower when she noticed a red scab on her left knee. She was told by DSP #5 that (Unnamed DSP) has already seen it that Sunday and reported it to LPN #1."

(5). DSP #1 reported - "On the overnight shift of June 29, 2017, DSP #1 was changing Individual #2's depends and noticed a dime sized open abrasion on Individual #2's left knee. There also was no pillow between Individual #2's knees upon arrival to her shift. She called Community Living Manager #1 at 6:30 AM to report."

(6). Community Living Manager (CLM) #2 reported- "that while she was sitting in the office, Individual #2 propelled her wheelchair about 1 foot forward. CLM #2 was surprised and said she didn't know Individual #2 had that skill. This happened after lunch."

A Physical Therapy (PT) report indicated: "PT was informed on 6/30/17 about the fracture. An

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appointment with the orthopedic surgeon was not available until 7/5/17, so the PT placed in an order for her to remain in bed until the appointment. Individual #2 will receive bed baths and all meals in bed. Re-positioning schedule put into place and pillows to be kept between her knees and ankles."

Findings: "The apparent cause of the injury is the dinning room table. We believe the staff has not considered the height and relationship of the new wheelchair to the dining room table and may have inadvertently pushed Individual #2 up to the table not aware of the contact of Individual # knee to the supporting board area under the table. We are researching getting a new table, and have training scheduled with our PT for staff members regarding Individual #2."

A nursing note dated 6/25/17 (No time given) indicated: "Received call of area on Individual #2's left knee. Arrived and assess the knee. Individual #2 has a 2 1/4 centimeter (CM) bruise on left knee. No swelling or signs of pain/discomfort. Continue to monitor."

A letter of Medical Necessity dated 5/5/17 submitted by the Physical Therapist indicated: "Individual #2's sitting posture is characterized by a forward head, protracted shoulders, depressed left shoulder, marked forward flexion of her trunk, and a marked listing to the left. Neurologically, deep tendon reflexes are brisk throughout. Coordination and balance are poor. Strength is fair throughout except for the left upper extremity, which is poor. She is no longer propelling her one arm-drive effectively. Her functional mobility has been greatly affected by several hospitalizations over the past year. She also has had several

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incidences of skin breakdown in sacral region over the past several years. More specifically, she has decreased trunk and right upper extremity strength which has affected her sitting posture. Individual #2 uses a wheelchair during mealtimes, grooming, training programs and in home recreational events. Her wheelchair is used to maintain her in the upright position to facilitate swallowing, to minimize reflux and aspiration, and facilitate stomach emptying. Despite significant support from a contour seating system and a chest support, she needs additional anterior support to maintain prolonged upright sitting. In addition, it was noted that the standard foot loops on the footrest would not keep her feet on the foot support system is needed to provide better ankle/foot alignment and to eliminate unsafe dependent positioning.

During the fitting for her new wheelchair and seating system it was noted that the (sic) because of poor trunk control, fluctuation in level of alertness, and fatigue she requires additional anterior and lateral support to maintain prolonged upright sitting. She was assessed by the seating specialist, and it was determined that a custom padded tray and a Body Point slim-cut chest support would provide adequate anterior and lateral support for safety and to improve her overall sitting posture."

A review of the clinical records and program plans did not indicate staff were trained in how to operate Individual #2's new wheelchair. There were no indication that the dining table measurements were incorporated in how best to accomendate Individual #2's' new wheelchair.

Individual #2 was observed seated in her

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wheelchair during the survey. According to staff, the table was removed as of July 7, 2017.

During an interview on 2/7/17 at 2:15 P.M. with the (CLM) Community Living Manager, she was asked if staff had immediately informed her of Individual #2's Injured left knee. The CLM stated staff had not immediately informed her of Individual #2's injured left knee. It was not until an injury to the left knee on June 30th 2017 that staff indicated Individual #2 had injured her left knee on June 25 2017.

A facility Policy and Procedure for Abuse, Neglect and Exploitation indicated: "The facility treats individuals with developmental, intellectual and other disabilities with dignity and respect. The facility fully supports, endorses and enforces the rights of individual from harm, abuse, exploitation and injury."

Section II Staff Responsibilities: "The state 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. 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

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individual (s) immediately. An incident report will completed by the reporting staff in accordance with established procedures."

W 153 STAFF TREATMENT OF CLIENTS
CFR(s): 483.420(d)(2)

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by:
Based on record review, and staff interviews the facility staff failed to ensure that injuries of unknown sources are reported immediately to the administrator or to other officials in accordance with state law through established procedures for one Individual (Individual #2) in the survey sample of 2 individuals.

The findings included:

Individual #2 was admitted to facility with diagnoses which included profound intellectual disability, left hemiplegia, cerebral palsy, status post hysterectomy, history of H pylori, tenea pedis, dysphasia, osteopenia and osteoporosis secondary to immobility and anticonvulsant therapy, constipation with functional vomiting likely secondary to intestinal dysmotility, hiatal hernia with reflux, erosive esophagitis and esophageal stricture, exotropia OD, bladder and bowel incontinence Prognosis. Individual #2 incurred an injury of unknown origin.

W 149

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1. VersAbility Resources' Abuse, Neglect, and Exploitation Policy states mistreatment, abuse, neglect, exploitation, unnecessary restraint, or other similar acts while under the care of VersAbilty Resources. This would include an injury of unknown origin as well. Policy indicates also that any suspicion of abuse, neglect, exploitation, mistreatment, medication error or criminal activity should be reported immediately and steps taken to stop the activity. However, policy and procedures were not implemented as written. (Reference Attachment # 12: VersAbiltiy Resources' Abuse, Neglect and Exploitation Policy #7) — 3/9/18

2. Upon review, it appears Individual #2 was only resident affected by this deficient practice. — 3/9/18

3. The Incident Review policy was reviewed with Cloverleaf Staff during their QIDP/Staff Mtg. on 3/8/18 relating to reporting injuries of unknown causes.. (Reference Attachment #13 Policy #89--Incident Reporting). — 3/8/18
This policy will also be reviewed with all VersAbility ICF-IID staff (including Nurses and CL Managers) during their March, 2018 QIDP/Staff Mtg. Disciplinary action was emphasized upon review of the policy as well. — 3/16/18

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W 153	Continued From page 17	W 153	4. The CL Manager will be responsible for monitoring staff compliance with policy and procedures related to reporting incidents of unknown origin. Disciplinary action will be implemented if incidents are not reported in a timely manner.	3/9/18

A nursing note dated 6/25/17 (No time given) indicated: "Received call of area on Individual #2's left knee. Arrived and assess the knee. Individual #2 has a 2 1/4 centimeter (CM) bruise on left knee. No swelling or signs of pain/discomfort. Continue to monitor."

An Incident Report dated June 30, 2017 indicated: Individual #2 left knee appeared to be swollen. The Incident Report detailed a report of DSP #2 - "On June 25, 2017 DSP #2 was getting Individual #2 ready for her shower and noticed that Individual #2 left knee appeared to be swollen. The nurse on call (LPN #1) was notified and came to the house to do a complete assessment for Individual #2 leg. After the assessment, LPN #1 reports, "The nurse came to the conclusion that Individual #2's knee was fine. Individual #2 did not appear to be in any pain before, during or after the assessment.

On June 30, 2017 (No time given) DSP #2 reports that when she got back to the facility from picking up the Individuals from Day Support Program, her and LPN #1 had a verbal exchange in the office regarding in (sic) LPN #1 told DSP #2 to write or not write an incident report on the 25th of June. DSP #2 says that LPN #1 told her it was not necessary to write an incident report because Individual #2's leg as (sic) as a result of her assessment. LPN #1 told her on the 30th that she should have written an Incident Report on the 25th."

"During our investigation to determine the etiology of this fracture, we found that Individual #2 had a bruise noted on her left knee on 6/25/17. The abrasion found on 6/30/17 that led Individual #2 to the ER. Individual #2 uses a wheelchair for

VersAbility's Incident Review Committee will also monitor suspicious reports bi-monthly and recommend follow-up as needed.

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mobility and two staff members are required with a Hoyer Lift to transfer her in and out of her wheelchair, so a fall of any kind is highly unlikely."

During an interview on 2/7/17 at 2:15 P.M. with the (CLM) Community Living Manager, she was asked if staff had immediately informed her of Individual #2's Injured left knee. The CLM stated staff had not immediately informed her of Individual #2's injured left knee. It was not until an injury to the left knee on June 30th 2017 that staff indicated Individual #2 had injured her left knee on June 25 2017.

A facility Policy and Procedure for Abuse, Neglect and Exploitation indicated: "The facility treats individuals with developmental, intellectual and other disabilities with dignity and respect. The facility fully supports, endorses and enforces the rights of individual from harm, abuse, exploitation and injury."

Section II Staff Responsibilities: "The state 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. 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

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authorized representative of the involved individual (s) immediately. An incident report will completed by the reporting staff in accordance with established procedures."

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W 154 STAFF TREATMENT OF CLIENTS
CFR(s): 483.420(d)(3)

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 facility staff failed to ensure that injuries of unknown sources were thoroughly investigated for one Individual (Individual #2) in the survey sample of 2 individuals.

The findings included:

Individual #2 was admitted to facility with diagnoses which included profound intellectual disability, left hemiplegia, cerebral palsy, status post hysterectomy, history of H pylori, tenea pedis, dysphasia, osteopenia and osteoporosis secondary to immobility and anticonvulsant therapy, constipation with functional vomiting likely secondary to intestinal dysmotility, hiatal hernia with reflux, erosive esophagitis and esophageal stricture, exotropia OD, bladder and bowel incontinence prognosis. Individual #2 incurred an injury of unknown origin.

An Incident Report dated June 30, 2017 indicated: Individual #2 left knee appeared to be swollen.

An Incident Report detailed of DSP #2 - "On June

W 154

W 154

Facility staff failed to ensure that injuries of unknown sources were thoroughly investigated for one Individual (Individual #2) in the survey sample of 2 Individuals.

1. Facility staff did not thoroughly investigate an injury of unknown cause or Individual #2, resulting in injury to Individual #2's left knee. An additional oversight for review of investigations of Abuse, Neglect and Exploitation were added to VersAbility's policy and procedures by the agency's Human Rights Advocate (Reference Attachment #6: VersAbility Resources' Abuse, Neglect, and Exploitation Policy #7). 3/8/18

2. Only Individual #2 was affected by this deficient practice. Upon review, no other ICF-IID facility residents were affected. 3/8/18

3. The revised VersAbility Resources' Abuse, Neglect and Exploitation policy will be reviewed with all ICF-IID facility staff during their March, 2018 QIDP/Staff Meeting. 3/16/18

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25, 2017 DSP #2 was getting Individual #2 ready for her shower and noticed that Individual #2 left knee appeared to be swollen, The nurse on call (LPN #1) was notified and came to the house to do a complete assessment for Individual #2 leg. After the assessment, LPN #1 reports, "The nurse came to the conclusion that Individual #2's knee was fine. Individual #2 did not appear to be in any pain before, during or after the assessment.

On June 30, 2017 (No time given) DSP #2 reports that when she got back to the facility from picking up the Individuals from Day Support Program, her and LPN #1 had a verbal exchange in the office regarding in (sic) LPN #1 told DSP #2 to write or not write an incident report on the 25th of June. DSP #2 says that LPN #1 told her it was not necessary to write an incident report because Individual #2's leg as (sic) as a result of her assessment. LPN #1 told her on the 30th that she should have written an Incident Report on the 25th."

"During our investigation to determine the etiology of this fracture, we found that Individual #2 had a bruise noted on her left knee on 6/25/17. The abrasion found on 6/30/17 that led Individual #2 to the ER. Individual #2 uses a wheelchair for mobility and two staff members are required with a Hoyer Lift to transfer her in and out of her wheelchair, so a fall of any kind is highly unlikely."

During an interview on 2/7/17 at 2:15 P.M. with the (CLM) Community Living Manager, she was asked if an investigation into Individual #2's Injured left knee been conducted. The CLM stated staff had not immediately informed her of Individual #2's injured left knee nor had an

4. VersAbility's Human Rights Advocate will ensure implementation of the revised Abuse, Neglect and Exploitation policy. 3/8/18

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investigation into the injury been conducted. It was not until an injury to the left knee on June 30th 2017 that staff indicated Individual #2 had injured her left knee on June 25 2017.

A facility Policy and Procedure for Abuse, Neglect and Exploitation indicated: "The facility treats individuals with developmental, intellectual and other disabilities with dignity and respect. The facility fully supports, endorses and enforces the rights of individual from harm, abuse, exploitation and injury. Examples of abuse, mistreatment, exploitation, neglect and criminal activity include, but are not limited to the following: 8. Injuries of unknown origin."

Section II Staff Responsibilities: "The state 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. 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. An incident report will completed by the reporting staff in accordance with established procedures."

Section V. Internal Investigation Report: "The

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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. Individual (s) 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. Conclusion/findings of the investigation"

W 189 STAFF TRAINING PROGRAM
CFR(s): 483.430(e)(1)

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on record review and staff interview the facility staff failed to provide each employee with continuing training that enables the employee to perform his or her duties effectively, efficiently and competently. Facility staff failed to provide on-going staff training on reporting injuries of unknown origin.

The findings included:

Individual #2 was admitted to facility with

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W189

Facility failed to provide each employee with continuing training that enables the employee to perform his or her duties effectively, efficiently and competently. Facility staff failed to provide on-going staff training on reporting injuries of unknown origin.

1. Injury of unknown cause was reported, however, improper use of wheelchair was suspected as the cause for injury, however, there was no documentation of training provided. Staff Training and Orientation Policy #23 indicates staff signatures would be maintained on file for all staff training. he CL Manager will be responsible for making sure all staff receive ongoing training provided to staff during the QIDP/Staff Meeting if a staff member was absent. They will also keep a record of training conducted by any of the Consultants on file. Record of this training will be maintained on file. The Nurse will also maintain a sign-in sheet for all trainings conducted by the Nurse. (Reference Attachment #7: Policy #23--Staff Training and Orientation) 3/8/18

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2. Only Individual #2 was affected by this deficient practice. 3/8/18

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diagnoses which included profound intellectual disability, left hemiplegia, cerebral palsy, status post hysterectomy, history of H pylori, tenea pedis, dysphasia, osteopenia and osteoporosis secondary to immobility and anticonvulsant therapy, constipation with functional vomiting likely secondary to intestinal dysmotility, hiatal hernia with reflux, erosive esophagitis and esophageal stricture, exotropia OD, bladder and bowel incontinence prognosis. Individual #2 incurred an injury of unknown origin.

A July 13, 2017 Interdiction Meeting note Indicated: "On 6/25, received call of an area on Individual #2's left knee. Individual #2 was assessed. A bruise was noted on the knee. No swelling or signs of discomfort/pain noted. Continue to monitor. On 6/30, received report of an abrasion and swelling on the left knee. Individual was transported to ER for evaluation and X-rays. Individual #2 was diagnosed with a transverse fracture of the patella."

The Chief Community Living Officer discussed the importance of reporting an incidence when an incident/injury or change in condition occurs. The Nurse and On-Call manager should be notified immediately. Reviewed Policy #89-Incident Reporting and the incident report itself. A staff signature sheet did not include all staff receiving the training.

During an interview on 2/8/18 at 10:15 A.M. with the Community Living Manager she stated, all staff who worked at the facility did not attend the meeting nor did all staff receive the training.

A facility Policy and Procedure for Abuse, Neglect and Exploitation indicated: "The facility treats

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3. Wheelchair Training will be provided by the Physical Therapy Consultant for all of VersAbility's ICF-IID Facility staff. This training will be conducted by March 30, 2018 and will be conducted annually, thereafter. It will be a mandatory training for all ICF-IID facility staff. The Relias Training system will monitor attendance for this training as a means of documentation. In addition, the Staff and Training Policy (Reference Attachment # 7: Policy #23 Staff and Orientation Policy) will be reviewed with staff during the QIDP/Staff Meeting during March, 2018. — 3/1917

Also, Policy #82-11 (Individual Wheelchair Usage) was updated and will be reviewed with all ICF-IID facilities at their March 2018 QIDP/Staff Meeting. (Reference Attachment #11: Policy 82-1--Individual Wheelchair Usage. — 3/8/18

4. Community Living's Quality Assurance/Support Coordinator will review staff training, as well as, training signature sheets to assure all staff have received training via audits conducted quarterly. These audits will be conducted at random among all ICF-IID facilities. — 3/9/18

The CL Manager will monitor staff training via Relias and sign-in sheets to assure compliance with Staff Training and Orientation policy.

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W 189	Continued From page 24 individuals with developmental, intellectual and other disabilities with dignity and respect. The facility fully supports, endorses and enforces the rights of individual from harm, abuse, exploitation and injury." Section II Staff Responsibilities: "The state 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. 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. An incident report will completed by the reporting staff in accordance with established procedures."	W 189		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of	W 242	W242 Facility failed to develop a program plan for the use of wheelchair. Individual #2 incurred a fractured left knee.	

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acquiring them.

This STANDARD is not met as evidenced by:
Based on observations, record review, and staff interviews the facility staff failed to develop an individual program plan for one Individual (Individual #2) in the survey sample of 2 individuals.

The facility staff failed to develop a program plan for the use of wheelchair. Individual #2 incurred a fractured left knee.

The findings included:

Individual #2 was admitted to facility with diagnoses which included profound intellectual disability, left hemiplegia, cerebral palsy, status post hysterectomy, history of H pylori, tenea pedis, dysphasia, osteopenia and osteoporosis secondary to immobility and anticonvulsant therapy, constipation with functional vomiting likely secondary to intestinal dysmotility, hiatal hernia with reflux, erosive esophagitis and esophageal stricture, exotropia OD, bladder and bowel incontinence prognosis.

A physician's order dated 2/14/17 indicated: "May have wheelchair postural support harness during meals, table activities and when being transported. Wheelchair safety straps on the positioning equipment to reduce the risk of falls from equipment."

A letter of Medical Necessity dated 5/5/17 submitted by the Physical Therapist indicated: "Individual #2's sitting posture is characterized by a forward head, protracted shoulders, depressed

1. The Physical Therapy Consultant was contacted to conduct a assessment of Individual #2 and provided recommendations specific to the care/support required for Individual #2. (Reference Attachment # 8: Physical Therapy Consultant Progress Notes dated 3/7/18, 2pgs) These recommendations were incorporated into Individual #2's current ISP and Nursing Care Plan. (Reference Attachment #9: Individual #2 Plan for Supports; and Attachment #10: Nursing Care Plan for Individual #2) — 3/7/18, 3/8/18
Cloverleaf staff will be trained on these PT recommendations for Individual #2 during their March 8, 2018 QIDP/Staff Mtg.

2. Only Individual #2 was affected by this deficient practice. — 3/8/18

3. VersAbility's Physical Therapy Consultant also provided general information on the following to all the VersAbility Resources ICF-IID Facilities: — 3/19/18
(a) Wheelchair Maintenance Checklist, (b) Wheelchair Operational Instructions, (c) Instructions for the Use of a Shoulder/Chest (d) Protocol for Cleaning Wheelchairs, and (e) Instructions for Proper Sitting Posture in a Wheelchair which the Physical Therapy Wheelchair Training will be conducted by the PT annually and staff attendance will be mandatory.

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W 242	Continued From page 26 left shoulder, marked forward flexion of her trunk, and a marked listing to the left. Neurologically, deep tendon reflexes are brisk throughout. Coordination and balance are poor. Strength is fair throughout except for the left upper extremity, which is poor. She is no longer propelling her one arm-drive effectively. Her functional mobility has been greatly affected by several hospitalizations over the past year. She has also has had several incidences of skin breakdown in sacral region over the past several years. More specifically, she has decreased trunk and right upper extremity strength which has affected her sitting posture. Individual #2 uses a wheelchair during mealtimes, grooming, training programs and in home recreational events. Her wheelchair is used to maintain her in the upright position to facilitate swallowing, to minimize reflux and aspiration, and facilitate stomach emptying. Despite significant support from a contour seating system and a chest support, she needs additional anterior support to maintain prolonged upright sitting. In addition, it was noted that the standard foot loops on the footrest would not keep her feet on the foot support system is needed to provide better ankle/foot alignment and to eliminate unsafe dependent positioning. During the fitting for her new wheelchair and seating system it was noted that the (sic) because of poor trunk control, fluctuation in level of alertness, and fatigue she requires additional anterior and lateral support to maintain prolonged upright sitting. She was assessed by the seating specialist, and it was determined that a custom padded tray and a Body Point slim-cut chest support would provide adequate anterior and lateral support for safety and to improve her overall sitting posture."	W 242	4. The Relias Training system will track and monitor staff training attendance throughout the year and annually for Wheelchair training. The CL Manager will monitor staff training attendance monthly. Sign-In sheets will be obtained for trainings not maintained in the Relias system.	3/9/18

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A review of the clinical records and program plans did not indicate staff were trained on how to operate Individual #2's new wheelchair. There were no indication that staff were trained on how best to accommodate Individual #2's new wheelchair to meet her needs.

During an interview on 2/7/17 at 10:00 A.M. with the Community Living Manager (CLM) she stated, there were no program plans developed for the use of Individual #2's new wheelchair.

An Active Treatment Policy and Procedures indicated: "Policy- It is the policy of the facility to ensure that each individual receives a continuous active treatment program.
Procedures-4. The ISP (Individual Service Plan) /IPP (Individual Program Plan) will be developed by the interdisciplinary team based on the individual's strengths and needs as assessed by team members and appropriate facility staff.
6. The ISP/IPP includes the adaptive equipment and assitive devices necessary to facilitate the acquisition of desired goals and objectives and support independence."
10. All assitive devices or mechanical supports will be documented in the Individual Support Plan/IPP along with the reason for the device/support, the situation in which it is applied and a schedule/description of use for each support."

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W 260 PROGRAM MONITORING & CHANGE
CFR(s): 483.440(f)(2)

At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.

W 260

W260
The facility failed to revise Individual #2's care plan to prevent the development of a stage II sacral pressure sore.

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This STANDARD is not met as evidenced by:
Based on record review, and staff interviews, the facility staff failed to revise the program plan for one Individual (Individual #2) in the survey sample of 2 individuals.

The facility staff failed to revise Individual #2's care plan to prevent the development of a stage II sacral pressure sore.

The findings included:

Individual #2 was admitted to facility with diagnoses which included profound intellectual disability, left hemiplegia, cerebral palsy, status post hysterectomy, sistory of H pylori, tenea pedis, dysphasia, osteopenia and osteoporosis secondary to immobility and anticonvulsant therapy, constipation with functional vomiting likely secondary to intestinal dysmotility, hiatal hernia with reflux, erosive esophagitis and esophageal stricture, exotropia OD, bladder and bowel incontinence prognosis.

A first Quarter Nursing Care Plan with a Target date of 4/30/17 Indicated: "Nursing Diagnosis Abscess on Buttocks Prevention - Objective: Monitor and Treat, Interventions - Appointments with PCP (primary care physician) every 90 days and PRN (as needed). Monitor for signs and symptoms of infections, discomfort and report concerns to MD. Administer medications and treatments as ordered by PCP 1. keep area clean and dry. 2. Reposition Q (every) 2 hours for 60 min. 3. Apply baby powder with each diaper change. Assigned Staff Nursing. Target date 4/30/17."

1. The Nursing Care Plan for Individual #2 was revised and updated to reflect prevention of pressure areas. (Reference Attachment #10: Nursing Care Plan for Individual #2). Policy #69: Pressure Ulcers was revised to include all individuals being assessed using the Braden Scale upon admission, quarterly, and at change of condition. (Reference Attachment # 14: Policy 69--Pressure Ulcers; Attachment #15: Braden Scale for Predicting Pressure Sore Risk and Attachment #16: Pressure Ulcer Preventions, per Braden Scale Score.) 3/8/18

2. Deficient practice can affect all residents of VersAbility's ICF-IID facility. 3/8/18

3. Nursing staff will provide training for all ICF-IID staff during their QIDP/Staff Meetings in March, 2018 in how to identify pressure areas and prevention. The Braden Scale will be reviewed as well. (Reference Attachment #17: How to Measure Wounds Using the Disposable Ruler Protocol and Attachment #18: Pressure Ulcer Prevention hand-out). The Pressure Ulcer Prevention hand-out was reviewed and signed in agreement by the Physical Therapy Consultant prior to using for training purposes. Also, Individual #2's ISP was revised to reflect informal supports provided to assist with prevention of pressure sores (per recommendation) and will be reviewed during the QIDP/Staff Meetings at Cloverleaf on 3/8/2018. 3/8/18 3/8/18

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W 260	Continued From page 29 A physician's order dated 2/14/17 indicated: "Baby powder - apply with each diaper change. Desitin- Apply with diaper changes PRN for skin irritation." A Physician's Progress Note dated 3/2/17 indicated: "Patient seen and examined in office per caregivers, open area on sacrum present since yesterday. patient has had similar lesions in the past. No fever noted by caregivers. Exam: Vitals BP 120/72, T- 96.0, R 20, P 80. Skin: There is a 4 (mm) millimeter, x 3 (mm) x 2 (mm) stage II ulceration on glutel fold midline. No erytheme, no fluetuence. Assessment and Plan: Sacral /glutel ulcer. No signs of infection Santyl/collegenase every other day Allyven 7.5 cm X 7.5 cm dressing change every other day will order home health wound care monitor for signs of infection Available if concerns/worsening follow-up in office in 2 weeks." A Nursing Note dated 3/2/17 indicated: "Received report on 3/1/17 PM (no time given) of open area on Individual #2's sacrum. Staff instructed to place Individual #2 in bed, repositioning left (L) plus (R) right side lying every two hours. She was seen by the doctor for evaluation. New orders given for Santyl ointment to open area cover with Allyven dressing (every other day) by nurse. Individual #2 home resting will continue to closely monitor. Monitor for s/s (signs and symptoms) of infection (fever, change of behavior)." A review of the clinical notes did not indicate	W 260	4. The CL Manager will monitor the staff implementation of the active treatment plan (ISP) for Individual #2, along with the QIDP/Support Coordinator. The CL Nurse will monitor staff implementation of the Nursing Care Plan and other medical procedures for prevention of pressure ulcers. Also, the Physical Therapy Consultant will continue to provide consultation regarding this issue, as needed. The CL RN Consultant will monitor and oversee the activities of the LPN's to ensure prevention of pressure ulcers are implemented.	3/9/18

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W 260	Continued From page 30 Individual #2 Pressure area was being monitored prior to reopening on 3/1/17. The Licence Practical Nurse (LPN) was asked during an interview on 2/7/17 at 11:15 AM, was there any monitoring data for when staff turned/repositioned Individual #2. The LPN stated there was no information to support monitoring the area. When asked about turning/ repositioning or changing Individual #2 every two hours, she stated "there was no information." During an interview on 2/7/17 at 10:00 A.M. with the Community Living Manager (CLM) she stated, there were no revision to Individual #2's the program plan for developing pressure sores. An Active Treatment Policy and Procedures indicated: "Policy- It is the policy of the facility to ensure that each individual receives a continuous active treatment program. Procedures: 3. The ISP/IPP will be monitored and revised by the QIDP (Qualified Intellectual Disability Professional)/Support Coordinator to prevent the regression or loss of optimal functional status. Procedures-4. The ISP (Individual Service Plan) /IPP (Individual Program Plan) will be developed by the interdisciplinary team based on the individual's strengths and needs as assessed by team members and appropriate facility staff.	W 260		
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.	W 339		

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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 339	Continued From page 31	W 339	W339	

This STANDARD is not met as evidenced by:
Based on observations, record review, and staff interviews the facility staff failed to ensure one Individual (Individual #2) in the survey sample of 2 skin integrity was maintained to prevent pressure sores.

The findings included:

Individual #2 was admitted to facility with diagnoses which included profound intellectual disability, left hemiplegia, cerebral palsy, status post hysterectomy, sistory of H pylori, tenea pedis, dysphasia, osteopenia and osteoporosis secondary to immobility and anticonvulsant therapy, constipation with functional vomiting likely secondary to intestinal dysmotility, hiatal hernia with reflux, erosive esophagitis and esophageal stricture, exotropia OD, bladder and bowel incontinence prognosis.

A first Quarter Nursing Care Plan with a Target date of 4/30/17 Indicated: "Nursing Diagnosis Abscess on Buttocks Prevention - Objective: Monitor and Treat, Interventions - Appointments with PCP (primary care physician) every 90 days and PRN (as needed). Monitor for signs and symptoms of infections, discomfort and report concerns to MD. Administer medications and treatments as ordered by PCP 1. keep area clean and dry. 2. Reposition Q (every) 2 hours for 60 min. 3. Apply baby powder with each diaper change. Assigned Staff Nursing. Target date 4/30/17."

A physician's order dated 2/14/17 indicated: "Baby powder - apply with each diaper change.

Facility staff failed to ensure one Individual (Individual #2) in the survey sample of 2 skin integrity was maintained to prevent pressure sores.

3/8/18

1. The Nursing Care Plan for Individual #2 was revised and updated to reflect prevention of pressure areas. (Reference Attachment #10: Nursing Care Plan for Individual #2). Policy #69: Pressure Ulcers was revised to include all individuals being assessed using the Braden Scale upon admission, quarterly, and at change of condition. (Reference Attachment # 15: Braden Scale for Predicting Pressure Sore Risk and Attachment #16: Pressure Ulcer Preventions, per Braden Scale Score.)

2. Deficient practice can affect all residents of VersAbility's ICF-IID facility. 3/8/18

3. Nursing staff will provide training for all ICF-IID staff during their QIDP/Staff Meetings in March, 2018 in how to identify pressure areas and prevention. The Braden Scale will be reviewed as well. (Reference Attachment #17: How to Measure Wounds Using the Disposable Ruler Protocol and Attachment # : Pressure Ulcer Prevention hand-out). The Pressure Ulcer Prevention hand-out was reviewed and signed in agreement by the Physical Therapy Consultant prior to using for training purposes. 3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 339	Continued From page 32 Desitin- Apply with diaper changes PRN for skin irritation." A Physician's Progress Note dated 3/2/17 indicated: "Patient seen and examined in office per caregivers, open area on sacrum present since yesterday. patient has had similar lesions in the past. No fever noted by caregivers. Exam: Vitals BP 120/72, T- 96.0, R 20, P 80. Skin: There is a 4 (mm) millimeter, x 3 (mm) x 2 (mm) stage II ulceration on glutel fold midline. No erytheme, no fluetuence. Assessment and Plan: Sacral /glutel ulcer. No signs of infection Santyl/collegenase every other day Allyven 7.5 cm X 7.5 cm dressing change every other day will order home health wound care monitor for signs of infection Available if concerns/worsening follow-up in office in 2 weeks." A Nursing Note dated 3/2/17 indicated: "Received report on 3/1/17 PM (no time given) of open area on Individual #2's sacrum. Staff instructed to place Individual #2 in bed, repositioning left (L) plus (R) right side lying every two hours. She was seen by the doctor for evaluation. New orders given for Santyl ointment to open area cover with Allyven dressing (every other day) by nurse. Individual #2 home resting will continue to closely monitor. Monitor for s/s (signs and symptoms) of infection (fever, change of behavior)." A Nursing Note dated 3/22/17 indicated: "Staff reported an open area on Individual #2's sacrum. Individual #2 was placed on bed rest, repositioning (Q 2 H) every 2 hours left side to	W 339	Also, Individual #2's ISP and Nursing Care Plan was revised to reflect informal supports provided to assist with prevention of pressure sores (per recommendation) and will be reviewed during the QIDP/Staff Meetings at Cloverleaf on 3/8/2018. (Reference Attachment #9: Individual #2 Plan of Care; and Attachment #10: Nursing Care Plan for Individual #2) 4. The CL Manager will monitor the staff implementation of the active treatment plan (ISP) for Individual #2, along with the QIDP/Support Coordinator. The CL Nurse will monitor staff implementation of the Nursing Care Plan and other medical procedures for prevention of pressure ulcers. Also, the Physical Therapy Consultant will continue to provide consultation regarding this issue, as needed. The CL RN Consultant will monitor and oversee the activities of the LPN's to ensure prevention of pressure ulcers are implemented.	3/8/18 3/9/18

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W 339	Continued From page 33	W 339		

right side lying. Individual #2 was transported to doctors office on 3/2/17 for evaluation and treatment. Individual #2 was diagnosed with a sacral lesion. The area was approximately 1/2 cm (centimeters) in diameter. New orders were given for Santyl Ointment, apply to effected area every other day and cover with Allyven foam dressing.

Individual #2 remained on bed rest while being treated. Individual #2 followed up at doctors office on 3/22/17. "The area is healed. Individual is up in wheelchair for showers and meals only for a total of 1 hour. The time up will increase by 15 minutes until she reaches 2 hours. Once she can tolerate 2 hours up, her time in bed will decrease. Individual #2 will return to day program on 3/24/17. Individual #2 will attend Day Program on Monday, Wednesday and Friday the following week. Individual #2 will resume her routine schedule on 4/3/2017."

A review of the clinical notes did not indicate Individual #2 Pressure area was being monitored prior to reopening on 3/1/17. The Licence Practical Nurse (LPN) was asked during an interview on 2/7/17 at 11:15 AM, was there any monitoring data for when staff turned/repositioned Individual #2? The LPN stated there was no information to support monitoring the area. When asked about turning/ repositioning or changing Individual #2 every two hours, she stated there was no information.

During an interview on 2/7/17 at 11:25 A.M. with the nurse (LPN) how did the area reopen she stated, "due to moisture and not repositioning".

A review of a Pressure Ulcer Policy and Procedures indicated: "Policy- It is the policy of

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the facility to identify early signs of compromised Skin integrity. Pressure ulcers occur due to prolonged pressure of an area. The ulcers may occur at any site usually over the boney areas. (Example: buttocks of individuals confined to a wheelchair). The combination of pressure, friction, shearing forces, and moisture can lead to the breakdown of the skin tissue.

Signs and Symptoms:
1. Irritation
2. Redness
3. Blistering
4. Open areas of the skin (Ulcers)

Procedures:
1. Individuals in wheelchairs are to be repositioned to relieve pressure as recommended per Physical Therapist.
2. Pressure reducing cushion for wheelchair as assessed by Physical Therapist
3. Individuals will be checked frequently, and changed as needed to keep buttocks clean and dry.
4. Frequently check the individuals bed linens to make sure they are clean and dry.
5. Individuals will receive good hydration and nutrition. (Menu's are prepared by Registered Dietitian).
6. The Direct Support Professional (DSP) will document any changes in skin condition and/or any signs or symptoms of pressure ulcers:
a. Documentation will be done in the ID notes
b. An incident report will be completed
c. The nurse will be immediately notified of any changes of skin condition
7. The nurse will instruct the DSP to have the individual remain off of the site until she/he can assess and evaluate. The nurse will document the skin changes in the nurses notes to include

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W 339 Continued From page 35

but not limited to size and location of the pressure area. (Reference: How to Measure Wounds Using the Disposable Ruler protocol.)
a. The physician will be notified within 24 hours of noting the beginning of a pressure area.
b. An appointment will be scheduled with the attending physician within 48 hours. (If unable to obtain an appointment with the attending physician the individual will be taken to an outside medical facility for evaluation.)
c. The MD will diagnose the pressure area and stage if considered a pressure ulcer.
d. Medication and/or treatments ordered by the MD will be initiated.
e. The physical Therapist will be notified of the possible area and recommendations/instructions from the Physical Therapist will be implemented.

W 441 EVACUATION DRILLS
CFR(s): 483.470(i)(1)

The facility must hold evacuation drills under varied conditions.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to ensure evacuation drills were conducted during various times on the 3-11 and 11-7 shifts.

The findings included:

Times Fire Drills were conducted:
3-11 P.M.
11/27/17 - 6:20 P.M.
8/30/17 - 5:49 P.M.
5/31/17 - 6:30 P.M.
1/31/17 - 4:44 P.M.

W 339

W 441

The facility failed to ensure evacuation drills were conducted during various times on the 3-11 and 11-7 shifts.

1. Fire Drill Log will be used to track whether drills were conducted at random, varying times and during varying weather conditions. (Reference Attachment #19: VersAbility Resources Fire Drill Log, 1pg) 3/9/18

2. All Cloverleaf ICF-IID residents were identified as being effected by this deficient practice. All other VersAbility ICF-IID Facilities will review their fire drill reports and will identify if there are similar incidents that have occurred. 3/8/18

W 441

3. Staff at Cloverleaf, as well as, other VersAbility Resources ICF-IID Facilities, will record the date, time, weather condition, etc. on the Versability Resources Fire Drill Log monthly. (Reference Attachment #19: VersAbility Resources Fire Drill Log). 3/16/18
The CL Manager will ensure staff receive proper training on the Fire Drill rotation process. As a result, all shifts will conduct drills at least quarterly; all shifts will conduct drills during various weather conditions; and all shifts will conduct drills at various times

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11 P.M.-7 A.M.
12/19/17 - 11:13 P.M.
9/26/17 - 5:12 A.M.
6/4/17 - 11:50 P.M.
3/27/17 - 11:37 P.M.

During an interview on 2/6/18 at 2:15 P.M. with the (CLM) Community Living Manager she was asked if staff conducted evacuation drills during various times. The CLM stated yes, it was the expectation not only to conduct evacuation drills at various times but under various conditions also.

during their shift. In addition, the "Conducting Fire and Safety Drills" policy was updated to reflect that Fire/Safety drills will be conducted randomly, alternating among shifts, times, and various weather conditions. (Reference Attachment #20: Policy # 97--Conducting Fire and Safety Drills, pgs 1-2). This policy, along with the Fire Log will be reviewed with Cloverleaf staff, as well as all other ICF-IID Facility Staff during their Staff Mtg. in March, 2018. Signatures will be obtained from all staff trained. (Reference Attachment #21: Quality Assurance Quarterly Fire/Safety Drill Report.)

4. The CL Manager is primarly responsible for review of the Fire Log monthly. DSPs will complete the form following each fire drill. The CL Assistant Manger will review the form monthly and report any discrepency to the CL Manager for correction. The CL Assistant Manager will also report the result of these reviews quarterly to the Chief Officer of CL, Assistant Director of CL, and the CL Quality Assurance Committee using the "Quality Assurance Quarterly Fire/Safety Drill Report". (Reference Attachment #21: Quality Assurance Quarterly Fire/Safety Drill Report). Any follow-up and/or corrections will be the responsibility of the CL Manager. 3/9/18

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W 339 Continued From page 35

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CFR(s): 483.470(i)(1)

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W 441

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Attachment
#1
Policy 85:
Physical Environment

Division: Community Living	Category: Physical Environment
Subject: Physical Environment	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: **Physical Environment**

NUMBER: **85**

POLICY: It is the policy of the Cloverleaf House to ensure that the physical environment of Cloverleaf House promotes the health, safety and independence and learning of the individuals who live there.

PROCEDURES:

1. Cloverleaf House considers the needs, functioning levels, ages, interests and social skills of residents to ensure that the health and safety of Individuals is not endangered.

2. Individuals are not segregated by physical disability.

3. Individual bedrooms have at least one outside wall, 80 square feet for a single room. Rooms with multiple occupancy will be 120 square feet. Height of the room will be at least 7 ½ feet, minimum.

4. Each bedroom is located in close proximity to a bathroom.

5. Each bedroom is equipped with a bed of proper size and height to meet the requirements of the Individual. Bed assessments will be done in consultation with the Physical Therapist Consultant. Each bed will have a clean, comfortable mattress, with appropriate bedding, functional furniture, appropriate closet and/or storage space. Staff will check under mattresses and/or furniture regularly to assure there are no unwarranted pests or infestations.

6. Clean linen will be stored in a linen closet/cabinet. Dirty linen will be stored in hampers for each Individual in their bedroom.

7. Cloverleaf House will maintain at least two bathrooms for four Individuals. They will be appropriate in size to accommodate the needs of the Individuals. Only one Individual will use a bathroom at a time to ensure privacy.

8. Each Individual will have their own separate closet space. All clothes, racks and shelves will be accessible to the Individual.

9. Water temperature in Cloverleaf House is regulated to not be hotter than 110 degrees Fahrenheit.

10. Each bedroom will have a window to the outside.

11. There will be adequate lighting in halls and bathrooms at night.

12. The temperature of Cloverleaf House will be maintained between 68 and 81 degrees.

13. Heating and air conditioning will be provided by centralized system. Space heaters are not permitted.

14. Floor surfaces are resilient and non-abrasive, slip resistant. Carpeting is non-abrasive.

15. The majority of floor surfaces will be tiled to afford accessibility to those Individuals with walkers or wheelchairs, easy mobility. Individuals will be free of any potential barriers to accessibility. (See Versability Resources Accessibility and Inclusion Policy # 1.00.000.30.)

16. Cloverleaf House will provide adequate space and storage for additional adaptive equipment and/or Individual personal possessions (e.g. T.V., Computer, etc.).

17. Recreational activities and materials will be available and will reflect the Individual's choice and chronological age.

18. Only lead free paint will be used in Cloverleaf House.

19. Trash pick up will occur at least weekly. Recycling will occur every other week.

20. Cloverleaf House sewer and water system will be inspected at least annually and sprinkler system quarterly. In an event of an emergency, crisis or disaster situation, Servepro will be contacted to address issues related to the sprinkler, sewer and water system, as warranted. These services will be available 24/7 and response from Servepro will be expedited immediately.

21. Cloverleaf House will be smoke free environment. There will be no smoking on the premises, during outing within the community and/or in the Versability Resources vehicles.

22. All doors (entrance/exit, bedroom, bathroom, etc.) will be provided with latches or other mechanisms suitable for keeping the door closed. No objects will prevent an individual from closing the door (e.g. including, but not limited to door stops, tying of the door knob to the wall, etc.) Cloverleaf House staff will ensure proper inspection of doors daily and the Community Living Manager will complete the Internal Inspection Facilities and Grounds report monthly *(See Cloverleaf House policy # 99, Building Equipment Repair and Maintenance for copy of Internal Inspection Facilities and Grounds report*) to indicate proper operation of doors within the facility.

23. Cloverleaf House provides a sanitary environment for all Individuals. All staff will follow Versability Resources OSHA Bloodborne Pathogens Policy (#1.00.000.6) and Infection Control Policy (#1.00.000.20). *See Appendix A, Versability Resources Corporate policies*

483.470 (a – g),(k - l) **12VAC 35-105-280, 12 VAC 35-105-300** **12 VAC 35-105-330, 12 VAC 35-105-340, 12 VAC 35-105-350, 12 VAC 35-105-360, 12 VAC 35-105-370, 12 VAC 35-105-380**	W406 - 435, W437, W452, 454 - 458
DATES	**SIGNATURE**
Issued Date: 12/06	Linda R. Kerns
Reviewed Date: 10/10; 7/11	
Revised Date: 10/10; 7/11; 8/13; 2/18; 3/18	Linda R. Kerns, LCSW Director of Community Living Versability Resources

Attachment
#2
ICF-IID
Emergency and Continuity of Operations Plan, pg. 16

Cloverleaf House's primary mode of transportation will be the facility vans. Additional vans can be procured through the Vehicle Maintenance Department by making a request to MAINTAIN-VEHICLE@Versanet (internal site for agency staff only). VersAbility maintains a fleet of approximately 20 vehicles that may be procured during an emergency, ten of which are handicapped-accessible vans**.**

VRI also maintains a contract with Enterprise Rentals through which additional vehicles may be rented.

In the event of barriers to transportation or emergency conditions that render the staff unable to utilize the assigned vehicles, the status of the program's transportation will be communicated through the VHASS system which will enable the area's emergency responders to provide emergency transportation.

The contact information for transportation resources is in this document's External Contacts List.

DISASTER RECOVERY AND RESOLUTION:

To ensure disaster recovery as soon as possible after an emergency event, the following procedures will be implemented as soon as possible after an emergency as deemed by the VRI Chief Community Living Officer or Designee.

SEWAGE AND WASTE DISPOSAL:
ServePro will be the contract company responsible for the elimination of waste, debri, and sewage draining/repairs following an emergency/crisis situation. ServePro staff will respond within 24 hrs of notification and operate 7 days per week. Additional instructions for utilizing facilities and eliminating waste will be provided by ServePro, if necessary.

SAFETY INSPECTION OF FACILITIES AND PROGRAM SITES:

Depending upon the nature of the disaster and/or the extent of any damage, an inspection will be completed by VRI's qualified Facilities staff. The result of this inspection will be provided to the Emergency Preparedness Team and will include: repairs needed prior to occupation, repairs that can be deferred, and the extent of required clean-up operations. The Facilities Department staff will make recommendations for Emergency Plan improvement.

Attachment
#3
Policy 18:
Communication

Division: Community Living	Category: Individual Protection
Subject: Communication	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: **Communication**

NUMBER: **18**

POLICY: It is the policy of the Cloverleaf House to encourage active participation of the Individual, their legally authorized representatives (e.g. Legal Guardian, Authorized Representative) and/or Families in the process of on-going supports provided to Individuals receiving services. As well as, maintain an open line of communication to assure Individual choice and preferences are considered.

PROCEDURES:

1. Family Members, Guardians and/or Authorized Representatives of the Individual, and the Individual are encouraged to participate in the development of the Individual's Support plan (ISP/IPP). The Individual, as well as, the family, Guardian, and/or Authorized Representative will be invited to participate in annual and quarterly review meetings. IDT Meetings are scheduled and held on dates and at times most convenient for them and the Individual, and may occur on weekends or after normal business hours. They may also be contacted to complete major components in the development of the ISP/IPP (e.g. Essential Information form, Personal Profile, ISP goals/outcomes, etc.) as warranted. If unable to attend meetings, they will be provided copies of the IDT reports and recommendations.

2. The Community Living Services Coordinator, QIDP and/or Director of Community Living may assist the Individual with admissions, transfer and discharge planning. The Individual, Family, Guardian, or Authorized Representative will be provided written notification and instructions regarding Admissions and/or any plans the Versability Resources may have to transfer or discharge the Individual from services. (Reference Cloverleaf House policy #39, Transfer and Discharge, and Policy # 38, Admissions)

3. The Community Living Services Coordinator or Director of Community Living will communicate with the Individual, Family, Guardian, or Authorized Representative regarding information related to financial benefits and entitlements. The Versability Resources Finance representative will communicate any additional financial resources received or billing questions, per request.

4. The QIDP/Support Coordinator, Community Living Manager, Community Living Nurse, Direct Support Staff , or designee will notify the Individual, family member and/or Legally Authorized Representative any time there is a change in the ISP/IPP requiring authorization (e.g. change in goal/outcomes, medical treatment/consent, consultant recommendations, etc.).

5. Other changes necessitating communication with Families, Guardians or Substitute Decision Makers may include, but are not limited to: illness or hospitalizations, accident/injury, death, abuse, unauthorized absence (e.g. missing person) within 24 hours, condition and location of individual in event of an emergency/crisis, etc.

6. Emergency Preparedness Plans will be discussed with the Individual and their Family, Guardian, or Substitute Decision Maker and written documentation of their approval of the plan maintained on file. The CL Manager (or designee) will maintain communication with the individual's family/Guardian/Substitute Decision Maker to provide information on the general condition of the individuals and their location. They will also be provided a list of Staff Emergency Contact information.

7. The QIDP/Support Coordinator, Nurse, Community Living Manager and Director of Community Living are reachable during weekend and evening hours. Emergency contact information will be available at the facility in event contact is warranted.

8. Staffs are to answer communications from family members promptly and appropriately in a courteous manner.

9. Families, Guardians, or Authorized Representatives, and the Individual will be notified in writing 30 days in advance in event the agency intends to cease operation/services. This written notification will be documented in the Individual's ISP/IPP.

483.420(c) 12 VAC 35-105-870)	W 144, W 148
DATES	**SIGNATURE**
Issued Date: 2/06	Linda R. Kerns
Reviewed Date: 3/18	
Revised Date: 5/07; 4/10; 10/10, 5/11, 3/18	Linda Kerns, LCSW Director of Community Living Versability Resources

Attachment #4

Policy 6: Authorization to Release Protected Health Information

Division: Community Living	Category: Individual Records
Subject: Authorization to Release Health Information	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: Authorization to Release Protected Health Information

NUMBER: 6

POLICY: It is the policy of Cloverleaf House to obtain written authorization from Individuals before using or disclosing protected health information(PHI) for any purpose not otherwise permitted or required by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.

PROCEDURES:

1. Cloverleaf House staff will obtain written authorization from the Individual and/or Legal Guardian/Authorized Representative prior to the release of protected health information. The Cloverleaf House staff will utilize the Versability Resources Health Insurance Portability and Accountability Act (HIPAA) policy # 1.00.000.61, the Human Rights policy #1.00.000.55—Section VI, Confidentiality; and the Confidential Service Record policy # 1.00.000.15).
2. The Services Coordinator (Support Coordinator) will obtain written consent for release of protected health information. Consent (authorization for disclosure) forms will be required to share protected health information about an individual. Consent will be obtained from the Individual, or his/her Legal Guardian, or their Substitute Decision Maker (Authorized Representative). Consent will be obtained during admission and updated annually, or as needed throughout the ISP plan year.
3. Written consent will be obtained from the Individual or Guardian, or Substitute Decision Maker regarding sharing of personal information as a result of Emergency procedures and planning. This will include sharing information with external agencies/volunteers and/or emergency health personnel. In event of an emergency or crisis, medical personnel will be provided basic information related to the individual's current medical condition, current medication, medical insurance, individual/family choice of medical facility or providers, need for medical equipment/supplies or adaptive equipment, family/Guardian/Substitute Decision Maker contact information, as necessary.

4. *(See Appendix A for Versability Resources Corporate Policies)*

483.109(c)	W113
DATES	**SIGNATURE**
Issued Date: 12/06	Linda R. Kerns
Reviewed Date:	
Revised Date: 02/06; 4/10; 10/10; 3/18	Linda Kerns, LCSW Director of Community Living Versability Resources

Attachment
#5
Consent to exchange Information

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____ am signing this form for _____
(Full Printed Name of Consenting Person) *(Full Printed Name of Individual)*

_____ _____ _____
(Individuals Address) *(Individuals Date of Birth)* *(Individuals Social Security Number - Optional)*

My relationship to the client is: ☐ Self ☐ Parent (if minor) ☐ Power of Attorney ☐ Guardian ☐ Authorized Representative
I want the following confidential information about the client (except drug or alcohol abuse diagnoses or treatment information) to be exchanged:
Please check *yes or no*:

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment	☐	☐	Medical Diagnosis	☐	☐	Medical Records
☐	☐	Educational Records	☐	☐	Employment Records	☐	☐	Psychiatric Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Criminal Justice Records
☐	☐	Psychological Records	☐	☐	Benefits/Services Needed, Planned and/or Received	☐	☐	Emergency or Crisis Situation/Event

Other information (specify): _____

I want Versability Resources:
And the following person(s) / agency to be able to exchange this information:
Name of Agency or Individual _____
Address_____

I want this information to be exchanged **ONLY** for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination
☐ Crisis or Emergency Events and/or Planning ☐ Other: _____

I want this information to be shared: *(check all that apply)*
☐ Written Information ☐ In Meetings or by Phone ☐ Computerized Data

This consent is good until:_____ (*Automatically expires one year from date signed*)

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agency/individuals from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when and with whom it was shared. If I ask, each agency will show me this information.
If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature:_____ Date:_____
(Consenting Person)

Person Explaining Form: _____ Title: _____ Phone Number:_____

Witness (*if required*):_____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:
☐ Revoked in entirety
☐ Partially revoked as follows:_____

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY: ☐ Letter (Attach Copy) ☐ Telephone ☐ In Person
DATE REQUEST RECEIVED:_____ **RECEIVIED BY (Name):**_____

VersAbility Resources
Community Living Program
Cloverleaf House
Emergency Plan Notification Form

I _____ have reviewed the Emergency Plan for
Name of Guardian/Substitute Decision Maker

Cloverleaf House and I'm in agreement with the procedures identified in the plan. I concur with all measures that will be utilized to ensure the health and safety of

_____ in event of an emergency.
Name of Individual

I am also aware that if I have any concerns with the implementation of the Emergency Plan in the future, I can address them with **Cloverleaf** CL Manager and/or the Chief Community Living Officer.

_____ _____
Signature - **GUARDIAN / SUBSTITUE DECISION MAKER** *Date*

_____ _____
Signature - **INDIVIDUAL** *Date*

Attachment

#6

Policy 7:

Abuse, Neglect and Exploitation Policy

Abuse, Neglect and Exploitation Policy	Policy # 7

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 Chief Operating Officer will have the sole authority to authorize an internal review, investigation committee or assignment of an external investigation.

1. The President/CEO and/or Chief Operating Officer 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 Chief Operating Officer 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 President 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. If the area where the alleged incident occurred was in a common area on-site that the agency currently videotapes, the videotape will be requested from IT and reviewed by the investigation team. The videotaped incident will be placed on a thumb drive secured in the Quality and Compliance Office and maintained for 30 days. After that time, it will be deleted. When appropriate, professional written reports will also become a part of the investigation. For example, if a PT is used to assess an injury, that report will be considered and kept as a part of the original investigation report.
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 Chief Operating Officer and/or Chief Human Resources Officer 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 Leader responsible 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 Chief Quality and Compliance Officer, 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 for 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 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.

4.0 Policy History

Adoption Date: December 1988

Review Dates(s): June 2000; November 2004; November 2005; April 28, 2006; December 15, 2008; March 7, 2011; July 16, 2012

Revision Date(s): November 2003; August 9, 2011; December 6, 2017, March 7, 2018

This policy is approved.

Kathryn "Kasia" Grzelkowski, President/CEO

March 7, 2018

JMP

Attachment
#7
Policy 23:
Staff Training and Orientation

Division: Community Living	Category: Facility Staffing
Subject: Staff Training and Orientation	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: **Staff Training and Orientation**

NUMBER: **23**

POLICY: It is the policy of the Cloverleaf House to provide all employees with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently and competently.

PROCEDURES:

Orientation for each Community Living employee will occur based on the phases identified in the Versability Resources' *New Employee Training and Development policy # 1.00.000.17.*

1. Cloverleaf House staff will be trained by the Community Living Manager on specific requirements as per Cloverleaf's "New Employee Orientation Checklist". A master training schedule will be maintained and documented for each employee (See the Versability Resources' *Employee Training and Development policy #1.00.000.24*).

2. The Community Living Manager will be responsible for assuring all Cloverleaf House staff receive training within the first 180 days of employment (orientation), annually, and/or as recommended/ needed for staff development; and training will occur within the expected time frames.

   All Cloverleaf House staff will receive training during orientation and annual recertification/review as required in First Aid/CPR, CPI (Crisis Prevention Institute Non-Violent Crisis Intervention), Medication Administration, OSHA (Occupational Safety and Health Act), Basic Vehicle Maintenance & Safety/Q'Straint and Human Rights.

3. Cloverleaf House staff will not administer medications prior to receiving Medication Administration training and passing associated tests. All Cloverleaf House staff are required to attend and pass associated tests for Mediation Administration during orientation and annually thereafter. In addition, upon request of the Community Living Manager, staff may be asked to attend a Refresher course of the Medication Administration training if problems/concerns are noted during a medication administration observation and/or if medication errors have occurred.

4. Cloverleaf House staff will not use CPI, CPR, Blood Borne Pathogens or other associated techniques/skills with an Individual/resident prior to receiving training and/or re-certification.

5. The Community Living Manager will assure that all Cloverleaf House staff receive training/instructions on how to complete reports or forms required by Community Living and/or Versability Resources.

6. Each Direct Support Professional staff will be trained on how to complete the Comprehensive Functional Assessment (CFA). The QIDP/Support Coordinator will provide Cloverleaf House staff with instructions on how to complete the form. The CFA is the tool used to assess developmental areas and levels and will be completed during trial visits, upon admission, annually, or as needed.

7. The QIDP/Support Coordinator and Community Living Manager will observe Direct Support Professionals (DSP) implementation of training/supports in all settings to ensure Cloverleaf House staff understand and are carrying out the ISP/IPP interventions as written, are using appropriate supplies/equipment, are interacting appropriately with the individual(s), etc. Immediate, as well as, appropriate feedback (e.g. verbal or written guidance, individual counseling, or instructions, etc.) will be provided to the DSP, as deemed necessary, for correction whenever concerns/problems are noted during observations.

8. New or updated training, policies, and health care interventions will be introduced to Cloverleaf House staff at mandatory and/or regularly scheduled staff meetings/training by the Community Living Manager, QIDP/Support Coordinator, Community Living Nurse, Director of Community Living, or other agency or external Trainers. Cloverleaf House staff is required to attend all mandatory, as well as, regularly scheduled training/meetings. The Community Living Manger will be responsible for arranging follow-up training and/or providing information to staff within 24 hrs. of the meeting/training, or as soon as possible, for "all" staff who were unable to attend the training/meeting due to unforeseen circumstances.

9. Signatures must be obtained from "all" Cloverleaf House staff during or immediately following mandatory or regularly scheduled training/meetings to confirm their attendance, review of minutes, training, and/or notification of information provided during the meeting. The Community Living Manager will be responsible for maintaining original/scanned copies of these signature/attendance sheets. On occasion, certificates may be provided to staff as proof of attendance at trainings. If so, the employee is responsible for providing the Community Living Manager with a copy of their certificate (when applicable). The Community Living Manager will provide copies of staff certificates to the agency's Training and Compliance Coordinator. Relias Training modules will be utilized also to document staff training.

10. Behavioral Intervention and Principles will be introduced to Cloverleaf House staff by the Psychologist consultant. On- going training may be provided to staff at mandatory meetings, individual meetings as a result of observations by the Community Living Manager or QIDP/Support Coordinator, or during agency scheduled ICF/IID trainings. Associated signature/attendance sheets and/or certificates will be obtained and scanned into Community Living files.

11. Community Living Nursing and/or RN Consultant will provide training to staff in appropriate health and hygiene methods, control of communicable diseases and infections, detection of signs and symptoms of illness or dysfunction, first aid for accidents or illness, and other basic skills required to meet the health needs of the Individuals as needed. Trainings may be conducted in a group setting) or with an individual staff member, however, all training provided by the RN Consultant or Community Living Nurse will be considered "mandatory" and associated signature/attendance sheets and/or certificates will be obtained and scanned into Community Living files.

12. Cloverleaf House staff will receive training/instruction relative to all Behavior, Occupational Therapy, Physical Therapy, Speech, Therapeutic Recreation , etc. plans developed for the residents; and/or use of any new adaptive/assistive devices or supports, etc.. The QIDP/Support Coordinator will coordinate training with the Community Living Consultants and Community Living Manager. The Community Living Manager will assure all Direct Support Staff receive training/instructions prior to implementation of plans and/or use of assistive devices or supports. Associated signature/attendance sheets and/or certificates will be obtained and scanned into Community Living files.

See Appendix A for Versability Resources' Corporate policies

483.420 (e); 483.430 (e); 48.460 (c) (e) 12 VAC 35-105-390; 12 VAC 35-105-440; 440; 12 VAC 35-105-450; 12 VAC 35-105-460; 12 VAC 35-105-470	W 189 – 193, W 340 – 342, W350
DATES	**SIGNATURE**
Issued Date: 12/06	Linda R. Kerns
Reviewed Date: 7/11, 1/15	
Revised Date: 02/06; 06/07; 4/10; 10/10, 7/11, 11/12, 1/15, 3/18	Linda Kerns, LCSW Director of Community Living Versability Resources

Attachment
#8
Physical Therapy
Progress Note
(2 pages)

PHYSICAL THERAPY PROGRESS NOTE

[redacted]
DATE: March 7, 2018

[redacted] re-positioning program should include pressure relief in and out of the wheelchair. 1) pressure relief in the wheelchair will be performed by tilting the chair back to 30 degrees as indicated on the side of the wheelchair, every hour for 15-20 minutes; 2) after 2 hours in the wheelchair at Envisions, she should be re-positioned out of the wheelchair onto her side over a wedge for 45-60 minutes (alternate between left and right side lying throughout the day), a pillow should be placed between her knees and ankles to eliminate pressure from boney prominences; at Cloverleaf, she should be re-positioned out of the wheelchair on to her side in bed for 45-60 minutes (alternate between left and right side lying), a pillow should be place between her knees and ankles to eliminate pressure from boney prominences. Following 45-60 minutes of side lying she is can go back into her wheelchair; 3) nighttime re-positioning in bed will be every 2 hours alternating between left and right side lying, 4) [redacted] should remain in an upright position for at least 30-45 minutes following meals before being re-positioned. Adult under garment changes are not a substitute for side lying positioning. Thank you.

Submitted by,

[redacted]

PHYSICAL THERAPY PROGRESS NOTE

[redacted]

DATE: March 07, 2018

[redacted] ability to propel her wheelchair is limited due to her fair (-) right upper extremity strength and her limited active right upper extremity mobility. Essentially, her left upper extremity is non-functional. In addition, her sitting posture is significantly compromised when she attempts to propel her wheelchair. Her new wheelchair provides an additional challenge for her to propel due to size and weight of the wheelchair. Considering the above upper extremity limitations, compromise to her sitting posture, and the size of the wheelchair, I am recommending that she does not self-propel her wheelchair. In addition, I am recommending that her wheelchair be placed in the fully upright position prior to pushing her up to a table to ensure her knees do not hit the bottom of the table. Once she is position with her knees under the table, staff should never try to tilt the wheelchair back when she is in this position. Always move her away from the table before trying to tilt the wheelchair back to ensure that her lower extremities do not hit the bottom edge of the table. Thank you.

Submitted by,

[redacted]

Attachment
#9
Individual
ISP

Part V. Plan for Supports

Providers: Cloverleaf ICF-IID

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			IMPORTANT TO ME:					
G1 Community Living			G) [redacted] will enhance her community living skills.					
	1.1 Leisure Activities	Partial Physical Support	O) [redacted] will participate in two combined hours of structured and/ or unstructured leisure activities. I) [redacted] will be supported during community meeting to choose activities that she would like to be placed on activity calendar. * Staff will implement activities that are on the calendar as planned. * Staff will document on calendar what activities [redacted] participated in and the length of the activity. I) [redacted] reaction to activities. (Smiling, interacting with others, asking to leave) will be documented in ID note.	Daily	Cloverleaf Staff	11/1/17	10/31/18	
G2 Domestic Skills			G) [redacted] will enhance her domestic skills,					
	2.1 Wiping Table	Partial Physical Support	O) [redacted] will wipe her place at the table after finishing her dinner meal for the next three months.	Daily	Cloverleaf Staff	11/1/17	1/31/18	

This ISP belongs to [redacted] **ISP Start:** 11/1/17 **End:** 10/31/18

****REVISED 03/08/2018****

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			I) Staff will ask [redacted] to wipe her place at the table after the dinner meal. I) Staff will wet a dishcloth with some soap and hand the dishcloth to [redacted] I) Staff will support [redacted] with verbal cues to wipe the table. I) If [redacted] does not respond to verbal prompts, staff will physically support [redacted] with wiping the table. I) Staff will record the level of support needed for [redacted] to wipe the table on the Data Support sheet and initial the Support Checklist. Note any concerns in the IDT notes.					
			IMPORTANT FOR ME:					
G3 Gross Motor Skills			G) [redacted] will develop her gross motor skills.					
	3.2 Right Arm in Shirt		O) [redacted] will, with partial physical support, place her right arm through the right armhole of her blouse or shirt daily in the morning for the next six months. I) Staff will support [redacted] with selecting a blouse or shirt of her preference each morning. I) Staff will ask [redacted] to put her right arm through the right armhole of the blouse or shirt	Daily	Cloverleaf Staff	11/1/17	4/30/18	

[redacted] **ISP Start:** 11/1/17 **End:** 10/31/18

****REVISED 03/08/2018****

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			that she has chosen. I) If [redacted] does not respond to verbal cues, staff will provide physical support, and/or modeling cues as needed, for [redacted] to put her right arm through the right armhole of her blouse or shirt daily in the morning. Staff will document the level of support needed for [redacted] to put her right arm through the right armhole of her blouse or shirt daily in the morning on the Support Data sheet and initial the Support Data sheet. Staff will also initial the Support Checklist. Document [redacted] reactions in IDT notes.					
G4 Personal Care Skills			G) [redacted] will become more independent with her personal care skills.					
	4.1 Brushing Hair	Partial Physical Support	O) [redacted] will, with partial physical support, brush her hair twice daily for the next five months. I) Staff will remind [redacted] that it is time to brush her hair when she completes her personal hygiene. I) Staff will hand the brush to [redacted] I) Staff will support [redacted] with verbal cues, as needed, to brush all of her hair. I) If [redacted] does not respond to verbal cues, staff will	Twice Daily	Cloverleaf Staff	11/1/17	3/31/18	

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			provide physical support to [redacted] with brushing her hair. Staff will document the level of support needed for [redacted] to brush her hair, using the Support Key, on the Support Data sheet. Staff will also initial the Support Checklist. Record [redacted] reaction and progress in IDT notes.					
G5 Money Management (Purchases)			G) [redacted] will continue to develop her skills in the area of making purchases of services and products.					
	5.2 Purchases	Partial Physical Support	**O) Once weekly, [redacted] will, with partial physical support, chose the store where she would like to make a purchase, given a choice of three different stores, for the next nine months.** I) Staff will remind [redacted] when it is time to make a purchase. I) Staff will ask [redacted] which store she would like to go to. I) If [redacted] does not respond, staff will provide [redacted] with a choice of at least three stores. Staff may provide the names and pictures representing each of the choices of store to [redacted] I)Staff will ask [redacted] to point to the store of her choice.	Weekly	Cloverleaf Staff	11/1/17	7/31/18	

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			I)Staff will ensure that [redacted] takes her money with her to make the purchase. I)Staff will support [redacted] with transportation to and from the store of her choice. I)Staff will support [redacted] with selecting an item that she wants to purchase, making sure that [redacted] receives the correct amount of change from her purchase and that her receipt is retained. I)Staff will indicate the cue level, following the Support Key, needed for [redacted] to chose the store where she would like to make a purchase. Staff will indicate the store that [redacted] chose on the appropriate week listed on the Support Data sheet. Staff will also initial the Support Data sheet and the Support Checklist. Document [redacted] reactions and preferences in IDT notes.					
G7 Community Living (Voting)			G[redacted] will enhance her leisure skills.					
	7.1 Voting	Partial Physical Support	O)[redacted] will, with partial physical support, participate in one voting activity monthly for the next six months.	Monthly	Cloverleaf Staff	11/1/17	4/30/18	

[redacted] **ISP Start:** 11/1/17 **End:** 10/31/18

****REVISED 03/08/2018****

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			I) Once a month, staff will gather housemates at Cloverleaf for a house meeting. I) Staff will explain the topic (community outings) to vote on. I) Staff will provide at least three options for the voting activities. I) Staff will ask each person to indicate their choice. I) Staff will announce the "winner" of the vote. I) Staff will fill out the voting form, indicating the topic to be voted on, the choices given, and [redacted] choice made, along with the level of support needed to indicate a vote. I) Staff will document the level of the support [redacted] required to participate in a voting activity in the ID notes, Support Data sheet and initial the Support checklist.					
G8 Medication			G) [redacted] will take her meds as prescribed by her attending MD.					
	8.2 Medication	Partial Physical Support	O) [redacted] will, with partial physical support, take a glass of water using her Nosey cup, when taking her medication, for the next twelve months. I)Staff will prepare prescribed medications in a	Twice Daily	Cloverleaf Staff	11/1/17	10/31/18	

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			medication cup. I)Staff will measure 20 cc of water, and only put this amount in Nosey cup. (Staff will use the 10 cc cups to measure 20 cc). I)Staff will hand the Nosey cup containing the water to [redacted] to swallow with her medication. * Per [redacted] PO her meds maybe taken in Applesauce* I)Staff will provide [redacted] with verbal cues to take her Nosey cup to drink her water. I) If [redacted] does not respond to verbal cues, staff will provide physical support to [redacted] with taking her Nosey cup. Staff will support [redacted] with using her Nosey cup to drink some water with her medications. I)Staff will ensure that [redacted] drinks only a small amount of water at a time. I)Staff will document the level of support needed, using the Support Key, for [redacted] to take her Nosey cup from staff while she is taking her medication on the Support Data sheet. Staff will also initial the Support Checklist. Documentation in IDT notes.					
G9 Cognitive			G) [redacted] will increase her cognitive skills.					
	9.1 Cause and Effect	Partial Physical Support	O) [redacted] will, with partial physical support, use her right hand to operate a hand-held communication device (e.g. Quick Talker 12) for the next six months.	Three times per week	Cloverleaf Staff	11/1/17	4/30/18	

[redacted] **ISP Start:** 11/1/17 **End:** 10/31/18

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			I) Staff will turn the device on. I) Staff will hold the device in front of [redacted] within her reach. I) Staff will ask [redacted] to depress one of the buttons and/or wind the device using her right hand to operate it. I) [redacted] will use her right hand to operate the device. I) If [redacted] does not respond to verbal cues, staff will provide physical support, hand over hand, for [redacted] to operate the device so that it produces sound and/or music. I)Staff will document the level of support, using the Support Key, needed for [redacted] to use her right hand to operate the communication device on the Support Data sheet. Staff will initial the Support Data sheet and the Support Checklist. Staff will document [redacted] reactions and what she enjoys about using the device in IDT notes.					
G10			G) [redacted] will respond during fire and safety drills.					
	10.1 Safety Drills	Full Physical Support	O) [redacted] will, with full physical support, participate in fire and safety drills exiting the home within 5 minutes. I) Staff, along with CL Manager, will determine when drills should be conducted.	Monthly	Cloverleaf Staff	11/1/17	10/31/18	

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			NOTE TO STAFF: Fire drills should be conducted each month on varying shifts, varying days, and varying weather conditions. Evacuation should occur within 5 minutes of when the alarm is sounded. I) Staff will need to awaken [redacted] during overnight hours when the fire alarm is sounded or when a safety drill is initiated. I) [redacted] requires two staff assistance and/or use of the Hoyer lift with sling to transfer into her wheelchair. I) Staff will ensure that [redacted] seatbelt, safety straps, and slim cut chest harness are intact. I) Staff will support [redacted] with using her wheelchair to evacuate to the designated location. **NOTE TO STAFF: Staff will follow Versability Resources policy regarding evacuation during Fire Drill found in the Versability's Health and Safety Manual.** I) Staff will support [redacted] with reentering the home after it has been determined that it is safe to do so. I)Staff will document on the Emergency Drill form the length of time that it took [redacted] to exit the home. Staff will also document the weather conditions and the type of drill being conducted on the Emergency Drill form. Document [redacted] reactions to the					

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			emergency drill in IDT notes and initial the Support Checklist.					
G11			G) [redacted] will remain free from skin breakdowns.					
	11.1 Prevention of Skin Breakdown	Full Physical Support	O) [redacted] with full physical support, maintain her skin integrity to prevent any skin breakdowns. I) Cloverleaf staff will complete skin checks on [redacted], paying particular attention to bony prominences, on each shift. Staff will report to CL Nurse any prolonged redness, blistering, open sores, or irritation. Staff will complete and initial the Skin Check chart during each shift. I) Staff will ensure that [redacted] linens are clean and soft, providing space in the toe area of the bed. I) [redacted] will use a pressure reducing cushion while she is sitting in her wheelchair. I) Staff will reposition [redacted] as follows to avoid uninterrupted sitting in her chair or wheelchair: Re-positioning program should include pressure relief in and out of the wheelchair. 1) pressure relief in the wheelchair will be performed by tilting the chair back to 30 degrees as indicated on the side of the wheelchair, every hour for 15-20 minutes; 2) after 2 hours in the wheelchair at Envisions, she should be re-positioned out of the wheelchair onto	Daily	Cloverleaf Staff	3/8/18	10/31/18	

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			her side over a wedge for 45-60 minutes (alternate between left and right side lying throughout the day), a pillow should be placed between her knees and ankles to eliminate pressure from boney prominences; at Cloverleaf, she should be re-positioned out of the wheelchair on to her side in bed for 45-60 minutes (alternate between left and right side lying), a pillow should be place between her knees and ankles to eliminate pressure from boney prominences. Following 45-60 minutes of side lying she is can go back into her wheelchair; 3) nighttime re-positioning in bed will be every 2 hours alternating between left and right side lying 4) [redacted] should remain in an upright position for at least 30-45 minutes following meals before being re-positioned. Adult under garment changes are not a substitute for side lying positioning I) Staff will complete ensure that excess moisture is eliminated, maintaining [redacted] skin clean from urine and feces. [redacted] Depends will be checked by staff hourly and changed when needed. Staff will complete the Undergarment Check chart every hour using the Support Key and initialing the chart. I) Support [redacted] with minimizing any swelling and/ or lymphedema. I [redacted] should avoid foods that exacerbate					

[redacted] **SP Start:** 11/1/17 **End:** 10/31/18

****REVISED 03/08/2018****

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			incontinence, such as carbonated soda, chocolate, coffee, tea, artificial sweeteners, spicy food, tomato-based foods, acidic fruit juices, and milk products.					
G12			G) [redacted] will remain safe while using her wheelchair.					
	12.1 Use of Wheelchair	Full Physical Support	O) [redacted] will, with full physical support, operate and maintain her wheelchair in a safe manner. I) [redacted] has a tilt-in-space wheelchair with a custom padded tray and a Body Point slim-cut chest support. Staff will support [redacted] while she is in her wheelchair as follows: 1. The brakes need to be locked before transferring in or out of the wheelchair. During transports on the van, brakes need to be locked and the wheelchair needs to be locked down by attaching the van straps to the transport brackets on the wheelchair. 2. When the brakes are engaged, the wheels should not move. Adjustments need to be made if the wheels can be moved. Staff will notify CL Manager if equipment is not working properly. 3. [redacted] feet should always be on the foot plates or foot box to prevent dependent edema and/or injury to her feet when being transported in the	Daily	Cloverleaf Staff	3/8/18	10/31/18	

[redacted] ISP Start: 11/1/17 End: 10/31/18

****REVISED 03/08/2018****

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			house, Envisions, and/or out in the community. Always push[redacted] slowly through door frames or openings ensuring that her feet are on the footrests and her arms are within the frame of the wheelchair to prevent injury to the lower and upper extremities and to prevent damage to the wheelchair. 4. A tilt-in-space wheelchair allows for better transfers and improved positioning in the seating system. Tilting the seating system results in shifting weight off the buttock and onto the trunk. [redacted] wheelchair should be placed in the fully upright position prior to pushing her up to a table to ensure her knees do not hit the bottom of the table. Once she is position with her knees under the table, staff should never try to tilt the wheelchair back when she is in this position. Always move her away from the table before trying to tilt the wheelchair back to ensure that her lower extremities do not hit the bottom edge of the table. 5. Footrests should be swung away whenever [redacted] is transferred into or out of the wheelchair. To reduce the footprint of a wheelchair to allow it to fit in small spaces, the					

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			footrests can be removed. 6. Full length adjustable height armrests allow for proper support and positioning of the upper extremities. The armrest height can be adjusted, or the armrest can be removed with the depression of push pin or lever on the side of the armrest. 7. All wheelchairs will have positional straps which will be engaged whenever [redacted] is in the wheelchair. The positioning strap is for safety during transport and to maintain proper pelvic position. 8. A harness will only be used when [redacted] is transported on the van. The harness will be applied prior to being placed on the van lift and remain on until [redacted] is removed from the van; and 2) the brakes will be engaged when entering and existing the van, 3 a safety strap for the van lift will be used to provide additional security. 10. Cleaning is an important part of wheelchair maintenance to ensure it operates efficiently. Staff will follow Protocol for Cleaning Wheelchairs each day after [redacted] has gone to bed. Staff will initial the Wheelchair Cleaning chart twice weekly. 11. Cloverleaf staff will support [redacted] with operating her wheelchair and [redacted] should not self-propel her					

[redacted] ISP Start: 11/1/17 End: 10/31/18

REVISED 03/08/2018

Part V. Plan for Supports

Goal	Outcome Important To/for #	List the actions/supports needed	Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found.	How often or by when?	Responsible Partner	Start Date	End Date	Completion Date
			wheelchair.					

- [redacted] **may go on day or overnight visits with her father and aunt at their discretion and as arranged with staff.**
- [redacted] **will receive the following informal supports:** Fire Drills (participate monthly, alternating shifts and days of the month) Haircuts (as needed), Fall Monitoring (High Fall Risk, Monitor Hourly), Repositioning (refer to Outcome #11); Wheelchair (tilt-in-space wheelchair with a custom padded tray and a Body Point slim-cut chest support), Seizure Monitoring (Hourly), Undergarment checks (Hourly, Change as needed) Bed Check (every 30 minutes nightly), Dining Plan (All foods will be pureed. [redacted] will be given 5 minutes to begin feeding herself. Staff will support [redacted] with alternating solids with (nectar thick) liquids at a ratio of 1 drink per every 2-4 bites. [redacted] will us a Nosey Cup to drink, but staff will support [redacted] to remain safe by measuring 20 cc of fluids, and only putting this amount in Nosey cup. Staff will use the 10 cc cups to measure 20 cc), Dental Hygiene (Full Physical support to brush teeth 5 times per day after all meals, after waking and before bed—3x brush teeth and 2x use toothettes).
- [redacted] **receives the following services monthly:** Psychological (Monitoring), Dental Hygienist(monthly), Occupational Therapist (monthly), Registered Dietitian(monthly), Physical Therapy (1x week, therapy will include passive range of motion and facilitation of sitting balance, and repositioning mat for trunk control).

* ICFIID *Certification Statement:* The signature of the QIDP hereby certifies the following for the facility/provider:

- Services are adequate to meet the health needs of each recipient, as well as the rehabilitative and social needs of each recipient, and to promote his/her maximum physical, mental, and psychosocial functioning; is receiving active treatment services and is certified as needing this level of care. [Reference: VA DMAS Nursing Facility Provider Manual]

Completed by [redacted] _____ Date: _____
QIDP/Support Coordinator

[redacted] **SP Start:** 11/1/17 **End:** 10/31/18

****REVISED 03/08/2018****

Attachment
#10
Nursing Care Plan

Versability Resources
CLOVERLEAF – ICF/IID

NURSING CARE PLAN

Individual's Name: [redacted] **DOB:** [redacted]

Date: _____ **1st Quarter** _____ **2nd Quarter** _____ **3rd Quarter** _____ **4th Quarter** _____

ALLERGIES: NKDA, NKFA

Nursing Care Plan Prepared By: **RN Supervisor Review:**

Nursing Diagnosis	Objective	Interventions	Assigned Staff	Target Date	Date Met
Impaired skin integrity	**Monitor, Prevent and Treat**	Appointments with PCP every 90 days and PRN Check skin weekly by LPN. Monitor for signs and symptoms of infection, discomfort and document findings. 1. Keep area clean and dry 2. Reposition Q2hs for 60 minutes out of wheelchair in side lying position 3. While in wheelchair, tilt chair at least 45 degrees every 30 minutes to relieve pressure 4. Apply baby powder with each brief change 5. Check brief hourly 6. While in bed, reposition Q2hr, left side to right side lying. Do not position on back If evidence of impaired skin integrity, seek medical attention per policy. Administer medications and treatments as ordered by MD: 1. Duoderm Dressing, apply to sacral wound PRN if redness returns. If skin breakdown returns, return to MD office. LPN will assess the area daily and note outcome Follow up with Physical Therapy Follow up with Dietician			

Versability Resources

CLOVERLEAF – ICF/IID

NURSING CARE PLAN

ADDENDUM

Individual's Name: [redacted] **DOB:** [redacted]

Date: _____ **1st Quarter**_____ **2nd Quarter** _____ **3rd Quarter** _____ **4th Quarter** _____

ALLERGIES: NKDA, NKFA, Environmental allergies (Dust and Mold)

Nursing Care Plan Prepared By: [redacted] **RN Supervisor Review:** [redacted]

Nursing Diagnosis	Objective	Interventions	Assigned Staff	Target Date	Date Met
Impaired skin integrity	**Monitor, Prevent and Treat**	7. should remain in an upright position for at least 30-45 minutes following meals before being re-positioned. 8. Apply baby powder with each brief change 9. Check brief hourly If evidence of impaired skin integrity, seek medical attention per policy. Administer medications and treatments as ordered by MD: 1. Duoderm Dressing, apply to sacral wound PRN if redness returns. If skin breakdown returns, return to MD office. LPN will assess the area as needed and note outcome Follow up with Physical Therapy Follow up with Dietician	Victoria McElrath, LPN		

Attachment #11

Policy 82-1:

Individual Wheelchair Usuage

Division: Community Living	Category: Health Care Services
Subject: Consumer Wheelchair Usage	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: **Individual Wheelchair Usage**

NUMBER: **82-1**

POLICY: Cloverleaf House staff will monitor individuals who use wheelchairs and provide proper care and support to assist with wheelchair usage.

PROCEDURES:

1. Cloverleaf staff will monitor sit-to-stand wheelchair transfers and provide the appropriate level of assistance to ensure that the transfer is safe and successful.
   A. Cloverleaf staff will monitor and ensure that wheelchair brakes are locked prior to transfer to and from the wheelchair.
   B. Two staff will be required to position an individual in and out of the wheelchair.
   C. Cloverleaf staff will ensure that in the event an individual's wheelchair has an approved seatbelt that it is operable and engaged at all times while the individual is seated in their chairs.
   D. After transferring the individual into the wheelchair either with a mechanical lift or pivot transfer, two staff will position themselves on the same side (one supporting the head and placing their hands around the shoulders and the second staff will place their hands under the hips and support the lower extremities). Hand placement should always be at the proximal joints (shoulders and hips). The two staff will gently lift the individual and position the individual's buttocks to the back of the wheelchair.
   E. Before buckling the seatbelt, staff should make sure that the feet are touching the foot plates and that the hips are in proper alignment. After this properly positioned in the wheelchair and the seatbelt is engaged, place the pads of the chest harness on the individual's shoulders. Staff will check for normal operation of buckles and adjust the straps for comfort and position.
2. Cloverleaf staff will provide the necessary intervention, whether verbal reminder or physical assistance, to ensure that while seated in their wheelchairs, individuals change position in program binder as recommended by the Physical Therapist or Attending Physician.

3. When pushing an individual up to a table in a standard wheelchair, the staff needs to ensure the individual's knees are going to clear the bottom of the table before pushing them up to the table. If the individual is in a tilt-in-space wheelchair, the staff needs to ensure the wheelchair is tilted in the upright position and the individual's knees clear the bottom of the table. Never try to tilt the wheelchair while the individual's knees are under the table.

4. Cloverleaf Staff will thoroughly clean individual's wheelchairs as needed in program binder. Duty roster binding on the wheelchair cleaning form.

5. Cloverleaf Staff will monitor and observe the condition of the wheelchair to ensure that it is in proper working condition. Staff will report any damages (i.e. rips in seat, inoperable brakes, etc.) to the Community Living Manager who will be responsible for ensuring that the damages are repaired or if necessary, that the wheelchair is replaced.

6. Cloverleaf staff will monitor individuals to prevent individuals from self-propelling the

wheelchair unless self-propelling is specifically recommended by Attending Physician and/or Physical Therapist.

7. Any recommendations by the Attending Physician and/or Physical Therapist regarding wheelchair usage will be incorporated into the individual's Individual Support Plan (ISP).

8. In-service training for staff related to individuals with wheelchairs will be provided by the Physical Therapist twice yearly at Cloverleaf to include using the wheelchair in and out of doors, pushing individuals in the house, and pushing the wheelchair up to the table for meals and tabletop exercises. In addition, the Physical Therapist will schedule in-service training for any new equipment and for all newly hired staff, as reported by the CL Manager. Staff are required to attend an in-service training every year.

483.440, 483.470, 483.430	W189, W242, W243, W436
DATES	**SIGNATURE**
Issued Date: 12/06	Linda R. Kerns
Reviewed Date:	
Revised Date: 10/10, 3/18	Linda R. Kerns, LCSW Director of Community Living Versability Resources

Attachment
#12
Policy 7:
Abuse, Neglect and Exploitation Policy

Abuse, Neglect and Exploitation Policy	Policy # 7

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 Chief Operating Officer will have the sole authority to authorize an internal review, investigation committee or assignment of an external investigation.

1. The President/CEO and/or Chief Operating Officer 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 Chief Operating Officer 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 President 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. If the area where the alleged incident occurred was in a common area on-site that the agency currently videotapes, the videotape will be requested from IT and reviewed by the investigation team. The videotaped incident will be placed on a thumb drive secured in the Quality and Compliance Office and maintained for 30 days. After that time, it will be deleted. When appropriate, professional written reports will also become a part of the investigation. For example, if a PT is used to assess an injury, that report will be considered and kept as a part of the original investigation report.
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 Chief Operating Officer and/or Chief Human Resources Officer 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 Leader responsible 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 Chief Quality and Compliance Officer, 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 for 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 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.

4.0 Policy History

Adoption Date: December 1988

Review Dates(s): June 2000; November 2004; November 2005; April 28, 2006; December 15, 2008; March 7, 2011; July 16, 2012

Revision Date(s): November 2003; August 9, 2011; December 6, 2017, March 7, 2018

This policy is approved.

Kathryn "Kasia" Grzelkowski, President/CEO

March 7, 2018

JMP

Attachment
#13
Policy 89:

Incident Reporting

Division: Community Living	Category: Physical Environment
Subject: Incident Reporting	

VersAbility Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: Incident Reporting

NUMBER: 89

POLICY: It is the Policy of Cloverleaf House to complete an Incident/Injury Report Form when an incident/injury or changes in condition occurs, in accordance with the overarching policies of VersAbility Resources.

PROCEDURES:

1. The original Incident/Injury report shall be maintained at the administration building in a locked cabinet.

2. The nursing staff will be contacted initially when any medical incident/injury or changes in condition occur. When direct care staffs are uncertain about a condition the nurse will be contacted.

3. The nursing staff will review the incident report. Nursing staff will document any comments, recommendations and/or actions taken on the Incident/Injury Report / or Incident Addendum form.

4. Nursing staff will notify the attending physician and Medical Consultant of incident and follow through as appropriate.

After an incident/injury occurs, all staff members involved or witnessing the incident/injury, change in condition, act or suspicion of abuse/neglect or exploitation must complete an Incident/Injury Report as applicable. This procedure also applies to trial visits.

- All sections of the report must be completed or marked as "not applicable (N/A)". The report should reflect only what was witnessed and the circumstances that actually took place. Inferences or hearsay should not be included anywhere on the report.
- If the staff member enters the scene of the incident after it originated, the staff member should only report what they witnessed from the time that they entered the situation.
- The report must be legibly written in ink or typed.
- Use appropriate grammar and spelling when completing an Incident/Injury Report.
- Injuries of unknown origin must be noted on the Incident Report and possible reason for injury indicated. Injuries of unknown origin will be investigated within 5 working days.

Blank Incident/Injury Report Forms can be found at Hilton House and at the main office of The Versability Resources. It is the Community Living Managers' responsibility to maintain a supply of blank forms. Inability to find a blank form does not relieve a staff member of the duty to report on all incidents and injuries. In the event a form cannot be located, the report must be made on blank paper until a formal form can be obtained. The original blank paper report will be attached to the formal report.

Copies of discharge reports from hospital visits will be attached to the report.

Staff should proofread the Incident/Injury Report for errors, sign it and submit it to the Community Living Manager immediately. The Community Living Manager is responsible for notifying the family/authorized representative as soon as possible when an incident, injury or change occurs. The nurse is responsible for communicating information with family/authorized representative if medical treatment is required. This should be documented on the Incident/Injury Report. The Community Living Manager must submit the Incident/Injury Report to the Director of Program and Quality Services immediately. Or, a report will be submitted the morning of the next working day if the report is written after normal working hours. The staff person completing the Incident Report will be responsible for recording the incident in the ID notes.

Incident Review Committee:

The Director of Program and Quality Services (Local Human Rights advocate) is responsible for reviewing the Incident/Injury Reports, and determining whether the Incident/Injury must be reported to licensing, police, Social Services, etc. The Director of Program and Quality Services will also route as necessary, maintain data as required, and report to the appropriate agencies.

Incident reports will be reviewed by the QIDP/Support Coordinator, RN Consultant, Community Living Nurse, Community Living Manager, Director of Community Living, and/or designee and signatures obtained.

483.470	W148, W456, W457
DATES	**SIGNATURE**
Issued Date: 5/07	
Reviewed Date: 10/13, 3/14, 1/15	
Revised Date: 5/07; 7/10; 10/10; 3/11, 10/13 3/14, 3/18	Linda R. Kerns Linda R. Kerns, LCSW Director of Community Living Versability Resources

Attachment
#14
Policy 69:

Pressure Ulcers

Division: Community Living	Category: Health Care Services
Subject: Pressure Ulcers	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: **Pressure Ulcers**
NUMBER: **69**
POLICY: It is the policy of Cloverleaf House to identify early signs of compromised Skin integrity. All individuals will be assessed utilizing the Braden Scale on admission, quarterly, and at change of condition.

Pressure ulcers occur due to prolonged pressure of an area. The ulcers may occur at any site usually over the boney areas. (Example; buttocks of individuals confined to a wheelchair). The combination of pressure, friction, shearing forces, and moisture can lead to the breakdown of the skin tissue.

Signs and Symptoms:

1. Irritation
2. Redness
3. Blistering
4. Open areas of the skin (Ulcers)

PROCEDURES:

1. Individuals in wheelchairs are to be repositioned to relieve pressure as recommended per Physical Therapist.
2. Pressure reducing cushion for wheelchair as assessed by Physical Therapist.
3. Individuals will be checked frequently, and changed as needed to keep buttocks clean and dry.
4. Frequently check the individuals' bed linens to make sure they are clean and dry.
5. Individuals will receive good hydration and nutrition. (Menu's are prepared by Registered Dietitian).
6. The Direct Support Professional will document any changes in skin condition and/or any signs or symptoms of pressure ulcers:
   a. Documentation will be done in the ID notes.
   b. An incident report will be completed.
   c. The nurse will be immediately notified of any changes of skin condition.
7. The nurse will instruct the Direct Support Professional to have the individual remain off of the site until she/he can assess and evaluate. The nurse will document the skin changes in the nurses notes to include but not limited to size and location of the pressure area. (Reference: How to Measure Wounds Using the Disposable Ruler protocol.) Nurse will assess skin as needed and per MD order; reassess Braden Scale and implement any changes per scoring. (Reference: Braden Scale and Pressure Ulcer Preventions, per Braden Scale Score)
   a. The physician will be notified within 24 hours of noting the beginning of a pressure area.
   b. An appointment will be scheduled with the attending physician within 48 hours. (If unable to obtain an appointment with the attending physician the individual will be taken to an outside medical facility for evaluation.)
   c. The MD will diagnose the pressure area and stage if considered a pressure ulcer.
   d. Medication and/or treatments ordered by the MD will be initiated.
   e. The Physical Therapist will be notified of the possible pressure area and recommendations/instructions from the Physical Therapist will be implemented.
   f. The Registered Dietitian will be notified of possible pressure area.

483.460	
DATES	**SIGNATURE**
Issued Date: 12/06	Linda R. Kerns
Reviewed Date:	
Revised Date: 7/10; 11/10; 7/13, 3/18	Linda R. Kerns, LCSW Director of Community Living Versability Resources

Attachment
#15
Braden Scale for Predicting Pressure

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name _____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort..				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				Total Score				

Attachment
#16

Pressure Ulcer Preventions, per Braden Scale Score

Pressure Ulcer Prevention Interventions, per Braden Scale Score

Total Score	Risk Category	Interventions
All patients		Daily head-to-toe skin check Keep positioned off bony prominences Do not use diapers in bed Minimal linens on bed Use Calazime and Nutrashield as needed Keep skin moisturized with lotion Encourage eating and drinking Encourage mobility Do not massage reddened areas Turn regularly as indicated.
15-18	At Risk	**All of the above, plus** Use cushion on chair when sitting Limit sitting time to a maximum of two hours if patient is unable to reposition self Use draw sheet or mechanical lift to move patient Limit friction and shear
13-14	Moderate Risk	**All of the above, plus** Use positioning aids as needed Check frequently if incontinent Limit sitting time to one hour or less Pre-albumin levels every 4 days
10-12	High Risk	**All of the above, plus** PROM to all extremities
5-9	Very High Risk	**All of the above, plus** Flexicare Eclipse
Note: If patient has other major risk factors, such as advanced age, fever, low pre-albumin levels, hypotension, or is unstable, upgrade patient to a higher risk category.		

Additional Pressure Ulcer Prevention Interventions, per Braden Scale Sub-scale Score

If Sub-scale score is 1 or 2:	Intervention
Sensory Perception	Pay extra attention, looking for subtle signs of pressure damage, as the patient is not able to report pain
Moisture	Check frequently if incontinent Keep skin clean and dry Use Calazime on perineal area and buttocks Change linens as needed to keep skin dry A low-air-loss surface (Flexicare) may be beneficial
Mobility and Activity	Consider Physical Therapy referral if indicated Reposition frequently
Nutrition	Consider Dietitian consult Provide foods patient wants, as able Encourage eating Keep patient hydrated Consider diet supplementation Consider NG, GT, or TPN feeding if indicated
Friction and Shear	Use draw sheet or mechanical lift Keep head of bed low Consider PT referral if indicated

Attachment
#17

How to Measure Wounds Using the Disposable Ruler Protocol

How to Measure Wounds Using the Disposable Ruler Protocol

Size is determined in centimeters by measuring in order, Length x Width x Depth.

1. Using the "Wound Measurement Guide", measure the length of the wound. Measurements should be taken from open wound edge to open wound edge at the longest point. Direction of length is from head to toe or "clock method" 12:00 – 6:00.

2. Using the "Wound Measurement Guide", measure the width of the wound. Measurements should be taken from open wound edge to open wound edge at the longest point. Direction of width is from side to side or "clock method" 3:00 – 9:00.

3. The depth of a wound can be described as the distance from the visible surface to the deepest point in the wound. Using moistened cotton tip applicator, place into the depth of the wound to be measured, and grasp the applicator at skin level while still grasping applicator, remove from the wound and place next to "Wound Measurement Guide" to determine measurement. (The depth off a wound will be measured if area is deep enough to get a measurement).

4. Document findings in the nurse's notes.

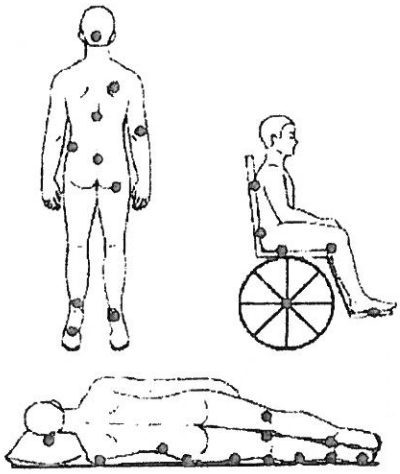
5. The ruler will be disposed of after each use.

Attachment
#18

Pressure Ulcer Prevention Hand-out

Pressure Ulcer Prevention
October 13th, 2008
Ed Heckler-Physical Therapy Consultant

1. What is a Pressure Ulcer?
    a. Injury usually caused by unrelieved pressure that damages the skin and underlying tissue.
    b. Can also be caused by friction, shearing forces, excessive moisture.
    c. Stage I-IV, Deep Tissue Injury and unstageable.
    d. Most are preventable
    e. Commonly occur over bony prominences.



2. Risk factors
    1. Chronic Bowel Incontinence
    2. Continuous urinary incontinence/chronic voiding dysfunction
    3. Paraplegia / Quadriplegia
    4. Severe Chronic Pulmonary Obstructive Problems
    5. Sepsis/ High Fevers
    6. Impaired mobility (bed or chair confinement)
    7. Poor nutrition
    8. Lowered mental awareness
    9. Age > 65
    10. Obesity
    11. Impaired sensation
    12. Terminal Disease: Cancer, Kidney, Liver, Heart/Lung
    13. Severe Peripheral Vascular Disease

3. Prevention strategies
    a. Skin checks-visualize skin particularly bony prominences
        i. Prolonged redness

ii. Blistering
iii. Open sores
iv. Any irritation

b. Clean, soft linen in beds
c. Provide space in toe area of bed
d. Use pressure reducing cushions
e. When assisting with moving and/or position changes avoid dragging/shearing
f. Eliminate excess moisture
g. Keep skin clean from urine and feces
h. Minimize swelling and/or lymphedema
i. Avoid/minimize foods that exacerbate incontinence:

Coffee/ Tea/Alcohol	Carbonated Sodas	Chocolate
Artificial Sweetener	Spicy Foods/ Tomato Based foods	Acidic Fruit Juices
Nicotine can irritate the Bladder	Smoker's Cough	Milk Products sometimes bothers People

j. Avoid uninterrupted sitting in chair or wheelchair- frequent position changes (Sidelying, prone and supine)
   i. In bed, change positions every 2 hours
   ii. In chair, change position every hour
   iii. In wheelchair, shift weight every 15 minutes.
k. Eat a well balanced diet. Protein and calories are very important.

Revised:

[redacted] 7-23-13

7/29/2013

7/30/13

[redacted] 3/7/18

Attachment
#19

VersAbility Resources
Fire Drill Log (1 pg)

VERSABILITY RESOURCES

CLOVERLEAF HOUSE ICF/IID

FIRE DRILL LOG

Year 2018

MONTH	DAY	SHIFT	TIME	CONDITION	INITIALS
JANUARY		A 7a-3p			
FEBRUARY		B 3p-11p			
MARCH		C 11p-7a			
APRIL		A 7a-3p			
MAY		B 3p-11p			
JUNE		C 11p-7a			
JULY		A 7a-3p			
AUGUST		B 3p-11p			
SEPTEMBER		C 11p-7a			
OCTOBER		A 7a-3p			
NOVEMBER		B 3p-11p			
DECEMBER		C 11p-7a			

REMINDER: Each drill must be performed under varied conditions. No 2 drills should occur under the same conditions if at all possible. Example: A shift drills are 7a-3p. No 2 drills should occur during the same time frame or for the same day of the week. Also be mindful of weather. Call drills in rain, snow, cold, heat etc.

Simple rule; break shifts up into 4, two hour intervals and be sure to hit each interval per year.

Example; A shift drill for January happened on Sat @ 8am. Aprils drill should not occur in that interval but sometime after 9am and not on Saturday.

Attachment
#20
Policy 97:

Conducting Fire and Safety Drills, pg. 1-2

Division: Community Living	Category: Physical Environment
Subject: Conducting Fire/Safety Drills	

Versability Resources
Cloverleaf House
ICF/IID
Policy and Procedures

SUBJECT: **Conducting Fire/Safety Drills**

NUMBER: **97**

POLICY: It is the policy of the Cloverleaf House to conduct Fire drills at the facility once per month and Safety drills quarterly. The Community Living Manager and staff will be responsible for conducting, monitoring, and documenting each drill--including putting the fire alarm system in and out of test.

PROCEDURES:

1. A Fire and Safety Drill will be conducted monthly, on varying shifts, during varying times, and during various weather conditions (e.g. rain, snow, cold, hot, etc.).
2. A Fire drill must also be conducted within the first 30 days following admission of a new resident.
3. The date and time of all Fire and Safety drills will occur randomly and should be unannounced.
4. Staff of Cloverleaf House will conduct and record fire, safety, and other emergency safety drills on the appropriate form (e.g. "VersAbility Resources Emergency Drill Response Record") and will record the type of drill conducted, individual/staff present, description of how the drill was initiated, the participants actions during and following the drill, evacuation start/end times, problems which may have interfered with evacuation, other areas for improvement, actions taken to improve the situation, etc. If problems arise during/following a drill that will limit an individual's ability to exit within 5 minutes, another drill must be conducted prior to the end of the same month until compliance is met
5. The Versability Resources Safety Committee will review drill reports and indicate procedures that could help improve the drill's effectiveness and efficiency in regards to safety, as well as, resolve any discrepancies.
6. Fire and Safety drills will be conducted based on the Versability Resources Safety Themes schedule (*see "Monthly Safety Themes list attachment)*
7. All residents will be supported by Cloverleaf House staff, if needed, to evacuate to a safe location outside the home during a drill or actual occurrence of Fire; and to a safe location (as applicable) during a drill or actual occurrence of a safety/emergency situation. The level and/or type of support provided to each individual will be based on their individual needs as assessed by their Comprehensive Functional Assessment and/or as support outlined in their ISP. The Support Coordinator/QIDP will be responsible for identifying special provisions required to evacuate, if necessary, in the Individual's ISP (e.g. type of wheelchair support, use of lifts, use of walker, etc.)
8. Fire extinguishers and smoke detectors will be checked monthly. Staff will complete the "Monthly Fire Extinguisher and Smoke Detector Check Off List" to indicate both are operating properly. If there is a problem or concern with the fire extinguisher or smoke detector, staff will contact the Facilities dept. immediately to report the problem and then follow-up with requesting repairs through NetFacilities

online.

9. Additional Safety or Fire Drills, along with associate reports may be conducted as needed and/or designated by the Safety Committee, and/or as directed by the Chief CL Officer, or CL Manager.
10. Cloverleaf House staff will receive training during Orientation on how to use the fire extinguisher and/or other fire and safety alarms. Staff will also receive training on the proper procedures for conducting Fire and Safety drills., including recognizing fire hazards (see Cloverleaf House Policy #23, Staff Training and Orientation)
11. The Versability Resources Facilities Department will conduct inspections of the Fire Alarms, Fire Extinguishers, Smoke Detectors, Generators at least annually and Sprinkler Systems quarterly. The Community Living Manager will report fire/safety equipment repair or replacement as needed from the Versability Resources Facilities Department via NetFacilities. In event there is a situation in which the fire detection/protection system do not work, Cloverleaf staff will follow procedures outlined in *Policy #97-1 Fire Watch policy*
12. A Safety Binder will be housed at Cloverleaf House and must include Fire and Safety drills conducted at the facility (both internal and external). The Quality Assurance Manager will review the binder quarterly to assure compliance with policy and assure Fire/Safety drills conducted randomly, alternating among shifts, times, and conditions. *(See attached Safety Binder Documents list.)*
13. The CL Assistant Manager will review the Safety Binder and complete the QA Fire/Safety Drill report and submit to the Chief Community Living Officer, Asst. Director of Community Living and QA Committee monthly.

	W438-- 451
DATES	**SIGNATURE**
Issued Date: 12/06	
Reviewed Date: 9/11; 1/15	
Revised Date: 02/06; 10/10; 7/11; 9/11, 2/13, 2/18	Linda R. Kerns Linda R. Kerns, LCSW Director of Community Living Versability Resources

Attachment
#21
Quality Assurance Quarterly Fire/Safety Drill Report

Versability Resources

COMMUNITY LIVING PROGRAM

Quality Assurance Quarterly Fire/Safety Drill Report

Program:_____ **Date of Review _____**

Month	Type of Drill	Drill occurred during month indicated *(Y) or (N)*	Drill occurred on varying shifts *(Y) or (N)*	Drill occurred randomly (different day and time, etc.) *(Y) or (N)*	Drill occurred during different weather conditions *(Y) or (N)*
January	**Medical Emergency/CI CPR**				
	Fire				
February	**OSHA/MSDS/Chemical Spill**				
	Fire				
March	**Vehicle Mishap**				
	Fire				
April	**Tornado**				
	Fire				
May	**Hail**				
	Fire				
June	**CPI Non-Violent Crisis Intervention**				
	Fire				
July	**Excessive Heat / Loss of**				

	A/C				
	Fire				
August	**Hurricane-Nor'easter**				
	Fire				
September	**Workplace Violence**				
	Fire				
October	**Blood Borne Pathogens**				
	Fire				
November	**Bomb Threat**				
	Fire				
December	**Blizzard**				
	Fire				

Comments:

Reviewer Signature **Date of Report**

Note: This form should be updated monthly and submitted to QA Committee representative for review.