STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G042	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HILTON HOUSE	703 HILTON BLVD NEWPORT NEWS, VA 23605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The unannounced annual 55 Fundamental Medicaid Certification survey was conducted on 08/30/16 through 09/01/16. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities. (ICF/ID) Federal Regulations. The Life Safety Code report will follow. The census in this 5 bed facility at the time of the survey was 4. The survey sample consisted of 2 current Individual records (Individual #1 through #2).	W 000	W153 Facility staff failed to immediately report an allegation of abuse. 1. Facility staff (DSP #1) failed to follow agency policy and procedures to report allegations of abuse. As a result, policies were reviewed and updated to highlight "immediate" reporting of abuse allegations, as well as, other incidents of neglect and exploitation. DSP #1, along with all ICF-IID Staff were re-trained on policy/procedures related to reporting incidents and/or allegations of abuse, neglect and exploitation. (Reference Attachment # 1: Policy #17--Individual Abuse, Neglect, Exploitation; Attachment #2: Policy #89-- Incident Reporting; and Attachment #3: VersAbility Resource administrative policy #1.00.000.07--Abuse, Neglect and Exploitation.)	9/14/16
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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 immediately report an allegation of abuse. The findings included: A review of an Incident/Injury Report dated 2/17/16 indicated facility staff failed to immediately report an allegation of abuse to the administrator or other officials. The Incident Report dated 2/17/16 indicated: "During the afternoon of 2/17/16 three staff members were leaving from Day Program at	W 153	2. No other residents were affected by this deficient practice and upon observation by Hilton House CL Manager , all residents were considered safe. Note: Also, following this incident, the Dental Hygienist provided training to all ICF-IID Facility Staff on proper toothbrushing techniques and Tips. 3. On 9/14/16 Hilton House staff were re-trained on the revised policies related to abuse, neglect and exploitation at their QIDP/Staff Meetings in September 2016. Emphasis was placed on reporting incidents,or suspicion thereof, "immediately". Staff were informed of disciplinary actions which may occur as a result of violating these policies. (Reference Attachment # 1: Policy	9/1/16 9/14/16

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

Linda R. Kerns, CCSW | Director of Community Living | 9-14-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 (Approximately 3:45 P.M.). Individual #1 was the first to get on the van. Staff noticed an odor coming from Individual #1's mouth. Staff (Direct Support Staff) DSP #1 stated Individual #1 will have an odor at times because she holds saliva in her mouth and over time, this creates an odor. As the conversation continued, DSP #2 wondered if Individual #1's toothbrush was contributing to the odor and other staff responding that the Community Living Manager replaces toothbrushes very frequently. DSP #1 stated the odor was coming from Individual 31 holding the saliva. At that point, DSP #3 said "She brushes Individual #1's teeth in the shower, saying she, "holds the water hose on her face until it takes her breath and then Individual #1 will open her mouth." DSP #1 was shocked she (DSP #3) said that, as she has never known anyone to have trouble with Individual #1 and brushing her teeth, and knew right then that was abuse. DSP #1 knew that DSP #3 would not be working with Individual #1 that evening since she was one-to-one with someone else, so at the conclusion of her shift, she went into her car and called (approximately 11:11 P.M.) the Community Living Manager and reported the allegation of abuse." DSP #3 was put on Administrative Leave immediately the next morning and scheduled for an interview. During the interview with DSP #3 she stated, she does brush individual #1's teeth in the shower. She does this because Individual #1 doesn't spit her saliva out or rinse well, so she has noticed when she (DSP #3) sprays water on her hair to	W 153	#17--Indiv. Abuse, Neglect, Exploitation; Attachment #2: Policy #89--Incident Reporting; and Policy #1.00.000.07--Abuse, Neglect &Exploitation.) All other ICF-IID staff were trained on the same policies at their QIDP/Staff Meetings in September, 2016. 4. The CL Manager will continue to educate staff on the proper procedures for reporting allegations and/or incidents of abuse, neglect and exploitation during new Employee Orientation and as a part of ongoing staff training. The CL Manager will continue to monitor staff performance monthly (at random) and document compliance with policy and procedures.	9/14/16

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W 153	Continued From page 2	W 153		

get shampoo out, the water goes on her face and she opens her mouth. DSP #3 said she does not "pulse the water in her face" but when she washes her hair, her mouth pops open.

Findings: There is finding of abuse on the part of DSP #3. DSP #1 reported immediately after her shift to the Community Living Manager what she heard. DSP #1 and DSP #2 were consistent in their written reports as well as during interviews. DSP #3 freely admitted she brushes Individual #1's teeth in the shower and uses the water to fall in her face to trigger her to open her mouth.

Individual #1 was admitted to the facility on 9/5/06 with diagnoses of cerebral palsy, mild scoliosis (sideways curvature of the spine), depression and profound intellectual disability.

A review of Individual #1's tooth brushing Program indicated: It is best to do oral hygiene while in the bathroom. This makes it easier to see what you are doing. It also relates being in a specific place with oral hygiene routines, Be sure to use a soft bristled tooth brush.
Only use a Pea-Size amount of toothpaste. Try to brush for 2 minutes, but if the individual starts to become agitated before 2 minutes is up, stop. Do not let tooth brushing become something undesirable. Brush in the AM, after Lunch, and in the PM.
If at any time a concern arises regarding an individual's oral health, be sure to relay your concerns to a nurse or house manager, who can then contact the dental hygiene consultant or the individuals's dentist for further evaluation.

During an interview on 8/31/16 at 10:30 A.M. with the Community Living Manager, she stated, "I

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W 153 Continued From page 3

could not understand why DSP #1 waited until after the shift was over to report the allegation of abuse. I was in the home until late that evening, she could have reported the incident to me at that time."

A review of the facility policy indicated: "All allegations of abuse must be reported immediately to the supervisor or an Administrator.

Facility staff failed to immediately report an allegation of abuse.

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

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 interviews, the facility staff failed to provide continuing training to immediately report an allegation of abuse.

The findings included:

A review of an Incident/Injury Report dated 2/17/16 indicated facility staff failed to immediately report an allegation of abuse to the administrator or other officials. The facility staff were not provided continuing training for handling allegations of abuse.

An Incident Report dated 2/17/16 indicated: "During the afternoon of 2/17/16 three staff members were leaving from Day Program at (Approximately 3:45 P.M.). Individual #1 was the

W 153 W 189

Staff failed to provide continuing training to immediately report an allegation of abuse.

1. DSP #1, along with all ICF-IID Staff, were re-trained on policy/procedures related to reporting incidents and/or allegations of abuse, neglect and exploitation. (Reference Attachment # 1: Policy #17--Individual Abuse, Neglect, Exploitation; Attachment #2: Policy #89-- Incident Reporting; and Attachment #3:VersAbility Resource administrative policy #1.00.000.07--Abuse, Neglect and Exploitation.) 9/14/16

W 189

2. Following this deficient practice, the Dental Hygienist provided training to Hilton House ICF-IID staff, as well as, all VersaAbility Resources ICF-IID Facility Staff on proper toothbrushing techniques and Tips. 3/17/16

3. On 9/14/16 Hilton House ICF-IID staff were re-trained on the revised policies related to abuse, neglect and exploitation at their QIDP/Staff Meetings in September 2016. Emphasis was placed on reporting incidents,or suspicion thereof, "immediately". Staff were informed of disciplinary actions which may occur as a result of violating these policies. (Reference Attachment # 1: Policy #17--Indiv. Abuse, Neglect, Exploitation; Attachment #2: Policy #89--Incident Reporting; and Policy #1.00.000.07--Abuse, Neglect &Exploitation.) All other ICF-IID staff were trained on the same policies at their QIDP/Staff Meetings in September, 2016. 9/14/16

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W 189	Continued From page 4 first to get on the van. Staff noticed an odor coming from Individual #1's mouth. Staff (Direct Support Staff) DSP #1 stated Individual #1 will have an odor at times because she holds saliva in her mouth and over time, this creates an odor. As the conversation continued, DSP #2 wondered if Individual #1's toothbrush was contributing to the odor and other staff responding that the Community Living Manager replaces toothbrushes very frequently. DSP #1 stated the odor was coming from Individual #1 holding the saliva. At that point, DSP #3 said "She brushes Individual #1's teeth in the shower, saying she, "holds the water hose on her face until it takes her breath and then Individual #1 will open her mouth". DSP #1 was shocked she (DSP #3) said that, as she has never known anyone to have trouble with Individual #1 and brushing her teeth, and knew right then that that was abuse. DSP #1 knew that DSP #3 would not be working with Individual #1 that evening since she was one-to-one with someone else, so at the conclusion of her shift, she went into her car and called (approximately 11:11 P.M.) the Community Living Manager and reported the allegation of abuse." DSP #3 was put on Administrative Leave immediately the next morning and scheduled for an interview. During the interview with DSP #3 she stated she does brush individual #1's teeth in the shower. She does this because Individual #1 doesn't spit her saliva out or rinse well, so she has noticed when she (DSP #3) sprays water on her hair to get shampoo out, the water goes on her face and	W 189	4. The CL Manager will continue to educate staff on the proper procedures for reporting allegations and/or incidents of abuse, neglect and exploitation during new Employee Orientation and as a part of ongoing staff training. Signature sheets will be maintained for all trainings. The CL Manager will continue to monitor staff performance monthly (at random) and document compliance as well.	9/1/16

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W 189	Continued From page 5	W 189		

she opens her mouth. DSP #3 said she does not "pulse the water in her face" but when she washes her hair, her mouth pops open.

Findings: There is finding of abuse on the part of DSP #3. DSP #1 reported immediately after her shift to the Community Living Manager what she heard. DSP #1 and DSP #2 were consistent in their written reports as well as during interviews. DSP #3 freely admitted she brushes Individual #1's teeth in the shower and uses the water to fall in her face to trigger her to open her mouth.

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During an interview on 8/31/16 at 10:30 A.M. with the Community Living Manager, she stated, "I could not understand why DSP #1 waited until after the shift was over to report the allegation of abuse. I was in the home until late that evening, she could have reported the incident to me at that time."

The Community Living Manager was asked if staff received training on reporting abuse following this incident, she stated, "No." We only had training on Individual #1's tooth brushing program.

A review of the facility policy indicated: "All allegations of abuse must be reported immediately to the supervisor or an Administrator.

Facility staff failed to provide continuing training on issues of reporting immediately an allegation of abuse.

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