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

PRINTED: 09/06/2018 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	- 16 ·	PLE CONSTRUCTION	(XJ) DATE SURVEY COMPLETED		
		49G069	B. WING	25-79	09/05/2018		
NAME OF P	POVIDER OR SUPPLIER		STREET ADDRESS, CITY. STATE. ZIP CODE 529 RIVERVIEW ROAD MADISON HEIGHTS, VA 24572				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE	D BE COMPLETION		
E 000	survey was conduct. The facility was in significant. CFR Part 483.73, Record Facilities. No during the survey. INITIAL COMMENT. An unannounced Free-certification survey through 09/5/18. The compliance with 42 for Intermediate Call with Intellectual Disa Safety Code survey, complaints were invested in the survey complaints were invested of 2 Individual two). PROGRAM IMPLET CFR(s): 483.440(d) As soon as the interformulated a client's each client must record treatment program of interventions and seand frequency to survey.	undamental Medicaid by was conducted 09/4/18 the facility was not in CFR Part 483 Requirements for Facilities for Individuals abilities (ICF/110). The Life foreport will follow. No frestigated during the survey. If certified bed facility was 4 at fey. The survey sample foreport will follow as 4 at foreport will follow as 5 at foreport will follow as 6 at forepo	WOO	a. Resident #2's IPP was cha 9/12/18 to reflect that oral is to be completed twice da 2.) Address how the facility will identify occurrences of the problem a. All individuals' IPPs in reviewed for similar iss 9/14/18 by the QIDP. b. If any care is indicated du day while the individual is support or other activity, i amended as needed by 9/1 the QIDP. 3.) Identify measures/systemic changes to deficient practices will not recur. a. The IPPs, Flow Sheets and Care Plans will be review compared monthly by the QIDP to ensure they agreement with one another b. If an order changes dur month, the IPPs, Flow She Nursing Care Plans is amended to reflect the within 48 hours. c. If the plan requires drastic training of the staff will during their next working the Residential Managinstructor-Counselor. RECEIVE	nged on hygiene illy. y similar will be sues by tring the s at day t will be 14/18 by Densure Nursing wed and RN and are in er. ring the eets and will be change change Il occur shift by ger or		
		not met as evidenced by: on, record review and staff		SEP 1 8 2018 VDH/OL			

BORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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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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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	II Marine Marine and		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		49G069	BWING	<u> </u>		09/	05/2018
NAME OF I	PROVIDER OR SUPPLIER			52	REET ADDRESS, CITY STATE, ZIP CODE 9 RIVERVIEW ROAD ADISON HEIGHTS, VA 24572		
(X4) 10 PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C 1 DENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTME ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)) BE	IX5) COMPLETION DATE
	active treatment plathe survey sample, The facility did not pread as indicated in treatment plan. The findings include Resident #2 was as 8/26/2014 with an inprofound and a merperiodontal disease. On 9/4/18 at 11:15 observed at the day the total assistance Resident #2's active being reviewed at the documented to provimeal of [sic] tooth pure After the completion to engage in tactile of activities this survey care person (DCP #Resident #2. When Resident #2. When Resident #2. When Resident #2. DCP # the day program do Review of Resident #2. On 9/5/18 at 9:45A presented to the facadministrator.	y failed to implement the an for one of 2 Individuals in Resident #2. provide oral care after each a Resident #2's active did that Resident #2 was a look a treatment record was also the time of the observation and wide "oral hygiene after each activities. After five minutes a veyor interviewed the direct #1) that had been feeding asked about oral care for a look and activities. After five minutes a look about oral care for a look about oral care for a look and activities. After five minutes a look about oral care for a look about oral care for a look about oral care. #2's last dental exam dated at that Resident #2 had a fitting from the look and a l	W2	249	 4.) Indicate how facility will mon performance. a. The IPPs, Flow Sheets and Nurse Plans will be reviewed and comonthly by the RN and QIDP to they are in agreement with one are b. If an order changes during the milPPs, Flow Sheets and Nursing Ciwill be amended to reflect the within 48 hours. c. If the plan requires drastic change of the staff will occur during the working shift by the Residential or Instructor-Counselor. 	ompared or ensure nother. onth, the are Plans change training neir next	9/14/18
ORM CMS-2	567(02-99) Previous Vers10ns	Obsolete Event ID: YGU7	11	Faal	IITY ID VAICEID75 If contin	Leation she	et Page 2 of 3
					orp 10	2010	

PRINTED: 09/06/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED ABUILDING-----B. WING 49G069 09/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE. ZIP CODE 529 RIVERVIEW ROAD **BOWYERICF** MADISON HEIGHTS, VA 24572 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG

W 249 Continued From page 2

W249

No other information was presented prior to exit conference on 9/5/18.

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DEFICIENCY)

An unannounced Emergency Preparedness survey was conducted 09/04/2018 through 09/05/2018. The facility was in substantial compliance with 42 CFR Part 483 Requirements for intermediate Care Facilities. No complaints were investigated during the survey. What Complaints were investigated during the survey. The cansus in this 4 certified bed facility was a at the time of the survey. The survey is main fundividual #1. The facility must develop and implement written policies and procedure was offectively conducted to ensure that one of two individuals was free from neglect, individuals #1 and individual#1 was not properly buckled in the linked time review, the facility swas of the client. An unannounced Fundamental Medicaid re-certification survey was conducted 09/04/2018 through 09/05/2018. The facility was not in compliance with 42 CFR Part 483 Requirements for intermediate Care Facilities. No complaints were investigated during the survey. What is started to properly the survey was conducted 09/04/2018 through 09/05/2018. The facility was not in compliance with 42 CFR Part 483 Requirements for intermediate Care Facilities in Individuals #1. An unannounced Fundamental Medicaid re-certification survey was conducted 09/04/2018 through 09/05/2018. The facility was not in compliance with 42 CFR Part 483 Requirements for intermediate Care Facilities for Individuals was not in compliants were investigated during the survey. The cansus in this 4 certified bed facility was 4 at the time of the survey. The survey sample consisted of 2 Individual reviews (Individual #1 and Individual #2). W149 STAFF TREATMENT OF CLIENTS CFR(s): 493.420(0)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	\$2000-00	1979	AND HUMAN SERVICES				_		APPR		
NAME OF PROVIDER OR SUPPLIER WARRENI CF WARRENI CF STRIET ADDRESS CITY, STATE ZIP CODE 527 RIVERVIEW ROAD MADISON HEIGHTS VA 24572 MADISON HEIGHTS VA 24572 MADISON HEIGHTS VA 24572 FREGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced Emergency Preparedness survey was conducted 09/04/2018 through 09/05/2018. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities No complaints were investigated during the survey. W 000 INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 09/04/2018 through 09/05/2018. The facility was not in compliance with 42 CFR Part 483.73, Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFILID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 4 certified bed facility was 4 at the time of the survey. The survey sample consisted of 2 Individual #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 staff interview, clinical record review and facility document review, the facility staff failed to ensure that one of two individuals was free from neglect, Individual#1.	6 A-900			(VOLMUII	TIDLE	CONCTOU		The state of the s		value of the contract of	1
NAME OF PROVIDER OR SUPPLIER WARRENICF SIMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PRETIX EACH DEFICIENCY MUST RE-PRECEDED BY PULL REGULATORY OR LISCIDENTIFYING INFORMATION) PRETIX An unannounced Emergency Preparedness survey was conducted 09/04/2018 through 09/05/2018. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. No complaints were investigated during the survey. W 000 INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 09/04/2018 through 09/05/2018. The facility was not in compliance with 42 CFR Part 483.73, Requirements for Intermediate Care Facilities (CFIIID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 4 certified bed facility was 4 at the time of the survey. The survey sample consisted of 2 Individual are views (Individual #1 and Individual #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. W149 This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure that one of two individuals was free from neglect, Individual#1, and individual#1, and facility and one of two individuals was free from neglect, Individual#1, and individual#2, and facility and develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.				1 1000 100				GR 50: 50 50513 2			
WARRENICF X4)1D SUMMARY STATEMENT OF DEFICIENCIES FROM PROPERTY FROM ADISON HEIGHTS, VA 24572			49G068	B. WING		2 0		09/	05/201	18	
MADISON HEIGHTS, VA 24572 MADISON HEIGHTS, VA 24572	NAME OF	PROVIDER OR SUPPLIER									
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced Emergency Preparedness survey was conducted 09/04/2018 through 09/05/2018. The facility was in substantial complaints were investigated during the survey. W 000 INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 09/04/2018 through 09/05/2018. The facility was not in complaints were investigated during the survey. An unannounced Fundamental Medicaid re-certification survey was conducted 09/04/2018 through 09/05/2018. The facility was not in complaints were investigated during the survey. The census in this 4 certified bed facility was 4 at the time of the survey. The survey sample consisted of 2 Individual reviews (Individual*1 and Individual #2). W 149 W 149 This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure that one of two individuals was free from neglect, Individuals*1.	WARRE	NICF									
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The census in this 4 certified bed facility was 4 at the time of the survey. The survey sample consisted of 2 Individual reviews (Individual #1 and Individual #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. W149 This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure that one of two individuals was free from neglect, Individual#1.		re-certification surve through 09/05/2018 compliance with 42 for Intermediate Car with Intellectual Disa Safety Code survey/	ey was conducted 09/04/2018 The facility was not in CFR Part 483 Requirements e Facilities for Individuals abilities (ICFIIID). The Life freport will follow. No			2.) Add occi	incident found neglect and it performance issues related to to the Staff A resigned pending discipant of the Staff B's performance issues addressed and documented. The staff B's performance issues addressed and documented. The staff B's performance issues addressed and documented.	dentified wo staff. Dine and ss were			
This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure that one of two individuals was free from neglect, Individual#1. c. Horizon Behavioral Health policy prohibits abuse, neglect and/or maltreatment. Both staff involved had been trained upon hire and annually. The reporting mechanism and investigation procedure was effective in determining neglect in this instance.	W 149	the time of the surver consisted of 2 Individual #2). STAFF TREATMENT CFR(s): 483.420(d)(The facility must devipolicies and procedure.	ey. The survey sample dual reviews (Individual #1 T OF CLIENTS (1) (1) (1) (2) (3) (4) (5) (6) (7) (7) (7) (8) (8) (9) (9) (1) (1) (1) (1) (2) (3) (4) (5) (6) (7) (7) (7) (7) (8) (9) (9) (1) (1) (1) (1) (1) (1	W1.	49		properly buckling residents wheelchair-accessible vehicles u and at least annually thereafte Residential Manager and In Counselor. Staff will receive training re proper medical follow up regard and vehicle incidents/accidents u and at least annually thereafte	into all pon hire r by the structor- ated to fing falls pon hire			
facility van during an outing. When all turn was		This STANDARD is Based on staff intervand facility document failed to ensure that free from neglect, Individual#1 was not	not met as evidenced by: riew, clinical record review t review, the facility staff one of two individuals was dividual#1.			c.	Horizon Behavioral Health prohibits abuse, neglect maltreatment. Both staff invol been trained upon hire and annu reporting mechanism and inve procedure was effective in det	and/or ved had ally. The stigation	VDH/OLC	SEP 1 8 2018	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

ny defiCiency statement ending with an asterisk (*) denotes a defleiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days sollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						9 09	0938-0391		
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER: 49G068			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED			
		B.WING	i i		09/05/2018				
NAME OF PROVIDER OR SUPPLIER WARREN ICF				52	REET ADDRESS, CITY, STATE, ZIP CODE 17 RIVERVIEW ROAD ADISON HEIGHTS, VA 24572	10	<i>310312</i>	010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COM	(X5) MPLETIO DATE	N
W 149	made Individual#1 sustained an injury. Findings were: As part of the entrar 09/04/2018 the Res Program Manager vincluding but not lim within the previous investigations/allegasince the last surveidentified as a new and a substantiated June 18, 2018. This survey sample and Individual #1 had the limited to: Profound osteoporosis, dysphological materials of the facility investigations/allegasince the last surveidentified as a new and a substantiated June 18, 2018. This survey sample and Individual #1 had the limited to: Profound osteoporosis, dysphological materials in the facility investigation of t	feU from her wheelchair and feU from her wheelchair and sidential Manager and the were asked for information nited to: New admissions six months and any ations of abuse or neglect y. One indivudal was admission as of 04/19/2018 allegation of neglect as of individual was added to the identified as Individual #1. In following diagnoses, but not Intellectual disability, agia, and diverticulosis. Ition was reviewed on tained the following tatement of the problem or see names] were transporting to other clients on an outing 7, 2018. [Name] was driving a u-turn they heard a back to see that [Individual wheelchair and was on the me] pulled over and [name]	w	149	Manager will track trainings to en staff receives training related to buckling residents into all whe accessible vehicles upon hire and annually thereafter.	properly eelchairat least sidential properly the mance. Sidential properly eelchairat least sidential issure all properly eelchairat least sidential issure all properly eelchairat least sidential issure all proper ills and	VDH/OLC	SEP 1 8 2018	RECEIVED

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TATEMENT OF DEFICIENCIES (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE S COMPL			
		49G068	B. WING			0910	51201	8
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIPCODE 527 RIVERVIEW ROAD MADISON HEIGHTS, VA 24572			
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	that is not secured should be secured [Name] reported that belt but she recalls van and doesn't know heelchair to the flareported that [Individual to unhook the belt of that when staff are that one staff works the clients in the validin't know if [Individual that was buckled and shooked her up approached to buckle [Individual that who secure while in human rights violatification of this was not secure while in human rights violatification to buckle findividual transporting [Individual that was straps secured that was straps secured that was straps secured to 109/05/2018 at a program manager was above information. Employees involved incident and the oth (09/05/2018). She sincident staff training how to secure indivitransporting and a mimplemented to hav behind each other to were securely buckled.	while she is in the home but it while being transported. at she forgot to secure that securing the other belts in the bw how she fell from her bor of the van. [Name] dual #1] may have been able on her own [Name] reported taking clients out on an outing the lift and the other buckles in [Name] stated that she idual #1's] wheelchair strap ine doesn't know if [name] repriately in the van [Individual#1] was the van. This is a founded on of neglect. While lual#1J in the agency van staff in appropriately. [Individual severe not buckled nor were ined. Due to this [Individual neelchair and sustained	W1	49		VDH/OLC	SEP 1 8 2018	RECEIVED

PRINTED: 09/06/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPSER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION TATEMENT OF DEFICIENCIES COMPLETED ND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING----49G068 B WING 09/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 527 RIVERVIEW ROAD WARRENICF MADISON HEIGHTS, VA 24572 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4)1D ID (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** OATE REGULATORY OR LSC IDENnFYINGINFORMATION) CROSSREFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 149 Continued From page 3 W149 [Individual#1] had a fracture. The facility notes from time period of the incident were requested and reviewed. The following information was included: "06/17/2018 She obtain [sic) a fall this afternoon while on an outing approx. 1:40 p.m. Bruise noted to the right outer corner of eye. Abrasion noted to right arm near elbow and red mark noted to the right lower leg...She was transported to [hospital] for evaluation... "06/17/2018 [Individual#1] arrived back from [hospital)@ [at] 8:15p.m. transported by staff worker...bruises to the right side of her eye, bottom of left foot bruised, left ankle swollen, also bruise to the right side of back. No broken bones..." "06/19/2018 Observed bruising to bottom of left foot and swelling on top of foot and around ankle..taken to ER for evaluation..." "06/20/2018 Accompanied [Individual#1] to [hospital] to evaluate bruising and swelling to left foot. [Individual#1] was seen first in radiology for a 3 view X-ray of the left foot. She was moved to the X-ray table via two person lift and tolerated

the X-rays weii...She was seen by [Doctor's name] who stated that her "bones were like paper" but that he didn't observe any breaks. He did say that it was possible that she may have a tiny fracture, but that he did not see it, and

planned to pass her X-rays to Radiology for those doctors to look at and he added that we would be notified of anything they found...he diagnosed her with a contusion to the foot and advised her to follow-up with her primary care physician..."

The facility policy regarding abuse and neglect contained the following statement: In receiving all services at [company name], each indivudal had

		HAND HUMAN SERVICES E & MEDICAID SERVICES		=	OM	FORM IB NO.	APPRO\ 0938-03	/ED 391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIERICLIA	362 0	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		49G068	B.WING		09/05/2018			
NAME OF F	PROVIDER OR SUPPLIER		202	STREET ADDRESS, CITY, STATE, ZIP CO	DE			
WARREN	NICF			527 RIVERVIEW ROAD MADISON HEIGHTS, VA 24572				
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W 149	abuse, neglect and	otected from harm including, l exploitation." ion was obtained prior to the	W1	49				
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