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 |
|---|---|---|---|
| | 49G063 | A. BUILDING ____ B. WING ____ | 09/07/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HIGHLANDS PLACE WEST | 1825 ROKEBY AVENUE CHESAPEAKE, VA 23320 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 09/05/18 through 09/07/18. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No complaints were investigated during the survey. | E 000 | | |
| E 004 | Develop EP Plan, Review and Update Annually CFR(s): 483.475(a)<br><br>[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]<br><br>* [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.<br><br>The emergency preparedness program must include, but not be limited to, the following elements:]<br>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.<br><br>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and | E 004 | An all Hazardous Risk Assessment was completed as stated in Emergency Preparedness Plan; however, a risk assessment and associated strategies were not completed on January snow storm. The Emergency was reviewed and revised on 9/19/18. The emergency plan delineates "Highlands Place will conduct a risk analysis with associated strategies on any event causing disruption or has the potential to cause disruption in the normal operational services of Highlands Place. The Emergency Plan will be reviewed and updated in accordance with the risk analysis of each event." A risk analysis and associated strategies were conducted on September 2018 Hurricane / Tropical Storm resulting in the update of Emergency Plan on 9/17/18. Staff will be trained on updates by 10/05/18.<br><br>AOC Date – 10/15/18 | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Program Supervisor (X6) DATE: 9/21/18

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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| E 004 | Continued From page 1<br>maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to have documentation of the facility's risk assessment and associated strategies.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 10:10 A.M. with the Program Manager and the Intellectual Residential Service Director they were asked for documentation for the facility based risk assessment and strategies for addressing the facilities Emergency Program Plan which included the risk of a January snow storm. The Intellectual Residential Service Director stated, the facility had not conducted a risk analysis of the Emergency Program Plan. | E 004 | | |
| E 006 | Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. | E 006 | An all Hazardous Risk Assessment with associated strategies listed under Annex-Response Types was completed as stated in Emergency Preparedness Plan; however, a risk assessment and associated strategies were no completed on January snow storm. The Emergency was reviewed and revised on 9/19/18. The emergency plan delineates "Highlands Place will conduct a risk analysis with associated strategies on any event causing disruption or has the potential to cause disruption in the normal operational services of Highlands Place. | |



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| E 006 | Continued From page 2<br>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to have documentation of the facility's risk assessment and associated strategies.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 10: 15 A.M. interview with the Program Manager and Intellectual Residential Service Director they were asked for documentation for the facility based risk assessment and strategies for addressing emergency events identified by the risk assessment. The Intellectual Residential Service Director stated, the facility had not conducted nor identified any strategies.<br><br>The facility staff failed document strategies for addressing emergency events identified by the risk assessment. | E 006 | The Emergency Plan will be reviewed and updated in accordance with the risk analysis of each event." A risk analysis and associated strategies were conducted on September 2018 Hurricane / Tropical Storm resulting in the update of Emergency Plan on 9/17/18. Staff will be trained on updates by 10/05/18.<br><br>AOC Date – 10/15/18 | |
| E 007 | EP Program Patient Population<br>CFR(s): 483.475(a)(3) | E 007 | Highlands Place Emergency Preparedness Plan identified the persons affected by the plan, delegation of authority and services provided during | |

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| E 007 | Continued From page 3<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]<br><br>(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**<br><br>*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.]<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview the facility staff failed to have documentation of the facility's patient population that would be at risk during an emergency and the strategies the facility have in place to address their needs. Also, the facility failed to have written delegation of authority and how the facility plan to continue to operate during an emergency.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 10:25 A.M. with the Program Manager and the Intellectual Residential Service Director, they were asked for documentation that Individuals in the facility had been identified who were at risk and the types of services needed. The facility staff stated, they had not identified individuals based on their risk nor had services been identified.<br><br>The facility staff failed to identify at risk individual's during an emergency. | E 007 | an emergency; however, a detailed description of population at risk, specific needs required by at risk population and a description of Essential Staff required to work during emergency were not identified in the plan. The Emergency Preparedness Plan was reviewed and updated on 9/19/18. Section labeled Person Affected was updated to include " Highlands Place serves Individuals who are severe to profound Intellectually Disable with severe speech impairments and limited physical mobility. Highlands Place identifies individuals needing additional assistance as those who PCP denotes a two person support. Staff will physically support individuals with severely limited mobility (non-ambulatory) while providing verbal and gestural support to ambulatory individuals on point of exit from building. Adaptive equipment (wheelchairs, gait belts, mobility sleds) will be utilized to support transporting out of building and providing continuation of services. In addition, adaptive equipment listed in each individuals' PCP will be made available for continuation of services. Staff will be trained on updates by 10/05/18.<br><br>AOC Date – 10/15/18 | |

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| E 013 | Development of EP Policies and Procedures<br>CFR(s): 483.475(b)<br><br>(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.<br><br>*Additional Requirements for PACE and ESRD Facilities:<br><br>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.<br><br>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These | E 013 | Annex C-Communication of the Emergency was not updated to include all methods utilized by Highlands Place to communicate and coordinate care with emergency management services. Annex C –Communication of the Emergency Plan was reviewed and updated on 9/19/18. The plan states "Highlands Place will follow procedures of the Chesapeake Integrated Behavioral Healthcare for the dissemination of information by email, telephone, fax, intranet posting, internal mailing, Chesapeake Alert System, Facebook, City Employee Alert Hotline, television, radio broadcasting and satellite radio with two way radio communications with Emergency Operation Center (EOC) for Chesapeake for periodic reports of status on Highlands Place." The communication plan was updated to include use of panic button as mode of communication. The plan states "Highlands Plane has a panic alarm system that provides a quick way to alert emergency personnel. If emergency occurs, staff will press the panic button to activate emergency services. All staff at the beginning of shift will check out a panic button and will return it at end of shift. Panic button is a wireless system with two 3VDC lithium batteries. | |



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| E 013 | Continued From page 5<br>emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview the facility staff failed review and update the communication plan.<br><br>During an interview on 09/06/18 at 10:35 A.M. with the Program Manager and the Intellectual Residential Service Director they were asked for documentation that the facility's communication plan had been reviewed and updated. The Residential Service Director stated, the communication plan had not been updated.<br><br>The facility staff failed to review and update its communication plan. | E 013 | Panic button will be tested quarterly to ensure functioning properly." Also, communication plan was updated to include tracking system and occupancy. Staff will be trained on updates by 10/05/18.<br><br>AOC Date – 10/15/18 | |
| E 015 | Subsistence Needs for Staff and Patients<br>CFR(s): 483.475(b)(1)<br><br>[(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:<br><br>(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:<br>(i) Food, water, medical and pharmaceutical | E 015 | Highlands Place emergency plan states" hotel accommodations will be utilized when sheltering outside of facility."; however, no written agreement for hotel accommodations has been secured. The Program Supervisor will work with the Director of Administration Services to secure a written RFP for hotel accommodation when sheltering outside of facility. If emergency situation occurs prior to final approval of RFP, Highlands Place will utilize the informal agreement for hotel accommodations currently established with Holiday Inn | |

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| E 015 | Continued From page 6<br>supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(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:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to provide documentation for provisions of subsistence when evacuating to a hotel.<br><br>The findings included: | E 015 | Express in Ashland. Va., Embassy Suites, Inc. and Delta in Chesapeake, Va.<br><br>AOC Date-10/15/18 | |

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| E 015 | Continued From page 7<br><br>During an interview on 09/06/18 at 11:05 A.M. with the Program Manager and the Intellectual Residential Service Director, they were asked for documentation that the facility had the contracts with hotels in the event of evacuation. The Program Manager and the Intellectual Residential Service Director stated they were working on securing hotel contracts with various vendors. The staff stated, the facility did not have a written agreement for hotel accommodations.<br><br>The facility staff failed to have a written agreement for hotel accommodations including subsistence needs. | E 015 | | |
| E 018 | Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2)<br><br>[(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:]<br><br>(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.<br><br>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] | E 018 | Highlands Place Emergency Plan included a tracking form for listing the location of staff and Individuals before during and after an emergency event; however, the emergency plan not describe the process of utilization of the form. The Emergency Preparedness Plan of Highlands Place was reviewed and updated on 9/19/18. The plan states "Tracking Form (attachment C3) will be initiated at onset of emergency event upon the closing of City of Chesapeake or the activation of Emergency Operation Center (EOC). The Tracking Form will include documentation of Individuals and on-duty staff locations before, during and after emergency event as well as the notification of | |



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| E 018 | Continued From page 8<br>Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.<br><br>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.<br>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.<br>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.<br><br>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br><br>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual | E 018 | Authorized Representative / Legal Guardian, staff, Emergency Operation Center, DBHDS, Emergency Response Agencies and American Red Cross of Southeastern Virginia. The tracking form will be updated with each change of location. In accordance with Highlands Place Policies and Procedures, an identification card will be placed on the individual via shirt pocket, pant pocket or any garment consisting of pockets whenever individual exits the facility." Staff will be trained on updates by 10/05/18.<br><br>AOC Date – 10/15/18 | |

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| E 018 | Continued From page 9<br>donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.<br><br>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to have documentation of an Emergency Preparedness tracking system.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 11:24 A.M. with the Program Manager and the Intellectual Residential Service Director, they were asked for documentation of the facility's emergency preparedness tracking system in the event Individuals and staff are relocated during an emergency. The staff stated, they did not have a tracking system.<br><br>The facility staff failed to have a tracking system during an emergency. | E 018 | | |
| E 029 | Development of Communication Plan<br>CFR(s): 483.475(c)<br><br>(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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to update the communication plan to include coordination with emergency | E 029 | Annex C-Communication of the Emergency was not updated to include all methods utilized by Highlands Place to communicate and coordinate care with emergency management services.<br>Annex C –Communication of the Emergency Plan was reviewed and updated on 9/19/18. The plan states " Highlands Place will follow procedures of the Chesapeake | |



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| E 029 | Continued From page 10 management agencies. <br><br> The findings included: <br><br> During an interview on 09/06/18 at 12:10 P.M. with the Program Manager and the Intellectual Residential Service Director they were asked for documentation of communication for the coordination of care with emergency management agencies and services. The staff stated, they had not updated there communication plan to include the coordination of care with Emergency Management Service. <br><br> The facility staff failed to update the communication plan. | E 029 | Integrated Behavioral Healthcare for the dissemination of information by email, telephone, fax, intranet posting, internal mailing, Chesapeake Alert System, Facebook, City Employee Alert Hotline, television, radio broadcasting and satellite radio with two way radio communications with Emergency Operation Center (EOC) for Chesapeake for periodic reports of status on Highlands Place." The communication plan was updated to include use of panic button as mode of communication. The plan states "Highlands Plane has a panic alarm | |
| E 030 | Names and Contact Information <br> CFR(s): 483.475(c)(1) <br><br> [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] 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:] <br><br> (1) Names and contact information for the following: <br> (i) Staff. <br> (ii) Entities providing services under arrangement. <br> (iii) Patients' physicians <br> (iv) Other [facilities]. <br> (v) Volunteers. <br><br> *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: | E 030 | system that provides a quick way to alert emergency personnel. If emergency occurs, staff will press the panic button to activate emergency services. All staff at the beginning of shift will check out a panic button and will return it at end of shift. Panic button is a wireless system with two 3VDC lithium batteries. Panic button will be tested quarterly to ensure functioning properly." Also, communication plan was updated to include tracking system and occupancy. Staff will be trained on updates by 10/05/18. <br><br> AOC Date – 10/15/18 | |

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| E 030 | Continued From page 11<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Next of kin, guardian, or custodian.<br>(iv) Other RNHCIs.<br>(v) Volunteers.<br><br>*[For ASCs at §416.45(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For Hospices at §418.113(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Hospice employees.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Other hospices.<br><br>*[For OPOs at §486.360(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Volunteers.<br>(iv) Other OPOs.<br>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the | E 030 | The Emergency Preparedness Plan Annex C-Communication was updated to include coordination of care with emergency management services. Annex C-Communication Plan was reviewed and updated on 9/19/18 to include an Emergency Directory. The plan states "The CIBH's communication resources will be utilized to communicate and coordinate care with Emergency Management Services. Emergency contact information for staff, entities providing services under agreement, Individuals' primary care physician and facilities is included in Emergency Directory (attachment C1)." Staff will be trained on updates by 10/05/18.<br><br>AOC Date-10/15/18 | |

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| E 030 | Continued From page 12<br>facility staff failed to review and update its Communication Plan to include coordination of care with emergency management agencies.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 12:28 P.M. with the Program Manager and the Intellectual Residential Service Director they were asked for documentation of the Communication Plan being review and updated. The staff stated, they had not updated there Communication Plan to include the coordination of care with Emergency Management Service.<br><br>The facility staff failed to review and update its Communication Plan. | E 030 | | |
| E 031 | Emergency Officials Contact Information<br>CFR(s): 483.475(c)(2)<br><br>[(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:<br><br>(2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br><br>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, or local emergency preparedness staff.<br>(ii) The State Licensing and Certification Agency.<br>(iii) The Office of the State Long-Term Care | E 031 | Highland Place Emergency Plan did not include an emergency officials' contact list. Annex C-Communication Plan was reviewed and updated on 9/19/18 to include an Emergency Directory. The plan states "The CIBH's communication resources will be utilized to communicate and coordinate care with Emergency Management Services. Emergency contact information for staff, entities providing services under agreement, Individual's primary care physician and neighboring facilities is included in Emergency Directory (attachment C1)." Staff will be trained on updates by 10/05/18.<br><br>AOC Date-10/15/18 | |



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| E 031 | Continued From page 13<br>Ombudsman.<br>(iv) Other sources of assistance.<br><br>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br>(iii) The State Licensing and Certification Agency.<br>(iv) The State Protection and Advocacy Agency.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to document emergency officials contact Information in the communication plan.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 12: 41 P.M. with the Program Manager and the Intellectual Residential Service Director they were asked for documentation of the Communication Plan Emergency Officials contact information. The staff stated, they had not updated there Communication Plan to include Emergency Officials contact information.<br><br>The facility staff failed to document Emergency Management Officials contact information. | E 031 | | |
| E 034 | Information on Occupancy/Needs<br>CFR(s): 483.475(c)(7)<br><br>[(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: | E 034 | Occupancy policy was not included in communication plan. The Emergency Preparedness Plan was reviewed and updated on 9/19/18. Annex C-Communication was updated to include Highlands Place's occupancy policy. The plan states "In compliant with federal, state and local regulations on | |

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| E 034 | Continued From page 14<br><br>(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.<br><br>*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.<br><br>*[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to have documentation about the facility's occupancy needs and its ability to provide assistance.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 12:56 P.M. with the Program Manager and the Residential Service Director, they were asked for documentation for identifying the needs of the facility, including the residents as well as the facility's ability to provide assistance to the Incident Command Center. The Residential Service Director stated, the facility had not identified the needs of the residents nor had the facility identified how the facility could provide assistance. | E 034 | Occupancy reporting, Highlands Place will provide information to the city of Chesapeake Health department, EOC of Chesapeake, Emergency Response Agencies, DBHDS and neighboring facilities of the policy of Highlands Place. Highlands Place is a licensed five bed ICF; however, the occupancy capacity of Highlands Place is six. Highlands Place Policies and Procedures states "that due to Highlands Place being at nearly 100% capacity Highlands Place is unable to provide assistance to neighboring facilities in housing transfer individuals." Staff will be trained on updates by 10/05/18.<br><br>AOC Date-10/15/18 | |

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| E 034 | Continued From page 15<br>The facility staff failed to provide documentation and have means of providing information about the facility's needs and its ability to provide assistance. | E 034 | | |
| E 036 | EP Training and Testing<br>CFR(s): 483.475(d)<br><br>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.<br><br>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).<br><br>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this | E 036 | Highlands Place's Emergency Preparedness Plan did not include a testing program. The Emergency Preparedness Plan was reviewed and updated on 9/19/18. Annex F- Training and Testing was updated to a competency test. The plan states "Highlands Place conducts drills as mandated by DBHDS regulations including training, exercising the drill, reporting the drill outcomes, reviewing those reports and making modifications to the drill and procedures as necessary. Changes will be shared with all staff as well as quarterly trainings on the Emergency Preparedness Plan including a competency test (attachment T1)." Staff will be trained on updates by 10/05/18.<br><br>AOC Date-10/15/18 | |

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| E 036 | Continued From page 16<br>section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview the facility staff failed to have an emergency preparedness training and testing program.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 1:27 P.M. with the Program Manager and Residential Service Director, they were asked for documentation of the facility's Emergency Preparedness testing program. The Residential Service Director stated, the facility did not have a Emergency Preparedness testing program.<br><br>The facility staff failed to have a Emergency Preparedness testing program. | E 036 | | |
| E 039 | EP Testing Requirements<br>CFR(s): 483.475(d)(2)<br><br>(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:<br><br>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] | E 039 | A full scale evacuation was completed on June 14, 2018 due to failure of AC units. A risk analysis was not completed on drill. The Emergency Preparedness Plan was reviewed and updated on 9/19/18. The Plan states " Highlands Place will conduct a risk analysis with associated strategies in any event causing disruption or has the potential to cause disruption in the normal operational services of Highlands Place. The Emergency Plan | |

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| E 039 | Continued From page 17<br><br>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based.<br>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. | E 039 | will be reviewed and updated in accordance with the risk analysis of each event."<br><br>AOC Date-10/15/18 | |

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| E 039 | Continued From page 18<br>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview the facility staff failed to have documentation of the facility's full scale evacuation exercise analysis and response.<br><br>The findings included:<br><br>During an interview on 09/06/18 at 1:43 P.M. with the program Manager and Residential Service Director, they were asked for the analysis of the facilities full evacuation exercise. The Residential Service Director stated, the facility had not conducted an analysis of the exercise.<br><br>The facility staff failed to have documentation of the facility's full scale evacuation exercise analysis and response. | E 039 | | |
| W 000 | INITIAL COMMENTS<br><br>An unannounced Fundamental Medicaid re-certification survey was conducted 9/5/18 through 9/7/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey.<br><br>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 000 | | |

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| W 317 | DRUG USAGE<br>CFR(s): 483.450(e)(4)(ii)<br><br>Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to have a gradual dose reduction for one Individual (Individual #1) in the survey sample of two individuals.<br><br>The findings included:<br><br>Individual #1 had an admissions date of 6/30/15 with diagnoses which included cerebral palsy, seizures, psychotic symptoms, anxiety and depression. The facility staff failed to conduct a gradual dose reduction of an antipsychotic medication (Seroquel) at least annually.<br><br>A physician's order dated 06/12/18 indicated: "Take one tablet by mouth every night at bed time." A Psychotherapy Services report dated 8/9/18 indicated: " The patient is a 68 year old female who presents for a Follow-up for Behavior concerns. The history is reported by a caregiver. No changes in management were made at the last visit. Symptoms include attention difficulties, interpersonal relationship issuers and aggressive behavior. Associated symptoms include sleep difficulties and agitation. Current treatment includes antidepressants, antianxiety medication and atypical antipsychotics." | W 317 | The Interdisciplinary Team reviews documentation on medications, documentation on behavioral data and physician's notes on a quarterly basis. A comprehensive review is completed annually including recommendations of Specially Constituted Committee on use of antipsychotic medication for updating of PCP. Individual # 1 prescribing physician notes did not reflect a review of a recommendation with prescribing physician for possible gradual drug dose reduction.<br><br>There is a potential for other individuals on antipsychotic medication to be affected.<br><br>RN will review Individual #2, Individual #3, Individual #4 and Individual #5 physician orders for use antipsychotic medications and check EHR for potential of missing annual documentation of gradual dose reduction if Individual physician's orders include antipsychotic medications.<br><br>In order to minimize the discrepancies form this time forward, the nursing staff will provide prescribing physician with a written copy of recommendations from SCC and IDT on gradual dose reduction and if withdrawal is | |



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| W 317 | Continued From page 20<br>Take home note from today's visit, indicated: 'Comment: Today, there were no changes to your medications." A review of the physician's orders and Psychotherapy Services notes from 04/03/17 thru 08/09/18 did not indicate a gradual dose reduction had been conducted.<br><br>During an interview on 09/07/18 at 11:00 A.M. with the Registered Nurse (RN) she stated, Individual #1 had not been evaluated for a gradual dose reduction by her physician's or pharmacy recommendations.<br><br>A review of the facility's Individual behavior and Facility Practices Drug Use policy indicated: " A gradual drug withdrawal occurs annually or sooner if warranted by progress to the criteria established in the PCP, unless clinical evidence justifies that withdrawal is contraindicated. If withdrawal is contraindicated, the prescribing physician will thoroughly document the rational and evidence in the resident's record on an annual basis."<br><br>The facility staff failed to conduct a gradual dose reduction at least annually. | W 317 | Contraindicated, the prescribing physician will document rationale. Recommendations from IDT meeting held on September 19, 2918 will be taken on next appointment to prescribing physician on October 5, 2018 for possible gradual dose reduction.<br><br>AOC-10/15/18 | |