HORIZON

March 28, 2018

Paul Wade
LTC Supervisor
Commonwealth of Virginia
Dept. of Health
Office of Licensure and Certification
9960 Maryland Drive, suite 401
Henrico, VA 23233-1485

Dear Paul

Enclosed is the plan of correction for Horizon Pearson and Powell Intermediate care facilities. Thank you for the survey and we appreciate the input to improve the safety of the individuals at the facilities.

Let me also use this opportunity to thank your office for the support and guidance given to us during the emergency flooding of the Pearson house.

If you have any questions or need anything, please feel free to contact the me or Leslie Ozz at 434 485 7812.

Thank you again,

Henry Mukhuna
Residential Manager/Administrator
Horizon Pearson and Powell Intermediate Care Facility

STATEMENT OF DEFICIENCIES AND PLAN CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3 DATE SURVEY
	49G055	A. BUILDING ---- - - B. WING	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
POWELL AND PEARSON	722 A AND B OLD GRAVES MILL ROAD LYNCHBURG, VA 24502

ID 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)	DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/13/18 through 03/14/18. 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	**1. Address the corrective action taken for the problem.** The shelter in place policy was revised to indicate the probable number of people in the house and it states the minimal amount of food and water in quantity by person on 3/23/18. All staff will be trained on the updated policy and location of the shelter in place kits by 4/30/18. **2. Address how the facility will identify similar occurrences of the problem.** The program reviewed all policies and procedures in relation to the CMS regulations for Emergency preparedness on 3/23/18. Several were improved to better meet the needs of the residents.	3/23/18 3/23/18
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 systems. (D) Sewage and waste disposal.	E 015		

Henry D. Mulcahy — RESIDENTIAL MANAGER

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

HENRY D. MULCAHY — 03/28/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	49G055	A. BUILDING _____ B. WING	03/14/2018

NAME PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL AND PEARSON	722 **AAND BOLD GRAVES MILL ROAD** **LYNCHBURG, VA 24502**

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 015	Continued From page 1 *[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 facility document review and staff interview, the facility staff failed to ensure policies and procedures for the provision of subsistence needs for staff and patients for food and water. The facility staff failed to ensure a policy and procedure regarding the provision of food and water subsidence for staff and patients was in place, in the event of an evacuation and/or shelter in place. Findings include: During the emergency preparedness review on 03/14/18 at approximately 3:00p.m., an interview was conducted with the RM (resident manager) and the PM (Program Manager).	E 015	**3. Identify measures/systemic changes to ensure deficient practices will not recur.** Policy and procedures will be reviewed annually to ensure they meet the regulations and the client needs. They were reviewed and updated 3/23/18. **4. Indicate how facility will monitor its performance.** Policy and procedures will be reviewed annually to ensure they meet the regulations and the client needs. They were reviewed and updated 3/23/18.	3/23/18 3/23/18

Residential Manager
03/28/18

STATEMENT AND PLAN DEFICIENCIES CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G055	A BUILDING--------- B. WING	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
POWELL AND PEARSON	722 **AAND 8 OLD GRAVES MILL ROAD LYNCHBURG, VA 24502**

(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)	DATE
E 015	Continued From page 2	E 015		

The facility's policy and procedure for the provision of food, water and pharmaceutical supplies for staff and residents did not evidence that the facility would provide 'adequate' subsistence for the duration of an emergency. The facility did not identify the facility's 'individual' subsistence needs and did not set requirements or standards in writing for the amount of provisions for patients and staff during an emergency situation.

The PM stated that the facility did have a separate policy regarding the specifics for food and water and that it (policy) was in their (the facility's) computer system. The RM stated that the policy could be printed and provided.

At approximately 3:45p.m., the RM stated that the facility's printer was not working and the document could not be printed.

At approximately 4:30p.m., the RM presented the printed policy. The facility's policy documented that the 'determination' of the minimal amount of food and water would be kept available in a designated area, but did not provide a standard amount and did not identify the designated area, nor did the policy address pharmaceutical needs. The printed policy did, however specify the amount of water in quantity per person, but did not specify the number of probable people.

The PM stated that the facility policies regarding emergency preparedness within the facility's computer system needed to be printed and part of the emergency preparedness plan/book.

No further information and/or documentation was

Residential Manager
03/28/18

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

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	49G055	A. BUILDING _____ B. WING _____	03/14/2018

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E 015	Continued From page 3 provided prior to the exit conference on 03/14/18 at 5:30p.m	E 015		
W 000	INITIAL COMMENTS	W000		

An unannounced Fundamental Medicaid re-certification survey was conducted 03/13/18 through 03/14/18. The facility was 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.

The census in this 8 certified bed facility was 8 at the time of the survey. The survey sample consisted of four Individual reviews (Individuals **1** through 4).

Residential Manager
03/28/18