

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

THINILD, USIZIIZUIU DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 (X1) PROVIDERJSUPPLIERJCLIA X3 DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION CORRECTION IDENTIFICATION NUMBER AND PLAN ABUILDING ---- -B. WING 49G055 03/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 722 A AND B OLD GRAVES MILL ROAD POWELL AND PEARSON LYNCHBURG, VA 24502 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 000 Initial Comments E 000 3/23/18 1. Address the corrective action taken for the problem. An unannounced Emergency Preparedness survey was conducted 03/13/18 through The shelter in place policy was 03/14/18. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, revised to indicate the probable Condition of Participation for Intermediate Care number of people in the house and Facilities for Individuals with Intellectual it states the minimal amount of Disabilities. No complaints were investigated during the survey. food and water in quantity by E 015 Subsistence Needs for Staff and Patients E 015 person on 3/23/18. CFR(s): 483.475(b)(1) All staff will be trained on the [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness updated policy and location of the policies and procedures, based on the emergency shelter in place kits by 4/30/18. 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 2. Address how the facility will reviewed and updated at least annually.] At a 3/23/18 minimum, the policies and procedures must identify similar occurrences of the address the following: problem. (1) The provision of subsistence needs for staff The program reviewed all policies and patients whether they evacuate or shelter in place, include, but are not limited to the following: and procedures in relation to the (i) Food, water, medical and pharmaceutical CMS regulations for Emergency supplies (ii) Alternate sources of energy to maintain the preparedness on 3/23/18. Several following: were improved to better meet the (A) Temperatures to protect patient health and needs of the residents. 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

MUKHUNA

Facility 10: VAICFMR66

REGIDENTIAL

(X6) DATE

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.

MANAGER

Muhlung

ARTMENT OF HEALTH AND HUMAN SERVICES

PHINTED: 03/21/2018

CENTER		& MEDICAID SERVICES			OM		0938-0391		
CENTERS MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION							DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING		COM	PLETED		
		49G055	B. WING			03/	14/2018		
NAME I	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE		·		
				722	AAND BOLD GRAVES MILL ROAD				
POWELL	AND PEARSON			LY	NCHBURG, VA 24502				
TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE		
T 045	Continued From no	ao 1	ΕO	115					
E 015	Continued From page	-		,,,	3. Identify measures/systemic	3	3/23/18		
	Policies and proced	ice at \$418.113(b)(6)(iii):]			changes to ensure deficient				
	(6) The following are additional requirements for hospice-operated inpatient care facilities only.				practices will not recur.				
		ocedures must address the			Policy and procedures will be				
		subsistence needs for			reviewed annually to ensure they				
		and patients, whether they			meet the regulations and the clier	nt 📗			
		in place, include, but are not			needs. They were reviewed and				
	limited to the following: (A) Food, water, medical, and pharmaceutical				updated 3/23/18.				
	• •	rces of energy to maintain the							
	following: (1) Temperatures to protect patient health						3/23/18		
		he safe and sanitary storage			4. Indicate how facility will	-	5/23/10		
	of provisions.			monitor its performance.					
	(2) Emergency lighting. (3) Fire detection, extinguishing, and alarm				Dell'arrandamentalishe				
					Policy and procedures will be				
	systems. (C) Sewage and	waste disposal.			reviewed annually to ensure they	- 11			
		not met as evidenced by:			meet the regulations and the clier	nt			
	Based on facility document review and staff				needs. They were reviewed and				
		staff failed to ensure policies			updated 3/23/18.				
		the provision of subsistence patients for food and water.							
		ed to ensure a policy and the provision of food and							
		or staff and patients was in							
		of an evacuation and/or							
	Findings include:								
	During the emergene 03/14/18 at approximately	cy preparedness review on nately 3:00p.m., an interview							

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Event ID: HZ4111

Facility ID VAICFMR66

If continuation sheet Page 2 of 4



was conducted with the RM (resident manager)

and the PM (Program Manager).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT DEFICIENCIES AND PLAN CORRECTION

(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X4) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

(X4) MULTIPLE CONSTRUCTION

(X5) DATE SURVEY COMPLETED

(X6) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

POWELL AND PEARSON

STREET ADDRESS, CITY, STATE. ZIP CODE 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

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Event ID: HZ4111

Facility ID VAICFMR66

If continuation sheet Page 3 of 4

Houldman 03/28/18

Residential Manager

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PHINTED: 03/21/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND PLAN OF PROVIDER OR SUPPLIER POWELL AND PEARSON SUMMANY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 015 Continued From page 3 provided prior to the exit conference on 03/14/18 at 5:30p.m W 000 INITIAL COMMENTS 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 (CFIIID). The Life Safety Code survey(report will follow. No compliants 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).	CENTER	15 FUR MEDICARE	& MEDICAID SERVICES				<u> </u>
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If continuation sheet Page 4 of 4

Residential Manager