HORIZON
BEHAVIORAL HEALTH

Nicole Keeney
Supervisor, Long Term Care Services
Dept of Health and Human Services
Centers for Medicare and Medicaid Services

October 26, 2018

Dear Nicole Keeney:

Enclosed is the plan of correction for Timothy & Bethany Homes. Thank you for the survey and appreciate the input to improve the quality of care for the individuals at Timothy & Bethany Homes. Thank you for you and your team's time. If you have any questions or need anything please feel free to contact me.

Thank you again,
Leslie Ozz
Program Manager of ICF Homes
Horizon Behavioral Health

HORIZON BEHAVIORAL HEALTH 3018 Forest Hills Circle, Lynchburg, VA 24501
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERJSUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G024	A. BUILDING-------- B. WING	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE.ZIP CODE
TIMOTHY AND BETHANY HOUSE	3011ROUNDELAY ROAD LYNCHBURG, VA 24502

(X4)10 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)	(XS) COI*LETION OATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/16/18 through 10/17/18. The facility was in substantial 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 a) Retraining of all staff in implementation of ISP as part of active treatment was completed on 10/25/2018 b) In service all staff related to consistent use of adaptive equipment during meals. 2) Identify how the facility will identify similar occurrences of the problem a) The Manager and Assistant Manager will observe meals once a week for the first quarter of this plan and then as needed b) During observations, Manager and Assistant Manger will ensure all areas of active treatment are being implemented. 3) Identify measures/systemic changes to ensure deficient practices will not recur a) Staff at all Horizon ICF housing programs will receive training related to proper implementation of ISP b) Staff at all Horizon ICF housing program will receive training on consistent use of adaptive equipment during meals 4) Address how the facility will monitor its performance a) Residential Manager and Assistant Manager Will monitor and track the use of adaptive Equipment at meal times once a week for the first quarter and then as needed.. b) Residential Manager and Assistant Manager will observe active treatment activities and track specific client documentation related to their domestic goal in the Individual service plan.	11/05/18
W 000	INITIAL COMMENTS An unannounced Focused Fundamental Medicaid re-certification survey was conducted 10/16/18 through 10/17/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with IntellectualDisabilities (ICF/110). 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 3 Individual reviews (Individuals #1 through 3).	WOO		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in suffiCient number and frequency to support the achievement of the objectives identified in the individual program plan.	W249		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X&) DATE

Program Manager Horizon Behavioral Health 10/26/18

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that :her safeguards provide suffiCient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correct on 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. Ifdeficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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W249	Continued From page 1	W249		

This STANDARD is not met as evidenced by:
Based on observation and clinical record review, the facility staff failed to implement the active treatment plan for one of three individuals in the survey sample, Individual #3.

The facility staff failed to implement the ISP (individual service plan)/active treatment plan for Individual#3 in the section titled, "domestic."

Findings include:

Individual#3 was admitted to the facility on 04/26/11. Diagnoses for Individual #3 included, but were not limited to: severe mental retardation in functioning level, legally blind, hypothyroidism, and osteoporosis.

Individual #3 was observed for two meals. A lunch meal was observed on 10/16/18 at approximately 12:30 p.m. The individual had a divided plate (as an assistive device), a spoon, a cup of milk and a cup of tea. The individual was being prompted to place his left hand in his lap and to eat with his right hand. The individual ate the entire meal, pushed away from the table and walked to the living room to his recliner. The DSP (direct staff person) working with the individual stated that the individual "gets up and goes" as soon as he is finished.

Individual#3 was again observed on 10/17/18 at approximately 7:30a.m. for breakfast. The individual had a divided plate, with a plate guard (as assistive device}, a spoon, a cup of coffee and a cup of milk. The individual completed the meal and again, pushed away from the table and walked to the living room to his recliner. The DSP working with the individual stated that when

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W 249	Continued From page 2 this individual is done, "he will get up and go." During a review of Individual #3's clinical records, the individual's "physical care plan" documented "adaptive equipmenr• to include a plate guard, a section plate and soup spoon. The individual's ISP (individual service plan/active treatment plan) was then reviewed and documented that the individual will take his cups to the sink in the kitchen area after the individual has completed his meal. On both observations the individual did not attempt to take his cups to the sink independently and was not prompted by support staff on either observation to encourage the individual with this support activity. On 10/17/18 at approximately 8:50a.m., the QIDP (qualified intellectual disability professional), the residential manager, and the program manager were interviewed and made aware of the observations. The QIDP was asked if the plate guard should be on the individual's ISP (active treatment plan) the QIDP stated, "If it's a support to help the individual." The QIDP was then asked about the ISP, the QIDP stated that if it (the active treatment plan) says to have the individual take his cups to the sink, staff should be encouraging the individual to do it. No further information and/or documentation was presented prior to the exit conference on 10/17/18.	W249		
W 446	EVACUATION DRILLS CFR(s): 483.470(i)(2)(ii)	W446		

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W 446	Continued From page 3 The facility must make special provisions for the evacuation of clients with physical disabilities. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to include special provisions for the evacuation of clients with physical disabilities in the facility's evacuation plan. Findings include: During a review of the facility's fire drills and emergency evacuation on 10/17/18 at approximately 11:30 a.m., the evacuation plan was reviewed and did not include special provisions for individual's in this facility with physical and/or cognitive disabilities. The evacuation plan did not include and/or identify individuals with medical and/or physical/cognitive disabilities and did not clearly specify any special evacuation procedures for these clients. The book of fire/evacuation drills (not the evacuation plan) was then revived and included a sheet for each drill completed since the last survey. In the front of the book was a sheet that documented that there is updated information on each individual in the facility's computer system for evacuation needs. In the back of the fire/evacuation drill notebook there were individual sheets that listed some special provisions (these were dated December 2016); this was not part of the facility's evacuation plan. On 10/17/18 at approximately 11:55 a.m., the	W446	1) Address the corrective action taken for the problem a) The Individual evacuation plan was updated, printed and filed in the Emergency preparedness book on 10/25/2018. 2) Address how the facility will identify similar occurrences of the problem. a) The Manager and Assistant Manager will audit the Emergency preparedness book quarterly to make sure that an updated Individual evacuation plan is in place. b) The QIDP will update the Individual evacuation plan annually and as needed. 3) Identify systemic measures/changes to ensure that the deficient practice does not recur a) QIDPs of all the Horizon ICF housing program will update the Individual evacuation plan annually and/or as needed b) All the Residential Managers and Assistant Managers of all Horizon ICF programs will be required to audit the emergency preparedness book quarterly to make sure the updated Individual evacuation plan is filed in the book 4) Identify how the facility will monitor its performance. The Program Manager and continuous quality improvement program will track the Audits done by Managers	11/05/18

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W 446	Continued From page 4 program director, the residential manager and the QIDP (qualified intellectual disability professional) were made aware of the above information. The above facility staff all agreed that all of the individual's in the facility have physical and/or cognitive limitations to some degree. The QIDP stated that there is an updated sheet for each individual in [name of facility's software program], the QIDP was made aware that the information has to be part of the actual evacuation plan. No further information and/or documentation was presented prior to the exit conference on 10/17/18.	W446		