PRINTED: 11/21/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			0		0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	St. 103		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G009	B. WING			11/1	6/2018
NAME OF P	ROVIDER OR SUPPLIER	and the second s			REET ADDRESS, CITY, STATE, ZIP CODE		
FINNEY A	VE RESIDENCE		ļ	000000	14 FINNEY AVE UFFOLK, VA 23434		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	10.0	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF!		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
E 000	Initial Comments		ΕC	000	This Plan of Correction is subrin accordance to federal comp		
	A				in accordance to rederal comp	mance.	
		Emergency Preparedness sted 11/14/18 through 11/16/18.				:	8.9
		t insubstantial compliance with					
	42 CFR Part 483.7	3, 483.475, Condition of					,
		ermediate care Facilities for ellectual Disabilities. No					
		edness complaints were					
	investigated during						
	The census in this	12 bed certified facility was 12					1%
	at the time of the s	urvey. The survey sample					
		ee Individuals (Individual #1,					
E 027	#2, and #3).		E	137	1) Training in emergency		11/28/18
E 037	EP Training Progra CFR(s): 483.475(d		L	,,,,	preparedness policies and		11/20/10
	G. 1 ((G): 100 ()	, , , , , , , , , , , , , , , , , , ,			procedures was provided 3/20	0/18	
		m. The [facility, except CAHs,			to all new and existing staff. F		
		nizations, PRTFs, Hospices, es) must do all of the following:			of training is maintained in the		
	and dialysis facilitie	as intust do all of the following.			personnel file in Human Reso		
	(i) Initial training in	emergency preparedness			as well as in the facility's Trail		
		dures to all new and existing			Testing section of the EPP bit		
		oviding services under volunteers, consistent with their					
	expected role.	Voidingers, consistent with their			2) Facility manager reviewed	the	11/28/18
		ency preparedness training at			training records and verified a	III new	
	least annually.	and a standard and standard and a st			and existing staff were trained	t	
		nentation of the training. taff knowledge of emergency			3/20/18 on emergency		
	procedures.	ran knowledge of entergettoy			preparedness policies and		
		\$482.15(d) and RHCs/FQHCs			procedures. Residential	Add :	
	at §491.12:] (1) Tra	aining program. The [Hospital			Supervisor will monitor quarte	erly.	
		ust do all of the following:			DEAL		10
		emergency preparedness dures to all new and existing			RECEIVE)	
	staff, individuals pr	oviding on-site services under			NOV 2 0 2010		
		volunteers, consistent with their			NOV 3 0 2018		
	1 DIDECTOR OF BOOM	ACDICI IDDILED DEDDREENTATIVE'S SIG	MATHER	-	- TITLEV DHIOLO	0 10 10 10	(X8) DATE

LABORATORY DIRECTOR'S OR PROVIDER'S UPPLIER REPRESENTATIVE'S SIGNATURE

TITLEV DH/OLQ

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.

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		49G009	B WING_		11/16/2018	
	PROVIDER OR SUPPLIER AVE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 FINNEY AVE SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
E 037	Continued From pa	ge 1	E 0:	3) As a part of new staff orientation facility manager or designee will putraining in emergency preparedne	rovide	
	least annually. (iii) Maintain docum	ncy preparedness training at sentation of the training. aff knowledge of emergency		policy and procedures. Electronic will be activated for the facility may regarding due dates for annual statemergency preparedness training ensure training is provided within	alerts 12/28/18 nager aff	
	hospice must do all (i) Initial training in a policies and proced hospice employees services under arra expected roles. (ii) Demonstrate sta procedures.	418.113(d):] (1) Training. The of the following: emergency preparedness lures to all new and existing and individuals providing ingement, consistent with their aff knowledge of emergency ency preparedness training at		required time lines. Facility policy #941 Staff Orientation/Training will be revised add "Emergency Preparedness Program" as required training, in addition to the existing training for Emergency Procedures and electrorianing for Workplace emergencinatural disasters.	ronic	
	emergency prepare employees (includio special emphasis p	iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and		 An established month will be designated as emergency prepare month to foster routine. 	dness 12/28/18	
	others. *[For PRTFs at §44 program. The PRT[(i) Initial training in	11.184(d):] (1) Training F must do all of the following: emergency preparedness		The Residential Supervisor will co a look behind to ensure the facility manager is training staff on emergoreparedness within required time	, gency 12/28/18	
	policies and proceed staff, individuals procedures. staff, individuals procedures arrangement, and vexpected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures.	lures to all new and existing oviding services under volunteers, consistent with their and provide emergencying at least annually. The services afficiently affici		Facility manager will process staff training documents and ensure co are maintained in the Training and Testing section of the Emergency Preparedness Program binder and forward to Human Resources for estaff's personnel files.	pies 12/28/18	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 88YD11

Facility ID: VAICFMR06

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G009	B. WING		11/16/2018
	PROVIDER OR SUPPLIER AVE RESIDENCE	,		STREET ADDRESS, CITY, STATE, ZIP CODE 404 FINNEY AVE SUFFOLK, VA 23434	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		OULD BE COMPLETION
E 037	Continued From pa	age 2	ΕO	937	
	organization must of (i) Initial training in policies and proced staff, individuals programment, controllers, consisted (ii) Provide emerge least annually. (iii) Demonstrate st procedures, including what to do, where the case of an emerge (iv) Maintain document of the controllers of the controller	nentation of all training. 85.68(d):](1) Training. The of the following: aining in emergency cies and procedures to all new individuals providing services t, and volunteers, consistent			
	The CAH must do	5.625(d):] (1) Training program. all of the following: emergency preparedness	1 107		2 3

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Event ID: 88YD11

Facility ID: VAICEMR06

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		& MEDICAID SERVICES	OMB NO. 0938					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		49G009	B. WING		11/16/2018			
	PROVIDER OR SUPPLIER AVE RESIDENCE		404	EET ADDRESS, CITY, STATE, ZIP CODE FINNEY AVE FFOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULT CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION			
E 037	reporting and extine and where necessal personnel, and gue cooperation with fir authorities, to all ne individuals providin and volunteers, corroles. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate significant existing staff, if under arrangement with their expected documentation of the demonstrate staff if procedures. There	dures, including prompt guishing of fires, protection, ary, evacuation of patients, ests, fire prevention, and refighting and disaster ew and existing staff, ag services under arrangement, insistent with their expected ency preparedness training at mentation of the training. Itaff knowledge of emergency sies and procedures to all new individuals providing services to and maintain the training. The CMHC must knowledge of emergency after, the CMHC must provide edness training at least	E 037					
	Based on record refacility staff failed to	is not met as evidenced by: eview and staff interview, the o develop an initial training ency preparedness policies and						
	11/15/18 at 3:20 P.	ed: ency Preparedness review on M. with the Residential Utilization Review Supervisor						

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they were asked for the Initial training in

Event ID 88YD11

Facility ID: VAICEMR06

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A 189	E CONSTRUCTION (X	(3) DATE SURVEY COMPLETED			
		49G009	B. WING		11/16/2018			
	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 404 FINNEY AVE SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION ATE DATE			
E 037	emergency prepare procedures to all no stated, that no Initiathe emergency preprocedures were differential Manag Supervisor stated, prior to survey reviewed to survey reviewed to survey reviewed to survey prepare mergency prepare procedures to all no stated to survey reviewed to	edness policies and ew and existing staff. The staff al training was conducted after paredness policies and eveloped on 11/8/17. The er and the Utilization Review they were waiting to train staff ew date. Iled to provide Initial training in edness policies and ew and existing staff.	E 03		35 25			
W 104	re-certification sunthrough 11/16/18. compliance with Clark for Intermediate Cawith Intellectual Dis Safety Code report were investigated of The census in this at the time of surve consisted of (3) thr #2, and #3). GOVERNING BOUCER(s): 483.410(a). The governing book budget, and operations.	12 bed certified facility was 12 ey. The survey sample ree Individuals (Individual #1,		1) The SRHA (property manager of the fawas notified 11/13/18 via weekly building inspection report, of repair needed for the downstairs laundry room "molding coming from the wall". The facility manager notific SRHA via phone on 11/15/18 during the sto request repair of the laundry room base the exposed faucet in the upstairs bathroot the bathroom door. SRHA maintenance of the baseboard on 11/15/18 and replaced faucet on 11/16/18 prior to the conclusion survey. The facility manager immediately covered the edge of the bathroom door was tape pending repair to prevent further inju SRHA maintenance was notified via week building inspection report 11/27/18 of the for door repair and shower head replacem SRHA measured the door and informed famanager on 11/29/18 that a new door was ordered and would be installed upon rece that a new shower head would be installe SRHA informed facility manager that maintenance would evaluate the non-func water supply should be disconnected. The facility manager submitted a requisition	g away ed survey eboard, om and repaired the of the ith duct iry. kly need nent. acility s 12/28/18 d. ctioning oval or			

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facility staff failed to maintain equipment and the

Event ID: 88YD11

Facility ID: VAICFMR08

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

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB 140, 0930-039					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		49G009	8. WING		11/16/2018			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	AN			
FINNEY A	VE RESIDENCE			404 FINNEY AVE SUFFOLK, VA 23434				
	CUBABADY CT	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		LD BE COMPLETION			
18/ 104	Continued From pa	ogo 6	(A)	11/16/18 for TYCO to replace windo	w chime			
VV 104	Switcher Control of the Control of t		V.V.	104 castings in the downstairs laundry re bedrooms #3, #4, and #5. TYCO sc	om and in			
	environment in a s	ate manner.		maintenance for 11/27/18, however				
	The Sediene includ	المرا		show to the facility, so the facility ma				
8	The findings include	ieo.		requested follow up through WTCSE				
	During on Environ	mental Tour on 11/15/18 at	91	procurement on 11/29/18. TYCO car				
8	10.20 A M with the	e Residential Manager and the		11/29/18 and replaced the castings i				
05		Supervisor, the downstairs		downstairs laundry room. Bedrooms				
	laundry room had	two window chime castings	B .	and #5 have non-activated chimes in				
8	(casting that encas	se the magnetic device in	10°	current activated chimes. TYCO ren				
		es to sound if a window is		non-activated chimes and evaluated				
		uncovered with exposed		chimes and castings as adequately	overed.			
	wires. The laundry room baseboard was			2) All living areas and residents' roo	ms were 11/17/18			
		a three foot section un-affixed	li .	inspected by the facility manager for				
	from the wall. Bed	rooms #3, #4 and #5 were		equipment maintenance and enviror				
	observed to have	loose fitting window chime	\$	safety issues and there were none.				
	castings. The dow	nstairs shower head was	89 87	MEDITOR DR 25 25 YR 900P 15 0MR2 25	No. Object 196			
	observed to be chi	ipped.	额	A designated staff person conduct	THE PROPERTY OF THE PROPERTY O			
			Į.	weekly building inspections. Facility	manager 12/28/18			
		sidential area, in bathroom #2,		will review the process with the desi				
	there was a sink w	vith an exposed faucet with		to ensure adequate inspection of eq and identify potential environmental				
	sharp jagged edge	es. The bathroom door was		concerns. Facility manager will wall				
		exposed sharp jagged edges.		the house with the designated staff				
		or was observed to not close		conduct the weekly building inspecti				
		operating water fountain was		Facility manager will review the writt	en building			
	observed in the up	ostairs hallway.		inspection report for accuracy before to the SRHA weekly.				
	During an interview	w with the Residential Manager	į					
	she stated, the pro	operty manager of the facility		4) Facility manager will track the sta				
		of the needed repairs.		requested maintenance or repairs a the Residential Supervisor during re	gular			
	The facility staff fa	ailed to maintain equipment and		monthly supervision. The utilization				
	the environment in	n a safe manner.		supervisor will continue to audit build	ding			
W 154	10.00		W 154 inspection reports as part of the annual facility					
	CFR(s): 483.420(c			inspection. Facility policy #934 Physical				
	· or rifely non-refelled			will revise procedures for "Housing Inspection"				
	The facility must have evidence that all alleged			to read "Inspections will be filed and weekly for review by the Residential				
		violations are thoroughly investigated.		Supervisor, the agency Procurement				
	Along the area and area and area and area.			and the Director of Community Supp	oort."			

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Event ID: 88YD11

Facility ID. VAICFMR06

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO.	MB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE COMF	SURVEY	
		49G009	B. WING		11/1	6/2018	
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	53.50	WARLE US	
CIMILEY /	AVE RESIDENCE			404 FINNEY AVE			
FIGHT	AE KEGIDENOL			SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPOPER (PROSS-REFERENCE)	OULD BE	(X5) COMPLETION DATE	
W 154	Continued From pa	age 6	W 1	Corresponding form #1934 Build 54 Inspection Report was revised to routing to the facility manager a	o include	11/30/18	
		is not met as evidenced by:		Residential Supervisor. Health			
		eview and staff interview the		repairs will also be sent to the V			
	facility staff to thor	oughly investigate two incidents		procurement manager to ensure	timeliness		
	for Individual's (#1	and #2) in the survey sample		of repairs by SRHA or WTCSB.			
		s. Individual #1 had an injury of		4 ()	40		
		nd Individual #2 had an	10	1) Incidents for Individuals #1 ar			
	elopement inciden			investigated following WTCSB a investigation protocol. Conclusi			
	The findings include	led·		investigation protocol. Conclusion investigation could not determine		8	
	The manys mode			specifically what caused the inc			
	1. Individual #1 wa	as admitted to the facility on		however evidence collected was			
	3/29/04 with diagn	oses of Profound Intellectual		to render accurate findings rega			
	Disability, Intermitt	ent Explosive Disorder, Sleep		specific allegation of neglect. The			
	Disorder, Seizures	, and Self -Injurious behavior.		were consistent with the eventu			
		noted to receive a laceration to		by APS.	haddod - Baller 201 of dever modella fine is You'vision	5	
	her right fifth digit	finger (pinky finger) which		DATE OF THE STATE		10 200420050 500 10	
		. The cause of the injury was		2) The Director of Community S		11/29/18	
100	unknown.			and Utilization Review Supervis			
	A Desidential Nues	ing Contine Dien detect 8/1/19		examined the investigation sum		¥0	
		sing Service Plan dated 8/1/18 al #1 in the area of		identified areas of witness discr		17	
		re Problem or Need: Impaired		pending clear resolution. Discre		ă.	
		ition related to cognitive ability,		witness accounts will be addres			
		id inability to speak.		recommended in the investigation	วท	24 24	
	Alteration in sleep	pattern related to diagnosis of		summary.			
8500	Profound MR and	history of insomnia.	į. Į	2) The Director of Quality Assur	anaa will	8	
		d skin integrity as related to self	K B	 The Director of Quality Assur review internal investigation pro 		12/28/18	
	injurious behaviors	s, incontinence, and bilateral	ă.	specific to resolving discrepance			
	lower extremities			staff qualified to conduct interna			
		exhibit target behavior of		investigations. The review will f			
		ealing food, overturning chairs		DBHDS Community Abuse/Neg			
	and removing clot	nes in public.		Investigations Training. When			
	5	and di Onali In I in a of		discrepancies or inconsistencies			
		cated: Goal; In Line of		statements, investigators will re			
	Signt-DSP (Direct	Support Professional) will be manifering and ensuring that I		the appropriate witnesses to res			
	support me visuali	ly monitoring and ensuring that I sight on all shifts daily. a) DSP		Any discrepancies or inconsiste			
	atti iti tireti ilile Ol	signit on all sinits daily. a) DOF		with one statements will be suffir			

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will visually monitor me and keep me in their line

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witness statements will be outlined in

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES						MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) DATE SURVEY COMPLETED	
		49G009	B WING		98729	11/1	6/2018	
NAME OF PROVIDER OR SUP	LIER		i i		STREET ADDRESS, CITY, STATE, ZIP CODE			
FINNEY AVE RESIDENCE	•				404 FINNEY AVE SUFFOLK, VA 23434		93	
PREFIX (EACH DEFI	IENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
A Residential	cun Shift	nent every 15 minutes. Daily. Note dated 09/05/2018: Time	W :	15	the conclusion of the investigated summary, along with respective resolutions. Residential super will provide mandatory staff to Shift Note, Documentation, and Collection.	/e rvisor aining on	12/28/18	
required this saccidental injuintoxication/ur refusal, Med Emedical intervious property destrandividual #1 lincident report follows: On Web. Medical individual with her jacket jacket on. In tandiced blood assessed the blood. It was leading making the late immediately an urse was nother (Nurse #2) call for call Super call 911 becaused would not paramedics and would not paramedics and left at 11: was notified of Nursing report #1 received 5	hift? ry, A scheirror entice entic entice en	eduled UA, AWOL, Med, med side effect requiring on, physical aggression, on, hospitalization): Yes an incident at 10:15 P.M. An accompleted by DSP #1 as esday September 5, 2018 10:15 went to the recreation room and, signaling staff to put her rocess of helping her, staff her jacket. DSP #1 and DSP #2 ation looking for any additional dithat Individual's right finger vidual #1 became combative, tion bleed freely. Staff ed first aid. 10:25 p.m. On call to fincident. A second nurse over at 10:45 P.M. to assess se #2 called on call supervisor. In came to the facility and said to individual #1 was combative by staff to assist her. The did at 11:15 p.m. DSP #2 and Individual #1 on the ambulance .m. Individual #1's Guardian			4) The Director of Community Supports and the Director of Cassurance will review all investigations are resolved profinal conclusions. An "Outcor section will be added to the investigation summary templated Residential Supervisor will us section to document status of recommended actions throug completion. All conclusions are outcomes of investigations will reviewed by the executive management and governing to A Root Cause Analysis (RCA conducted of all serious incided fined by the DBHDS licens regulations as Level I and Level The process will follow the DBR isk and Quality Management training material to formulate statement of cause and identifications to mitigate recurrence RCA's will be reviewed by the executive management and goody.	Quality stigation for to nes" Ite. The e this any n d II be body. Will be ents ng vel II. BHDS t RCA a fy ce. All	12/28/18	

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fingers and the laceration was repaired with 6

Event ID: 88YD11

Facility ID; VAICFMR06

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PRINTED: 11/21/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 11/16/2018 49G009 B WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **404 FINNEY AVE** FINNEY AVE RESIDENCE SUFFOLK, VA 23434 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **IEACH DEFICIENCY MUST BE PRECEDED BY FULL** PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 154 W 154 Continued From page 8 sutures. A finger splint was put in place and Individual #1 returned to facility with new medication orders and instructions for follow up with Sports Medicine and Orthopedic Center. Individual #1 received surgical repair of her right pinky finger at hospital on 9/7/18 and returned back to the facility with discharge instructions for monitoring and follow up with surgeon in 1 week." During an interview on 11/16/18 at 11:30 A.M. with the Residential Manager she was asked how did Individual #1 injure her finger and she stated, she was not sure how the incident occurred. A review of an Internal Review report dated September 11-13, 2018 Indicated the following: The incident took place during the end of the second shift and the beginning of the third shift. All staff members were present when the incident occurred. One staff person reported late to work. A review of the line of sight documentation did not indicate Individual #1 was in the line of staff sight, facility investigation of Staff did not indicate where Individual #1 was located when the injury occurred. The facility staff failed to thoroughly investigate an injury of unknown origin. 2. Individual #2 eloped from the facility on 11/21/17 without staff knowledge.

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Intellectual Disability.

Individual #2 was admitted to the facility on 6/16/03 with a diagnoses of Autism, Moderate

Individual #2 had targeted behaviors of running

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Facility ID: VAICEMR06

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

PRINTED: 11/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) DATE SURVEY COMPLETED		
			A BUILL	ING	-				
		49G009	B. WING		70 <u>10 10 10 10 10 10 10 10 10 10 10 10 10 1</u>		11/16/2018		
2000 7002	PROVIDER OR SUPPLIER AVE RESIDENCE			404 F	ET ADDRESS, CITY, STATE, ZIP CODE FINNEY AVE FOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD B			
W 154	out of building, hittinagitation, shouting, A Residential Shift P.M. Indicated: "Stationer room preparappeared to have to a few minutes into by a neighbor that I facility off the premiclothes in his hands. A Behavioral Support this resident as have Aggression: hitting, shouting, verbal abouters, Running out Running Out of the facility have alarms been opened. Whe alarms, they immediately staff with building and in of the building and in of the building. B). Whenever Individuals building, staff shoulding, staff shoulding, staff shoulding are unlocked so the whenever he choose be open. An Internal Facility 11/21/17 indicated: without staff knowled A neighbor knocked staff he was on the building throwing as Staff estimated he	ng, scratching others, throwing objects at others. note dated 11/21/17 at 8:43 aff and Individuals were in the ring for dinner. Individual #2 ween using the restroom. After the dinner staff was informed individual #2 was behind the rises down the street with	•	154					

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

PRINTED: 11/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(E)(E) = (E)((A)(A)((E)((A)(A)((E)((E)((E)((E)((E	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		49G009	B. WING		11/16/	2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 FINNEY AVE SUFFOLK, VA 23434		20 1 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) OMPLETION DATE
W 154	1/8 of a mile from t investigation indica Individual #1 got or know he was out of alarms were noted. Individual #2's Beh Individual #2 should There was no data maintained line of \$#2 during the 4:00 went missing.	I #2 was found approximately he facility. A review of the ted staff did not know how at of the facility. Nor did Staff of the facility. Door chimes and	W 15	4		2/28/18
W 249	Residential Manage Supervisor, they we #2 get out of the bealarms were on. The sure. He possibly gwindow, was the deasked had on-duty staff been equestion. The Residential The facility staff fair missing person from PROGRAM IMPLE CFR(s): 483.440(d). As soon as the interformulated a client each client must retreatment program interventions and sand frequency to si	er and Utilization Review ere asked how did Individual utilding if the door chimes and he staff stated they were not not out through a bedroom uplicative answer given. When interviewed and asked that dential Manager stated, No. Iled to thoroughly investigate a methe facility.	W 24	1) The facility added a third staff person to the overnight shift (10: to 8:00am) to ensure a structured program of care to meet individuand #2 needs for supervision and monitoring within staff line of sigh Staff shifts were extended to ensure coverage during shift change. The facility contracted TYCO to repair broken alarm sensors and install to all alarm sensors to prevent tampering and/or accidental disalof the alarm system. The facility	00pm d als' #1 d visual nt. ure he r covers	

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	MENT OF TIERETTS		OMB NO. 0938-0391					
CENTER	S FOR MEDICARE	& MEDICAID SERVICES						
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000		E CONSTRUCTION		PLETED	
	90	49G009	B. WING	35		11/1	6/2018	
NAME OF F	ROVIDER OR SUPPLIER	-22 NK NA			TREET ADDRESS, CITY, STATE, ZIP CODE			
FINISEV	VE RESIDENCE		1	8550	04 FINNEY AVE			
LIMMETA	ME KESIDENCE	25 0001452000 97 (1926)0 42 44		S	SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 249	Continued From pa		w	249	implemented new protocol to keep the system armed 24 hours a day to ale anytime the doors or windows are of the psychologist consultant reviewer.	ne alarm rt staff pened. ed	11/13/18	
	Based on record re facility staff to cons treatment programs	s not met as evidenced by: eview and staff interview the istently implement active s for two individuals #2) in the survey sample of	5		individual #2's Behavior Support Pla any needed changes and indicated a changes necessary. A Root Cause was conducted of the incident involv Individual #1. Facility manager infor staff via email 11/29/18 of individual updated Line of Sight program outco	no Analysis ring rmed all #1's	1	
	Individual #1's and were not consisten	#2's line of sight program tly implemented.			reminding all staff to provide line of supervision continuously and to do in resident shift notes.		12/28/18	
	The findings includ	ed:			2) Facility manager and Residential			
	3/29/04 with diagnor Disability, Intermitted Disorder, Seizures, Individual #1 was in her right fifth digit for required 6 sutures, unknown, Individual	is admitted to the facility on bees of Profound Intellectual ent Explosive Disorder, Sleep and Self-Injurious behavior, loted to receive a laceration to larger (pinky finger) which The cause of the injury was all #1's Program plan for line of emented consistently.	**************************************		Supervisor reviewed all residents' Por Centered Plans to determine addition of Sight supervision needs. A third individual's PCP was modified to add of sight program outcome effective oper physical therapist recommendate. Staff were informed during the follow staffing meeting. Data collection showere developed accordingly.	nal Line: d a line 7/23/18 ion. ving		
	assessed Individual Medical/Health Calverbal communical social isolation, and Alteration in sleep Profound MR and At risk for impaired injurious behaviors lower extremities elehavior Support-	re Problem or Need: Impaired tion related to cognitive ability, if inability to speak. pattern related to diagnosis of history of insomnia. I skin integrity as related to self, incontinence, and bilateral			3) The facility psychologist consultar provide training to all facility staff to the definition of "line of sight" supervand strategies to ensure that level of supervision is provided per Individua and #2 PCP. Facility policy #943 Fact Staffing and Supervision, specifically referencing line of sight supervision, reviewed during the training. The Collection sheet for Individual #1's listing to utcome was corrected to reflect 15 minute interval and include staff	review vision f als #1 acility y will be Data ne of		

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and removing clothes in public.

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		AND HUMAN SERVICES					0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		49G009	B. WING	.		11/	16/2018
NAME OF F	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY STATE ZIP CODE		
FININES/	WE DECIDENCE				104 FINNEY AVE		
FINNET	AVE RESIDENCE			\$	SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 249	Sight-DSP (Direct S support me visually am in their line of si will visually monitor of sight. B). DSP will docum A Residential Shift In 10:00 PM: Indica required this shift? accidental injury, A intoxication/unsche refusal, Med Error, medical intervention property destruction	ated: Goal; In Line of Support Professional) will monitoring and ensuring that I ight on all shifts daily. a) DSP me and keep me in their line ent every 15 minutes. Daily. Note dated 09/05/2018: Time sted: "Was an incident report (ER Visit, Self-Injury, ssault, duled UA, AWOL, Med med side effect requiring in, physical aggression, in, hospitalization): Yes	W	249	signatures. Support instruction on In #1's PCP line of sight outcome was redefine the purpose of documenting eminutes "to verify that line of sight survas provided continuously for the prominutes. Residential supervisor or dwill ensure a debriefing occurs will all any incidents involving injuries of unlorigin or elopement to identify prever strategies to mitigate recurrence. Farmanager will ensure that the psychologonaultant is informed the next busing any incidents that require review or unbehavioral support plans. 4) Root Cause Analysis (RCA) of all Il serious incidents will be reviewed a include evaluation of appropriate struprogram of care to meet needs for priguidance, and supervision. The facil	nodified to very 15 pervision evious 15 esignee I staff after known cility ogist ess day of pdate of Level I and quarterly to actured otection, ity	12/28/18
	incident report was follows: On Wedne p.m. Individual #1 v with her jacket in hi jacket on. In the pronoticed blood on he assessed the situal blood. It was noted was bleeding. Individual #1 hurse was notified (Nurse #2) came or Individual #1. Nurse On call Supervisor call 911 because in and would not allow paramedics arrived DSP #3 escorted in	n incident at 10:15 P.M. An completed by DSP #1 as sday September 5, 2018 10:15 yent to the recreation room and, signaling staff to put her ocess of helping her, staff er jacket. DSP #1 and DSP #2 tion looking for any additional that Individual's right finger idual #1 became combative, on bleed freely. Staff d first aid. 10:25 p.m. On call of incident. A second nurse ver at 10:45 P.M. to assess a #2 called on call supervisor. came to the facility and said to adividual #1 was combative v staff to assist her. The lat 11:15 p.m. DSP #2 and adividual #1 on the ambulance m. Individual #1's Guardian			manager will respond to any determi- line of sight supervision was not prov- necessary by emailing reminders to a appropriate and arranging additional necessary or as recommended by th team. The facility manager will review resic notes to ensure line of sight supervis being provided and documented. Tr manager, residential supervisor, and review supervisor will coordinate to c least 3 unannounced site visits to me line of site supervision is being provi- according to individuals' PCP outcom ensure consistent and sustained ove facility manager will develop a monit to track among other things, the freq time of scheduled unannounced site facility manager will document site vi- resident shift notes. Residential supe- note in the Adverse Incident Report of psychologist was informed of the inc	ided as all staff as training as e RCA ent shift ion is e facility utilization onduct at initor that ded nes. To right, the oring tool uency and visits. The sits in the invisor will hat the	

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was notified of the incident.

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Facility ID: VAICEMR08

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES		10000 1000 1000 1000 1000 1000 1000 10	OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	10 10 10 10 10 10 10 10 10 10 10 10 10 1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G009	B. WING _		11/16/2018	
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 404 FINNEY AVE SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
W 249	Nursing report date #1 received 5 mg (Ativan IM due to be agitation. Individua fingers and the lac sutures. A finger sy Individual #1 return medication orders with Sports Medici Individual #1 receiv pinky finger at hos back to the facility monitoring and foll During an interview with the Residentia did Individual #1 in she was not sure if When asked how	ed 9/6/18 indicated: "Individual milligrams) of Haldol and 2 mg eing combative and increased #1 received and X-Ray of her eration was repaired with 6 plint was put in place and ned to facility with new and instructions for follow up ne and Orthopedic Center. Wed surgical repair of her right poital on 9/7/18 and returned with discharge instructions for low up with surgeon in 1 week." You on 11/16/18 at 11:30 A.M. In Manager she was asked how jure her finger and she stated, low the incident occurred.	W 24	49		
	Manager stated, S A review of an Inte	rnal Review report dated			1 2 3	
	The incident took place during the er beginning of the th	2018 Indicated the following: and of the second shift and the ird shift. All staff members a the incident occurred. One ed late to work.			1	
	indicate Individual sight. Facility inves	e of sight documentation did not #1 was in the line of staff stigation of staff did not indicate 1 was located when the injury			n II	
		iled to consistently implement ve treatment program plan.				

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G009	B. WING		11/1	6/2018	
	PROVIDER OR SUPPLIER AVE RESIDENCE		404	REET ADDRESS, CITY, STATE, ZIP COD	E		
				FFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE API DEFICIENCY)	10ULD BE	(X5) COMPLETION DATE	
W 249	2. Individual #2 elop 11/21/17 without st	ped from the facility on aff knowledge. Individual #2's	W 249				
	line of sight program on a consistent bas	m plan was not implemented ses					
	Individual #2 was admitted to the facility on 6/16/03 with a diagnoses of Autism, Moderate Intellectual Disability.						
	out of building, hitti	argeted behaviors of running ng, scratching others, throwing objects at others.					
	P.M. Indicated: "Sta dinner room prepar appeared to have be a few minutes into by a neighbor that I	note dated 11/21/17 at 8:43 aff and Individuals were in the ring for dinner. Individual #2 been using the restroom. After the dinner staff was informed Individual #2 was behind the ises down the street with s."			3 2		
	this resident as have Aggression: hitting, shouting, verbal abothers, Running ou Running Out of the facility have alarms been opened. Whe alarms, they immediately, staff with the building and in of the building.	ort Plan dated 9/5/17 assessed ving Target Behaviors of scratching others, Agitation: use, throwing objects at the of building. Strategies for Building- a) The doors of the to indicate when they have an ever staff hear one of the diately will check on Individual of the cannot be located will begin looking for him inside the area immediately outside vidual #2 is outside the					

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are unlocked so that he can return to the building whenever he chooses. The doors do not have to

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Facility ID: VAICEMR08

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	- W			Oleio 140	7. 0000 CC .	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49G009	B WING	Policy Subsection of the Contract of the Contr		11	/16/2018	
NAME OF PROVIDER OR SUPPLIER FINNEY AVE RESIDENCE			<i>.</i>	STREET ADDRESS, CITY, STATE ZIP CODE 404 FINNEY AVE SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 249	should sit or stand road for safety. Wh walking around the an awareness of hi not make eye contake is outdoors. If Individual #2 is m where he is, staff s missing persons primmediately contacts Supervisor On-Call An Internal Facility 11/21/17 indicated: without staff knowled A neighbor knocke staff he was on the building throwing a Staff estimated he about 5 to 10 minu neighbor. Individual 1/8 of a mile from to investigation indicated Individual #1 got on know he was out on alarms were noted. Individual #2's Beht Individual #3's Beht Individual #3'	t is outside, one of the staff outdoors between him and the bile Individual is outdoors house, staff should maintain s whereabouts but they should act with him or talk to him white hissing and staff do not know hould follow the agency rocedures. Staff also should at the Residential Manager or I for instructions. Investigation report dated Individual #2 exited the facility edge while in the dinning area. Individual #2 exited the facility edge while in the dinning area. Individual #2 exited the facility edge while in the dinning area. Individual #2 exited the facility edge while in the dinning area. Individual #2 exited the facility edge while in the dinning area. Individual #2 exited the facility behind the way clothing in a trash can, had been out of the building tes when alerted by the lated staff did not know how out of the facility. Nor did Staff the facility. Door chimes and	W 2	249				
i	During an interview	v un 11/10/10 at 10.43 a.xii.		988	S			

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	G 22 YE		CINDIA	7. 0000-0001	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NOITOURTENOO BLITTLE		(X3) DATE SURVEY COMPLETED	
		49G009	B. WING			/16/2018	
NAME OF PROVIDER OR SUPPLIER FINNEY AVE RESIDENCE				DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE	
W 249	Continued From page 16 with the Residential Manager and Utilization Review Supervisor, they were asked how did Individual #2 get out of the building if the door chimes and alarms were on. The staff stated they were not sure. He possibly got out through a bedroom window, was the duplicative answer given. When asked had on duty staff been interviewed and asked that question. The Residential Manager stated, No. The facility staff failed to Implement Individual #2's active treatment program on an consistent bases.		W	249		d g	
3							

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