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
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/14/18 through 11/16/18. The facility was not insubstantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey. The census in this 12 bed certified facility was 12 at the time of the survey. The survey sample consisted of (3) three Individuals (Individual #1, #2, and #3).	E 000	This Plan of Correction is submitted in accordance to federal compliance.	
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their	E 037	1) Training in emergency preparedness policies and procedures was provided 3/20/18 to all new and existing staff. Record of training is maintained in the personnel file in Human Resources as well as in the facility's Training & Testing section of the EPP binder. 2) Facility manager reviewed the training records and verified all new and existing staff were trained 3/20/18 on emergency preparedness policies and procedures. Residential Supervisor will monitor quarterly. RECEIVED NOV 30 2018 VDH/OLQ	11/28/18 11/28/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul M Mirenda TITLE: Director (X6) DATE: 11/30/18

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
E 037	Continued From page 1 expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037	3) As a part of new staff orientation facility manager or designee will provide training in emergency preparedness policy and procedures. Electronic alerts will be activated for the facility manager regarding due dates for annual staff emergency preparedness training to ensure training is provided within required time lines. Facility policy #941 Staff Orientation/Training will be revised to add "Emergency Preparedness Program" as required training, in addition to the existing training for Emergency Procedures and electronic training for Workplace emergencies and natural disasters. 4) An established month will be designated as emergency preparedness month to foster routine. The Residential Supervisor will conduct a look behind to ensure the facility manager is training staff on emergency preparedness within required time lines. Facility manager will process staff training documents and ensure copies are maintained in the Training and Testing section of the Emergency Preparedness Program binder and forward to Human Resources for each staff's personnel files.	11/28/18 12/28/18 12/28/18 12/28/18 12/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
E 037	Continued From page 2	E 037		

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
E 037	Continued From page 3 policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop an initial training program in emergency preparedness policies and procedures. The findings included: During the Emergency Preparedness review on 11/15/18 at 3:20 P.M. with the Residential Manager and the Utilization Review Supervisor they were asked for the Initial training in	E 037		

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
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
E 037	Continued From page 4 emergency preparedness policies and procedures to all new and existing staff. The staff stated, that no Initial training was conducted after the emergency preparedness policies and procedures were developed on 11/8/17. The Residential Manager and the Utilization Review Supervisor stated, they were waiting to train staff prior to survey review date. The facility staff failed to provide Initial training in emergency preparedness policies and procedures to all new and existing staff.	E 037		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 11/14/18 through 11/16/18. The facility was not in compliance with CFR 42 Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code report will follow. No complaints were investigated during the survey. The census in this 12 bed certified facility was 12 at the time of survey. The survey sample consisted of (3) three Individuals (Individual #1, #2, and #3).	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain equipment and the	W 104	1) The SRHA (property manager of the facility) was notified 11/13/18 via weekly building inspection report, of repair needed for the downstairs laundry room "molding coming away from the wall". The facility manager notified SRHA via phone on 11/15/18 during the survey to request repair of the laundry room baseboard, the exposed faucet in the upstairs bathroom and the bathroom door. SRHA maintenance repaired the baseboard on 11/15/18 and replaced the faucet on 11/16/18 prior to the conclusion of the survey. The facility manager immediately covered the edge of the bathroom door with duct tape pending repair to prevent further injury. SRHA maintenance was notified via weekly building inspection report 11/27/18 of the need for door repair and shower head replacement. SRHA measured the door and informed facility manager on 11/29/18 that a new door was ordered and would be installed upon receipt and that a new shower head would be installed. SRHA informed facility manager that maintenance would evaluate the non-functioning water fountain to determine whether removal or water supply should be disconnected. The facility manager submitted a requisition	12/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 104	Continued From page 5 environment in a safe manner. The findings included: During an Environmental Tour on 11/15/18 at 10:30 A.M. with the Residential Manager and the Utilization Review Supervisor, the downstairs laundry room had two window chime castings (casting that encase the magnetic device in windows for chimes to sound if a window is broken or opened) uncovered with exposed wires. The laundry room baseboard was observed to have a three foot section un-affixed from the wall. Bedrooms #3, #4 and #5 were observed to have loose fitting window chime castings. The downstairs shower head was observed to be chipped. In the upstairs Residential area, in bathroom #2, there was a sink with an exposed faucet with sharp jagged edges. The bathroom door was observed to have exposed sharp jagged edges. The bathroom door was observed to not close completely. A non-operating water fountain was observed in the upstairs hallway. During an interview with the Residential Manager she stated, the property manager of the facility would be notified of the needed repairs. The facility staff failed to maintain equipment and the environment in a safe manner.	W 104	11/16/18 for TYCO to replace window chime castings in the downstairs laundry room and in bedrooms #3, #4, and #5. TYCO scheduled maintenance for 11/27/18, however did not show to the facility, so the facility manager requested follow up through WTCSB procurement on 11/29/18. TYCO came out 11/29/18 and replaced the castings in the downstairs laundry room. Bedrooms #3, #4, and #5 have non-activated chimes in addition to current activated chimes. TYCO removed the non-activated chimes and evaluated the active chimes and castings as adequately covered. 2) All living areas and residents' rooms were inspected by the facility manager for any other equipment maintenance and environmental safety issues and there were none. 3) A designated staff person conducts the weekly building inspections. Facility manager will review the process with the designated staff to ensure adequate inspection of equipment and identify potential environmental safety concerns. Facility manager will walk through the house with the designated staff weekly to conduct the weekly building inspection report. Facility manager will review the written building inspection report for accuracy before submitting to the SRHA weekly. 4) Facility manager will track the status of any requested maintenance or repairs and report to the Residential Supervisor during regular monthly supervision. The utilization review supervisor will continue to audit building inspection reports as part of the annual facility inspection. Facility policy #934 Physical Plant will revise procedures for "Housing Inspection" to read "Inspections will be filed and forwarded weekly for review by the Residential Supervisor, the agency Procurement Manager and the Director of Community Support."	11/17/18 12/28/18 12/28/18
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 154	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff to thoroughly investigate two incidents for Individual's (#1 and #2) in the survey sample of three individuals. Individual #1 had an injury of unknown origins and Individual #2 had an elopement incident. The findings included: 1. Individual #1 was admitted to the facility on 3/29/04 with diagnoses of Profound Intellectual Disability, Intermittent Explosive Disorder, Sleep Disorder, Seizures, and Self -Injurious behavior. Individual #1 was noted to receive a laceration to her right fifth digit finger (pinky finger) which required 6 sutures. The cause of the injury was unknown. A Residential Nursing Service Plan dated 8/1/18 assessed Individual #1 in the area of Medical/Health Care Problem or Need: Impaired verbal communication related to cognitive ability, social isolation, and inability to speak. Alteration in sleep pattern related to diagnosis of Profound MR and history of insomnia. At risk for impaired skin integrity as related to self injurious behaviors, incontinence, and bilateral lower extremities edema. Behavior Support- exhibit target behavior of scratching self, stealing food, overturning chairs and removing clothes in public. Program Plan indicated: Goal; In Line of Sight-DSP (Direct Support Professional) will support me visually monitoring and ensuring that I am in their line of sight on all shifts daily. a) DSP will visually monitor me and keep me in their line	W 154	Corresponding form #1934 Building Inspection Report was revised to include routing to the facility manager and Residential Supervisor. Health and safety repairs will also be sent to the WTCSB procurement manager to ensure timeliness of repairs by SRHA or WTCSB. 1) Incidents for Individuals #1 and #2 were investigated following WTCSB agency investigation protocol. Conclusions of each investigation could not determine specifically what caused the incidents, however evidence collected was sufficient to render accurate findings regarding the specific allegation of neglect. The findings were consistent with the eventual findings by APS. 2) The Director of Community Supports and Utilization Review Supervisor examined the investigation summaries and identified areas of witness discrepancies pending clear resolution. Discrepancies in witness accounts will be addressed as recommended in the investigation summary. 3) The Director of Quality Assurance will review internal investigation protocol specific to resolving discrepancies, with all staff qualified to conduct internal investigations. The review will follow the DBHDS Community Abuse/Neglect Investigations Training. When there are discrepancies or inconsistencies in witness statements, investigators will re-interview the appropriate witnesses to resolve. Any discrepancies or inconsistencies in witness statements will be outlined in	11/30/18 11/29/18 12/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 154	Continued From page 7 of sight. B). DSP will document every 15 minutes. Daily. A Residential Shift Note dated 09/05/2018: Time In 10:00 PM: Indicated: "Was an incident report required this shift? (ER Visit, Self-Injury, accidental injury, Assault, intoxication/unscheduled UA, AWOL, Med refusal, Med Error, med side effect requiring medical intervention, physical aggression, property destruction, hospitalization): Yes Individual #1 had an incident at 10:15 P.M. An incident report was completed by DSP #1 as follows: On Wednesday September 5, 2018 10:15 p.m. Individual #1 went to the recreation room with her jacket in hand, signaling staff to put her jacket on. In the process of helping her, staff noticed blood on her jacket. DSP #1 and DSP #2 assessed the situation looking for any additional blood. It was noted that Individual's right finger was bleeding. Individual #1 became combative, making the laceration bleed freely. Staff immediately applied first aid. 10:25 p.m. On call nurse was notified of incident. A second nurse (Nurse #2) came over at 10:45 P.M. to assess Individual #1. Nurse #2 called on call supervisor. On call Supervisor came to the facility and said to call 911 because Individual #1 was combative and would not allow staff to assist her. The paramedics arrived at 11:15 p.m. DSP #2 and DSP #3 escorted Individual #1 on the ambulance and left at 11:33 p.m. Individual #1's Guardian was notified of the incident. Nursing report dated 9/6/18 indicated: "Individual #1 received 5 mg (milligrams) of Haldol and 2 mg Ativan IM due to being combative and increased agitation. Individual #1 received and X-Ray of her fingers and the laceration was repaired with 6	W 154	the conclusion of the investigation summary, along with respective resolutions. Residential supervisor will provide mandatory staff training on Shift Note, Documentation, and Data Collection. 4) The Director of Community Supports and the Director of Quality Assurance will review all investigation summaries to ensure any discrepancies are resolved prior to final conclusions. An "Outcomes" section will be added to the investigation summary template. The Residential Supervisor will use this section to document status of any recommended actions through completion. All conclusions and outcomes of investigations will be reviewed by the executive management and governing body. A Root Cause Analysis (RCA) will be conducted of all serious incidents defined by the DBHDS licensing regulations as Level I and Level II. The process will follow the DBHDS Risk and Quality Management RCA training material to formulate a statement of cause and identify solutions to mitigate recurrence. All RCA's will be reviewed by the executive management and governing body.	12/28/18 12/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 154	Continued From page 8	W 154		

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.

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

Individual #2 had targeted behaviors of running

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 154	Continued From page 9 out of building, hitting, scratching others, agitation, shouting, throwing objects at others. A Residential Shift note dated 11/21/17 at 8:43 P.M. Indicated: "Staff and Individuals were in the dinner room preparing for dinner. Individual #2 appeared to have been using the restroom. After a few minutes into the dinner staff was informed by a neighbor that Individual #2 was behind the facility off the premises down the street with clothes in his hands." A Behavioral Support Plan dated 9/5/17 assessed this resident as having Target Behaviors of Aggression: hitting, scratching others, Agitation: shouting, verbal abuse, throwing objects at others, Running out of building. Strategies for Running Out of the Building- a) The doors of the facility have alarms to indicate when they have been opened. When ever staff hear one of the alarms, they immediately will check on Individual #2's whereabouts. If he cannot be located immediately. staff will begin looking for him inside the building and in the area immediately outside of the building. B). Whenever Individual #2 is outside the building, staff should ensure that exterior doors are unlocked so that he can return to the building whenever he chooses. The doors do not have to be open. An Internal Facility Investigation report dated 11/21/17 indicated: Individual #1 exited the facility without staff knowledge while in the dinning area. A neighbor knocked on the facility door alerting staff he was on the property directly behind the building throwing away clothing in a trash can. Staff estimated he had been out of the building about 5 to 10 minutes when alerted by the	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 154	Continued From page 10 neighbor. Individual #2 was found approximately 1/8 of a mile from the facility. A review of the investigation indicated staff did not know how Individual #1 got out of the facility. Nor did Staff know he was out of the facility. Door chimes and alarms were noted. Individual #2's Behavior Support Plan indicated: Individual #2 should be in line of sight at all times. There was no data to support that staff maintained line of sight on 11/21/17 for Individual #2 during the 4:00 P.M. hour when Individual went missing. During an interview on 11/16/18 at 10:43 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 thoroughly investigate a missing person from the facility.	W 154		11/13/18
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.	W 249	1) The facility added a third staff person to the overnight shift (10:00pm to 8:00am) to ensure a structured program of care to meet individuals' #1 and #2 needs for supervision and visual monitoring within staff line of sight. Staff shifts were extended to ensure coverage during shift change. The facility contracted TYCO to repair broken alarm sensors and install covers to all alarm sensors to prevent tampering and/or accidental disarming of the alarm system. The facility	12/28/18

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
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 249	Continued From page 11 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff to consistently implement active treatment programs for two individuals (Individual's #1 and #2) in the survey sample of three individuals. Individual #1's and #2's line of sight program were not consistently implemented. The findings included: 1. Individual #1 was admitted to the facility on 3/29/04 with diagnoses of Profound Intellectual Disability, Intermittent Explosive Disorder, Sleep Disorder, Seizures, and Self -Injurious behavior. Individual #1 was noted to receive a laceration to her right fifth digit finger (pinky finger) which required 6 sutures. The cause of the injury was unknown. Individual #1's Program plan for line of sight was not implemented consistently. A Residential Nursing Service Plan dated 8/1/18 assessed Individual #1 in the area of Medical/Health Care Problem or Need: Impaired verbal communication related to cognitive ability, social isolation, and inability to speak. Alteration in sleep pattern related to diagnosis of Profound MR and history of insomnia. At risk for impaired skin integrity as related to self injurious behaviors, incontinence, and bilateral lower extremities edema. Behavior Support- exhibit target behavior of scratching self, stealing food, overturning chairs and removing clothes in public.	W 249	implemented new protocol to keep the alarm system armed 24 hours a day to alert staff anytime the doors or windows are opened. The psychologist consultant reviewed individual #2's Behavior Support Plan for any needed changes and indicated no changes necessary. A Root Cause Analysis was conducted of the incident involving Individual #1. Facility manager informed all staff via email 11/29/18 of individual #1's updated Line of Sight program outcome, reminding all staff to provide line of sight supervision continuously and to document in resident shift notes. 2) Facility manager and Residential Supervisor reviewed all residents' Person Centered Plans to determine additional Line of Sight supervision needs. A third individual's PCP was modified to add a line of sight program outcome effective 7/23/18 per physical therapist recommendation. Staff were informed during the following staffing meeting. Data collection sheets were developed accordingly. 3) The facility psychologist consultant will provide training to all facility staff to review the definition of "line of sight" supervision and strategies to ensure that level of supervision is provided per Individuals #1 and #2 PCP. Facility policy #943 Facility Staffing and Supervision, specifically referencing line of sight supervision, will be reviewed during the training. The Data Collection sheet for Individual #1's line of sight outcome was corrected to reflect each 15 minute interval and include staff	11/13/18 12/28/18

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
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY STATE ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 249	Continued From page 12 Program Plan indicated: Goal; In Line of Sight-DSP (Direct Support Professional) will support me visually monitoring and ensuring that I am in their line of sight on all shifts daily. a) DSP will visually monitor me and keep me in their line of sight. B). DSP will document every 15 minutes. Daily. A Residential Shift Note dated 09/05/2018: Time In 10:00 PM: Indicated: "Was an incident report required this shift? (ER Visit, Self-Injury, accidental injury, Assault, intoxication/unscheduled UA, AWOL, Med refusal, Med Error, med side effect requiring medical intervention, physical aggression, property destruction, hospitalization): Yes Individual #1 had an incident at 10:15 P.M. An incident report was completed by DSP #1 as follows: On Wednesday September 5, 2018 10:15 p.m. Individual #1 went to the recreation room with her jacket in hand, signaling staff to put her jacket on. In the process of helping her, staff noticed blood on her jacket. DSP #1 and DSP #2 assessed the situation looking for any additional blood. It was noted that Individual's right finger was bleeding. Individual #1 became combative, making the laceration bleed freely. Staff immediately applied first aid. 10:25 p.m. On call nurse was notified of incident. A second nurse (Nurse #2) came over at 10:45 P.M. to assess Individual #1. Nurse #2 called on call supervisor. On call Supervisor came to the facility and said to call 911 because Individual #1 was combative and would not allow staff to assist her. The paramedics arrived at 11:15 p.m. DSP #2 and DSP #3 escorted Individual #1 on the ambulance and left at 11:33 p.m. Individual #1's Guardian was notified of the incident.	W 249	signatures. Support instruction on Individual #1's PCP line of sight outcome was modified to define the purpose of documenting every 15 minutes "to verify that line of sight supervision was provided continuously for the previous 15 minutes. Residential supervisor or designee will ensure a debriefing occurs will all staff after any incidents involving injuries of unknown origin or elopement to identify prevention strategies to mitigate recurrence. Facility manager will ensure that the psychologist consultant is informed the next business day of any incidents that require review or update of behavioral support plans. 4) Root Cause Analysis (RCA) of all Level I and II serious incidents will be reviewed quarterly to include evaluation of appropriate structured program of care to meet needs for protection, guidance, and supervision. The facility manager will respond to any determination that line of sight supervision was not provided as necessary by emailing reminders to all staff as appropriate and arranging additional training as necessary or as recommended by the RCA team. The facility manager will review resident shift notes to ensure line of sight supervision is being provided and documented. The facility manager, residential supervisor, and utilization review supervisor will coordinate to conduct at least 3 unannounced site visits to monitor that line of site supervision is being provided according to individuals' PCP outcomes. To ensure consistent and sustained oversight, the facility manager will develop a monitoring tool to track among other things, the frequency and time of scheduled unannounced site visits. The facility manager will document site visits in the resident shift notes. Residential supervisor will note in the Adverse Incident Report that the psychologist was informed of the incident.	11/13/18 12/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 249	Continued From page 13	W 249		

Nursing report dated 9/6/18 indicated: "Individual #1 received 5 mg (milligrams) of Haldol and 2 mg Ativan IM due to being combative and increased agitation. Individual #1 received and X-Ray of her fingers and the laceration was repaired with 6 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. When asked how was Individual #1 able to get out of the line of sight of staff, the Residential Manager stated, She was not sure.

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 consistently implement Individual #1's active treatment program plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 249	Continued From page 14	W 249		

2. Individual #2 eloped from the facility on 11/21/17 without staff knowledge. Individual #2's line of sight program plan was not implemented on a consistent bases

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

Individual #2 had targeted behaviors of running out of building, hitting, scratching others, agitation, shouting, throwing objects at others.

A Residential Shift note dated 11/21/17 at 8:43 P.M. Indicated: "Staff and Individuals were in the dinner room preparing for dinner. Individual #2 appeared to have been using the restroom. After a few minutes into the dinner staff was informed by a neighbor that Individual #2 was behind the facility off the premises down the street with clothes in his hands."

A Behavioral Support Plan dated 9/5/17 assessed this resident as having Target Behaviors of Aggression: hitting, scratching others, Agitation: shouting, verbal abuse, throwing objects at others, Running out of building. Strategies for Running Out of the Building- a) The doors of the facility have alarms to indicate when they have been opened. When ever staff hear one of the alarms, they immediately will check on Individual #2's whereabouts. If he cannot be located immediately. staff will begin looking for him inside the building and in the area immediately outside of the building.
B). Whenever Individual #2 is outside the building, staff should ensure that exterior doors are unlocked so that he can return to the building whenever he chooses. The doors do not have to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(X5) COMPLETION DATE
W 249	Continued From page 15 be open. When Individual #2 is outside, one of the staff should sit or stand outdoors between him and the road for safety. While Individual is outdoors walking around the house, staff should maintain an awareness of his whereabouts but they should not make eye contact with him or talk to him while he is outdoors. If Individual #2 is missing and staff do not know where he is, staff should follow the agency missing persons procedures. Staff also should immediately contact the Residential Manager or Supervisor On-Call for instructions. An Internal Facility Investigation report dated 11/21/17 indicated: Individual #2 exited the facility without staff knowledge while in the dinning area. A neighbor knocked on the facility door alerting staff he was on the property directly behind the building throwing away clothing in a trash can. Staff estimated he had been out of the building about 5 to 10 minutes when alerted by the neighbor. Individual #2 was found approximately 1/8 of a mile from the facility. A review of the investigation indicated staff did not know how Individual #1 got out of the facility. Nor did Staff know he was out of the facility. Door chimes and alarms were noted. Individual #2's Behavior Support Plan indicated: Individual #2 should be in line of sight at all times. There was no data to support that staff maintained line of sight on 11/21/17 for Individual #2 during the 4:00 P.M. hour when the Individual went missing. During an interview on 11/16/18 at 10:43 a.m.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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)	(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		