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

PRINTED: 06/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G040	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLBY WAY RESIDENCE	6316 COLBY WAY VIRGINIA BEACH, VA 23464

(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 5/30/18 through 6/1/18. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No complaint(s) were investigated during the survey.	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Cassaldo	DS Director	6/28/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 006	Continued From page 1 that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to identify and document facility-based and community-based risk. The facility staff failed to complete facility-based and community-based risk assessment, utilizing an all-hazards approach. The findings included; An interview was conducted on 5/31/18 at 1:35 p.m., with the Intermediate Care Facility Administrator. The Administrator stated, they did not have documentation to demonstrate they addressed emergency events identified by the risk assessment.	E 006	The facility will conduct an individual risk assessment to identify the individual's potential risk factor related to emergency situations and emergency evacuations. The facility will conduct individual risk assessment to identify all individuals' potential risk level. The Comprehensive Functional Assessment will be updated with an Emergency Preparedness section. Based on the Individual's risk assessment, strategies will be listed to assist staff to know how to provide supports during emergency situations. If any change in an individual's condition warrants an update to the risk assessment, and the related strategies, the QIDP will make the needed changes and forward the updated information to the designate staff responsible for maintaining the Emergency Preparedness binder. All staff will be trained on the updated Emergency Preparedness policy and the QIDP will update all Comprehensive Functional Assessments.	7/15/18 7/15/18 7/15/18 7/15/18
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC,	E 007		

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E 007	Continued From page 2 hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to ensure continuity of operations, including delegations of authority and succession plans during an emergency. The facility staff failed to have systems in place to specify their population, identify individuals with unique vulnerabilities and to address persons at risk. The findings included; An interview was conducted on 5/31/18 at 1:35 p.m., with the Intermediate Care Facility Administrator. The Administrator stated, they did not have documentation to ensure systems were in place to identify individuals who would require additional assistance, ensure that means for transport are accessible and available and that those involved are aware of the procedure to evacuate and identify types of services that the facility would be able to provide in an emergency.	E 007	The facility will create a list of strategies to provide supports during emergency events based on the individuals' risk assessments and the level of supports needed. The Chain of Communication section of the Emergency Preparedness policy will be updated to denote the delegation of authority during an emergency: "During an unforeseen emergency, the on-site Shift Leader/Direct Support Staff has the authority to manage the emergency situation including making emergency decisions; maintaining communication with emergency contacts; initiating purchases and use of contracts; directing staff, EMS and other resources necessary to manage the emergency and maintain the safety of the individuals served. Once the imminent danger has subsided, the on-site Shift Leader/Direct Support Staff will notify the ICF Supervisor or designee for support and directions." The Emergency Preparedness policy, including the delegation of authority, will be reviewed at a minimum of annually and as needed. All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 7/15/18 7/15/187/15/18
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be	E 015		

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E 015	Continued From page 3	E 015		

reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm

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E 015	Continued From page 4 systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to ensure a system was in place communicating provision of subsistence needs for staff and individuals. The facility staff failed to determine their supply needs during an emergency. The findings included: An interview was conducted on 5/31/18 at 1:35 p.m., with the Intermediate Care Facility Administrator. The Administrator stated, they did not have documentation to demonstrate their supply needs; food, pharmaceuticals, medical supplies, fire detection including extinguishing and alarm systems as well as sewage and waste disposal.	E 015	The facility will update the Facility Based Hazard Procedure section of the Emergency Preparedness policy to include the Fire Watch procedure. The Fire Watch form will be added to the Emergency Preparedness binder. The facility has contracts through the City of Virginia Beach with Elite Seats and Servpro. In the event of loss of sewage and waste disposal, Elite Seats will provide handicap accessible portable toilets, wash stations and sewage holding tanks within 4 hours of the order, 24 hours a day. Servpro will provide emergency restoration services due to fire, water and sewage damage. The policy and the emergency contact list will be updated to include these contract and emergency contact numbers. All staff will be trained on the updated Emergency Preparedness policy and contact list.	7/15/18 7/15/18 7/15/18 7/15/18
E 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]	E 018		

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E 018	Continued From page 5 (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and	E 018	The facility will update the Tracking Clients section of the Emergency Preparedness policy with the following: In order to track the location of on-duty staff and clients during an emergency, the facility will submit a list of the facility's clients and on-duty staff to the City of Virginia Beach's Emergency Management Office (EMO) for tracking purposes. In the event of evacuation, the facility will also submit the specific name, location, and contact numbers of the evacuation site. If there is a change in evacuation site, the ICF Supervisor or designee will provide the EMO with the specific name, location, and contact numbers of the new evacuation site, as well as a list of the clients and staff at the new location. Facility will research ID bands with identifying and contact information for tracking purposes in case the individual becomes separated from staff during emergency evacuation. All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 7/15/18 7/15/18 7/15/18

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E 018	Continued From page 6	E 018		

treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.
This STANDARD is not met as evidenced by:
Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to develop a means to track individuals and on-duty staff in the facility's care during an emergency event.

The facility staff failed to ensure a system was in place to track the location of on-duty staff and sheltered individuals who are relocated during the emergency.

The findings included;

An interview was conducted on 5/31/18 at 1:35 p.m., with the Intermediate Care Facility Administrator. The Administrator stated, they did not have documentation to describe the facility's method to ensure tracking the location of sheltered individuals and staff during and after an

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E 018	Continued From page 7 emergency event would be ready, available, accurate, and shareable among officials they to be to.	E 018		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to ensure policies and procedures were in place for shelter in the event that an evacuation cannot be executed.	E 022	The facility will update the Shortage of Staff section of the Emergency Preparedness policy to outline the limited duties of volunteers during an emergency: "If sheltering in place, a trained volunteer may provide assistance with only those duties for which they have previously been trained; volunteers may not accompany staff and residents to the evacuation site if evacuation is deemed necessary. Volunteers who have not gone through the City of Virginia Beach's vetting process will not be utilized except in an extreme emergency situation. During the extreme emergency, the volunteer will not provide any direct client care. The volunteer may only assist with non-client care related tasks, such as help securing the area, cleaning the grounds, or clearing access to the facility, calling 911 and directing arriving Emergency Services to the location. Once the immediate emergency has passed, the volunteer will be thanked for their assistance and dismissed. It is the policy of the ICF that only volunteers who have gone through a criminal background check and received training may assist with any direct client care." All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 7/15/18

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E 022	Continued From page 8 The facility's staff failed to provide documentation to include how it will provide a means to shelter individuals, staff, volunteers and visitors who remain in a facility. The findings included: On 5/31/18 at 1:35 p.m., an interview was conducted with the Intermediate Care Facility Administrator. The Administrator stated, he did not have documentation describing how the facility would shelter in place individuals, staff, volunteers and visitors in the event that an evacuation cannot be executed.	E 022		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E 025		

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E 025	Continued From page 9 *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to ensure policies and written agreements for evacuations were in place for other providers to transport and receive Individuals. The facility staff failed to have documentation describing arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. The findings included: On 5/31/18 at approximately 1:35 p.m., an interview was conducted with the the Intermediate Care Facility Administrator. The Administrator	E 025	The facility will identify the individual services the host ICF will provide to surged individual. The facility will update the Surge Capacity section of the Emergency Preparedness policy to include a list of services that will be provided to all received surged individuals. The facility will update the Surge Capacity section of the Emergency Preparedness policy to include the services that the facility will provide when receiving an individual from another facility: "The host ICF will only accept surged individuals from another City of Virginia Beach ICF. The host ICF will provide needed supplies such as protective undergarments, bathing facilities, available hygiene products and available adaptive equipment. The host ICF will provide a space for medication storage as well as basic nutrition. The host ICF will provide the individual with a personal space as outlined in the Surge Capacity Assessment. The host ICF will ensure privacy as much as possible. Nursing services will be provided as available." All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 7/15/18 7/15/18 7/15/18

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E 025	Continued From page 10 stated the facility didn't have a written agreement with other facilities to receive individuals in the event the facility was not able to care for them during an emergency.	E 025		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation describing the facilities role in providing care in an alternate care site. The facility staff failed to have documentation	E 026	The facility will update the Surge Capacity section of the Emergency Preparedness policy to include the services that will be provided to a surged individual at another facility: The ICF will only surge individuals to another City of Virginia Beach ICF. The guest ICF will supply direct care staff to support the surged individual and specialized nutrition, if applicable. The direct care staff's responsibilities will be outlined in the policy. "The DSP will provide assistance with all Activities of Daily Living including hygiene, medication administration, Physical Management and Active Treatment. The DSP will assist the individual with all of their nutritional needs and will provide basic First Aid within the scope of their training. Nursing services will be provided as available. This is not an all-inclusive list." All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 7/15/18

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E 026	Continued From page 11 describing the joint collaboration with a local facility on issues related to staffing, equipment and supplies at the alternate sites during a declared emergency. The findings included: An interview was conducted with the Intermediate Care Facility Administrator on 5/31/18 at 1:35 p.m. The Administrator stated, he did not have documentation describing the facilities role or the care that would be provided at an alternate care site as well as address potential transfers of patients; timelines of patients at alternate facilities, etc.	E 026		
E 033	Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]	E 033		

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E 033	Continued From page 12 (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the communication plan included a method for sharing information and medical documentation to maintain continuity of care. The facility staff failed to develop an emergency communication plan for sharing information and medical documentation with other health care providers to maintain continuity of care in the event of evacuation. The findings included; During an interview on 5/31/18 at 1:35 p.m., with the Intermediate Care Facility Administrator. The Administrator was asked to present evidence that	E 033	The facility will update the Emergency Preparedness policy to include obtaining a general authorization for release of information in an emergency from the Legal Guardian or Authorized Representative during admission and annually thereafter. All individuals will have a to-go bag which will include their Emergency Medical Information, Physical Management Plan and a picture of the individual. A copy of the Physical Management plan for all individuals will also be kept in the Emergency Preparedness binder as a backup. The ICF's Electronic Health Record is a web-based operating system and can be accessed remotely in case of emergency. A laptop with a hot spot will accompany the ICF during an evacuation to access medical information if needed. The City the Virginia Beach's Emergency Management Office will have contact with the ICF's Recovery Supervisory staff who will have remote access to the EHR as another backup to be able to share information. All staff will be trained on the updated Emergency Preparedness policy.	7/15/18 11/15/17 7/15/18 7/15/18

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E 033	Continued From page 13 the facility had a method for sharing information and medical care for individuals with other health care providers to maintain continuity of care. The Administrator stated the facility did not have documentation for sharing information and medical care needs for individuals at an alternate care site or with other health care providers.	E 033		
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have a method for sharing information of the Emergency Preparedness Plan with residents and families. The facility staff failed to develop an emergency communication plan for sharing information with Individual's, families or representatives. The findings included: During an interview on 5/31/18, at 1:35 p.m., with the Intermediate Care Facility Administrator, he was asked how, had the facility staff shared	E 035	The facility will provide a copy of the Emergency Preparedness plan to all Legal Guardians and Authorized Representatives. The review of the Emergency Preparedness will be documented by the Legal Guardian's and Authorized Representative's signature on the Natural Disaster/Weather Emergency Directions /Authorization Regarding Possible Evacuation of Client Form. This form will be kept in the individual's record. The Emergency Preparedness policy will be reviewed at admission and annually thereafter.	7/15/18 7/15/18

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E 035	Continued From page 14 information with residents and families? The administrator stated, the facility had not informed residents and families about the emergency preparedness plan and currently the facility staff had no method to share information of the emergency preparedness plan with residents and families.	E 035		
W 000	INITIAL COMMENTS An unannounced annual 55 Fundamental Medicaid Certification survey was conducted 5/30/18 through 6/1/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 5 bed facility at the time of the survey was 4. The survey sample consisted of 2 current individual records (Individual #1 and #2).	W 000		
W 136	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(11) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, clinical record review and staff interview, the residence staff failed to make accommodations during community integrations for one individual (Individual #2), in the survey sample of 2 Individuals. The residence staff failed to ensure community	W 136	Individual #2 had no adverse effects from attending a group community outing. 5/31/18 QIDP will meet with day support clinicians and discuss appropriate size of groups and community outing destinations for all individuals attending day support programs. 7/15/18 During the annual IDT meeting, the team will discuss preferred outing destinations. This will not be an exclusive list in order to not limit the individuals' experiences. 7/15/18 The preferred community outing destinations and activities will be discussed and noted in the IDT meeting minutes and IPP, annually. This will not be an exclusive list in order to not limit the individuals' experiences. 7/15/18	

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integration activities for Individual #2 took place in a small group.

The findings included;

Individual #2 was originally admitted to the residence 12/14/10. The current diagnoses included; Severe Intellectual Disability, Autism, and a seizure disorder.

On 5/31/18 at approximately 10:15 a.m., Individual #3, 5 peers and 2 staff members were observed boarding a bus at the day support program for a community outing. The bus ride ended at a local library. The bus stopped in front of the library entrance, one staff and Individual #2 along with the 5 peers unboarded the bus to enter the library as the second staff parked the bus. A lady leaving the library stopped and talked with the individuals. The surveyor was unable to hear what the lady was saying. The staff regained the individual's attention and proceeded to lead them into the library.

Once the individuals entered the library, 3 sat in an area which accommodated 3 individuals, 2 sat within a few steps from the 3 and the last individual sat at a table with a computer key board within arm reach of the 2. Shortly after the staff who drove the bus entered the library and monitored the individuals while the other staff assisted Individual #2 to the bathroom. Some peers were observed thumbing through magazines while others just sat. Once Individual #2 returned from the bathroom, one staff assisted him and another peer to speak with the library staff about obtaining computer access as the other 4 peers remained seated.

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An interview was conducted with the bus driving staff 5/31/18 at approximately 11:40 a.m., he stated usually they travel with 3 staff and 7 residents but on this day, their supervisor and one individual stayed at the day support program for a meeting.

Individual #2's Persons Centered Plan (PCP) dated 4/5/18 indicated he would continue to attend the 5 day per week program and the individual enjoys the group outings as well as the sister is satisfied with the services.

An interview was also conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 5/31/18 at approximately 5:10 p.m. The QIDP stated individuals should participate in activities they enjoy and in a group smaller than the one observed by the surveyor.

On 6/1/18 at approximately 10:25 a.m., an interview was conducted with the Direct Support Professional (DSP). The DSP stated; Individual #2 enjoys community outings such as swimming, motorcycle riding, church services, amusement parks and walking/shopping in the mall. The DSP further stated the residence has their own transportation and they usually travel with 2 individuals each.

The residence didn't have a policy on community integration opportunities and sizes of groups to maintain dignity.

On 6/1/18 at approximately 12:10 p.m., the above findings were shared with the Administrator, ICF Supervisor, Nurse Manager QIDP, House Manager. The Administrator commented, how did the surveyor know the lady at the library didn't

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W 136	Continued From page 17 know the Individuals because they frequented the library. The Administrator was informed the surveyor didn't hear what the lady said but the surveyor was sure the staff could inform them of the conversation. The above residential staff nodded, that if the individuals entering the library on 5/31/18 were their family of 7 persons or the average family, no one would have stopped them to interact or make remarks. They also stated the day support should have smaller groups when venturing into the community.	W 136		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on record review and staff interviews. the residence staff failed to notify Authorized Representatives of information pertinent to receiving necessary services for 2 individual (Individual #1 and #2), in the survey sample. 1. The residence staff failed to notify Individual #1 Authorized Representative (AR) of the inability to obtain dental services. 2. The residence staff failed to notify Individual #2 AR of the inability to obtain dental services.	W 148		

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The findings included;

1. Individual #1 was originally admitted to the residence 12/1/16. The current diagnoses included; Severe Intellectual Disability, Down's Syndrome, dementia and a seizure disorder.

Individual #1's undated Comprehensive Functional Assessment revealed, under hygiene; the individual was unable to select basic tooth brushing essentials and did not have tooth brushing skills.

Review of the clinical record revealed Individual #1, last received dental services 12/28/16. The consult stated the individual's teeth were cleaned by the hygienist and examined by the dentist. The individual was without cavities but was diagnosed with moderate - severe gingivitis (a gum disease which causes irritation, swelling and redness). The 12/28/16 consult instructions read; brush gumline 2 times each day for 2 minutes and floss 1 time each day, cleaning every 6 months (2 times each year). Gingivitis can be reversed if individual improves home care. Follow proper daily hygiene routine. Return in 6 months. The appointment date was 7/5/17.

Further review of the clinical record revealed no more dental services therefore; an interview was conducted with Licensed Practical Nurse (LPN) #1 on 5/31/18 at approximately 3:50 p.m. LPN #1 stated Individual #1 had not returned to the dentist because of insurance issues and non-payment for previous services. LPN #1 also stated the information had been forwarded to the appropriate staff twice but no information had

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W 148	Continued From page 19 been provided to the residence staff regarding the status of the bills or the ability to obtain additional dental appointments. LPN #1 was asked if the AR was notified of the residence staff inability to schedule further appointments. LPN #1 stated "no". On 5/31/17 at approximately 4:30 p.m., LPN #1 stated she received information from the person she had been communicating with about the dental bills that the bill was paid 5/15/18. Approximately 5:40 p.m., LPN #1 told the surveyor an appointment had been obtained for Individual #1 to see the dentist 6/14/2018. The above findings of the residential staff failing to notify the AR that the dentist wouldn't see Individual #1 was shared during a pre-exit meeting with the Administrator, ICF Supervisor, Nurse Manager QIDP, and House Manager on 6/1/18. The residence staff was offered the opportunity to present additional information but; did not. 2. Individual #2 was originally admitted to the residence 12/14/10. The current diagnoses included; Severe Intellectual Disability, Autism, and a seizure disorder. Individual #2's undated Comprehensive Functional Assessment revealed, under hygiene; the individual needs practice to select basic tooth brushing essentials and has basic tooth brushing skills; applies toothpaste to brush, brushes all teeth thoroughly, and rinses using mouthwash. Review of the clinical record revealed, Individual #2 also saw the dentist 2/1/17 for a cleaning and examination, which revealed additional areas of	W 148		

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W 148	Continued From page 20 decay. An appointment was scheduled for 2/1/17 at 14:40, during this visit 5 cavities were filled and moderate plaque and inflamed gum tissue was observed. Daily brushing and flossing was recommended. Documentation was also noted that the bill was processed through (name of the person) and carbon copied to the House Manager. Individual #2 saw the dentist again on 7/12/17 for routine cleaning, examination and x-rays. The individual had 4 areas with decay, moderate periodontal disease, heavy plaque and moderate calculus. Recommendation were brush minimally 2 times each day with a power brush and floss 1 time each day. Individual #2 was scheduled to return to the dental office for completion of above described services. Individual #2 last dental visit was 8/9/17. During the 8/9/17 dental visit the individual received 2 fillings anesthetic with and instructed not to eat or drink for 2 hours. The dental consult also stated "lots of plaque, needs to be brushed better 2 times each day. Next appointment 1/17/18 at 9:20 a.m. Further review of the clinical record revealed no more dental services therefore; an interview was conducted with Licensed Practical Nurse (LPN) #1 on 5/31/18 at approximately 3:50 p.m. LPN #1 stated Individual #2 had not returned to the dentist because of insurance issues and non-payment for previous services. LPN #1 also stated the information had been forwarded to the appropriate staff but no information had been provided to the residence staff regarding the status of the bills or the ability to obtain additional dental appointments. LPN #1 was asked if the AR	W 148	Individual's overdue bill was paid, his appointment was rescheduled and his family/AR was informed of upcoming appointment. Facility RN will review all individuals' charts and note upcoming dental service due dates. ARs/LGs of all individuals will be notified by RN or designee of upcoming dental appointments. Nursing quarterlies for all individuals, including date of last dental service, will be sent to QIDP for review. Communication policy will be updated: "AR/LG will be notified if Individual is not able to receive the treatment within the required timeframe." All staff will be retrained on updated Communication policy.	6/1/18 7/15/18 7/15/18 7/15/18 7/15/18 7/15/18

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W 148	Continued From page 21 was notified of the residence staff inability to schedule further appointments. LPN #1 stated "no". On 6/1/17 at approximately 12:10 p.m., LPN #1 stated an appointment had been obtained for Individual #2 to see the dentist 6/2018. The above findings of the residential staff failing to notify the AR that the dentist wouldn't see Individual #2 was shared during a pre-exit meeting with the Administrator, ICF Supervisor, Nurse Manager QIDP, and House Manager on 6/1/18. They acknowledged by nodding the ARs should have been notified. The residence staff was offered the opportunity to present additional information but; did not. The residence had no policy on notification or AR/designee but on 5/31/18 at approximately 5:00 p.m., the QIDP stated, AR's are notified of significant incidents, serious conditions, and changes in condition.	W 148		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by:	W 242		

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	49G040	A. BUILDING _____ B. WING _____	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLBY WAY RESIDENCE	6316 COLBY WAY VIRGINIA BEACH, VA 23464

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W 242	Continued From page 22 Based on observation, record review and staff interviews, the facility staff failed to to implement an Individual Program Plan (IPP) for one Individual (Individual #1), in the survey sample. The facility staff failed to implement; self use of a specialty cup, which encouraged Individual #1 independence with fluid consumption. The findings included; Individual #1 was originally admitted to the residence 12/1/16. The current diagnoses included; Severe Intellectual Disability, Down's Syndrome, dementia and a seizure disorder. On 5/30/18 at approximately 3:15 p.m., Individual #1 was observed seated in the family room. The individual held a specialty cup in hand and proudly showed the multi-colored cup to the surveyor and proceeded to take a drink repetitively. At approximately 5:10 p.m., Individual #1 was observed seated in the custom wheel chair perpendicular to the Direct Service Professional (DSP) assisting with the meal. The DSP spooned the food and introduced it into the individual's mouth, the staff handed the individual the specialty cup and sips were taken until he completed what was wanted from the meal. On 5/31/18 at approximately 5:25 p.m., Individual #1 was again observed consuming the supper meal. The individual was seated in the custom wheel chair, leaning more to the right side though, a positioning device was present. The DSP introduced spoonfuls of food into the individual's mouth and introduced the specialty cup to give sips. Throughout the meal the individual wasn't offered or prompted to utilize the	W 242	Staff will be retrained on Individual #1's active learning objective related to self-use of specialty cup (Obj. 2.01). QIDP will observe all individuals' meal times and use of appropriate supports based on the individuals' IPP. Staff will be retrained on all residents' ADL related objectives, especially focusing on trainings in personal skills that are essential for independence. Staff training materials - annual PPTs - will be updated with the following information: "Active treatment is implemented to allow the individual to function with as much independence as possible." Staff will be retrained on active treatment components: objectives, methods and prompt levels. Periodic observation by the QIDP/House Manager will ensure that staff follow all individuals' IPPs as written.	7/15/18 7/15/18 7/15/18 7/15/18 7/15/18 7/15/18

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specialty cup.

The occupational therapist assessment dated 5/10/18, provided the following instructions for mealtime characteristics and positioning; Present the cup to (name of individual)'s right hand for self-feeding and provide verbal cues to take a drink after each bite. Provide 1:1 supervision to be readily available to provide verbal cues to maintain upright positioning and drink independently from the specialty cup to maintain self-feeding skills.

The undated Comprehensive Functioning Assessment read; (name of individual) drinks from a specialty cup without assistance, as uncovered cups are difficult to handle due to frequent clonus.

The residence had no policy on implementing individual programs to maintain independence but, on 5/31/18 at approximately 5:00 p.m., an interview was conducted with the QIDP. The QIDP stated, a new plan had been developed but not yet instituted. The QIDP further stated, some days Individual #1 experiences difficulty with the specialty cup and the DSP staff has to provide the service as the individual continues to decline in functional abilities related to disease process.

The above findings of the residential staff failing to ensure Individual #1 was allowed as much independence as possible using the occupational therapist issued specialty cup, were shared during a pre-exit meeting with the Administrator, ICF Supervisor, Nurse Manager QIDP, and House Manager on 6/1/18. The residence staff was offered the opportunity to present additional information but did not.

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W 348	DENTAL SERVICES CFR(s): 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to secure dental services for 2 individual (Individual #1 and #2), in the survey sample. 1. The facility staff failed to ensure Individual #1 received every 6 month and other necessary dental services. 2. The facility staff failed to ensure Individual #2 received scheduled maintenance, as needed and every 6 month dental services. The findings included; 1. Individual #1 was originally admitted to the residence 12/1/16. The current diagnoses included; Severe Intellectual Disability, Down's Syndrome, dementia and a seizure disorder. Individual #1's undated Comprehensive Functional Assessment revealed, under hygiene; the individual was unable to select basic tooth brushing essentials and did not have tooth brushing skills. Review of the clinical record revealed Individual #1, last received dental services 12/28/16. The	W 348	Individual #1 is scheduled to receive dental services on 7/23/18. Individual #2 received dental services on 6/14/18 as scheduled.	7/23/18
			Facility RN will review all individuals' charts and note upcoming dental service due dates.	7/15/18
			A Dental Service Tracking Form will be developed for nurses to use in order to track and schedule dental services recommended by the individuals' dentists.	7/15/18
			Reminders to schedule appointments will be placed on Outlook group calendar by RN or designee.	7/15/18
			The Dental Service Tracking Form will be monitored monthly by the Nurse Manager noting when services are due and when services are completed.	7/15/18

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consult stated the individual's teeth were cleaned by the hygienist and examined by the dentist. The individual was without cavities but was diagnosed with moderate - severe gingivitis (a gum disease which causes irritation, swelling and redness). The 12/28/16 consult instructions read; brush gumline 2 times each day for 2 minutes and floss 1 time each day, cleaning every 6 months (2 times each year). Gingivitis can be reversed if individual improves home care. Follow proper daily hygiene routine. Return in 6 months. The appointment date was 7/5/17.

Further review of the clinical record revealed no more dental services therefore; an interview was conducted with Licensed Practical Nurse (LPN) #1 on 5/31/18 at approximately 3:50 p.m. LPN #1 stated Individual #1 had not returned to the dentist because of insurance issues and non-payment for previous services. LPN #1 also stated the information had been forwarded to the appropriate staff twice but no information had been provided to the residence staff regarding the status of the bills or the ability to obtain additional dental appointments.

On 5/31/18 at approximately 4:30 p.m., LPN #1 stated she received information from the person she had been communicating with about the dental bills that the bill was paid 5/15/18. Approximately 5:40 p.m., LPN #1 told the surveyor an appointment had been obtained for Individual #1 to see the dentist 6/14/2018.

The above findings of the residential staff failing to ensure Individual #1 received necessary dental services were shared during a pre-exit meeting with the Administrator, ICF Supervisor, Nurse Manager QIDP, and House Manager on 6/1/18.

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The residence staff was offered the opportunity to present additional information but; did not.

2. Individual #2 was originally admitted to the residence 12/14/10. The current diagnoses included; Severe Intellectual Disability, Autism, and a seizure disorder.

Individual #2's undated Comprehensive Functional Assessment revealed, under hygiene; the individual needs practice to select basic tooth brushing essentials and has basic tooth brushing skills; applies toothpaste to brush, brushes all teeth thoroughly, and rinses using mouthwash.

Review of the clinical record revealed, Individual #2 also saw the dentist 2/1/17 for a cleaning and examination, which revealed additional areas of decay. An appointment was scheduled for 2/1/17 at 14:40, during this visit 5 cavities were filled and moderate plaque and inflamed gum tissue was observed. Daily brushing and flossing was recommended. Documentation was also noted that the bill was processed through (name of the person) and carbon copied to the House Manager.

Individual #2 saw the dentist again on 7/12/17 for routine cleaning, examination and x-rays. The individual had 4 areas with decay, moderate periodontal disease, heavy plaque and moderate calculus. Recommendation were brush minimally 2 times each day with a power brush and floss 1 time each day. Individual #2 was scheduled to return to the dental office for completion of above described services.

Individual #2 last dental visit was 8/9/17. During

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the 8/9/17 dental visit the individual received 2 fillings anesthetic with and instructed not to eat or drink for 2 hours. The dental consult also stated "lots of plaque, needs to be brushed better 2 times each day. Next appointment 1/17/18 at 9:20 a.m.

Further review of the clinical record revealed no more dental services therefore; an interview was conducted with Licensed Practical Nurse (LPN) #1 on 5/31/18 at approximately 3:50 p.m. LPN #1 stated Individual #2 had not returned to the dentist because of insurance issues and non-payment for previous services. LPN #1 also stated the information had been forwarded to the appropriate staff but no information had been provided to the residence staff regarding the status of the bills or the ability to obtain additional dental appointments.

On 6/1/18 at approximately 12:10 p.m., LPN #1 stated an appointment had been obtained for Individual #2 to see the dentist 6/2018.

The above findings of the residential staff failing to ensure Individual #2 received necessary dental services were shared during a pre-exit meeting with the Administrator, ICF Supervisor, Nurse Manager QIDP, and House Manager on 6/1/18. The residence staff was offered the opportunity to present additional information but; did not.

The residence dental policy dated 12/1/15 read; It is the policy of (name of the agency) to follow procedures that ensure dental screenings and treatment are appropriately provided to individuals. Under procedure the policy read; dental care will be provided outside the facility. Under dental services, #2b read; Resident's with

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W 348	Continued From page 28 teeth will receive oral examinations and prophylaxes at least every 6 months; however, individual's dental health needs, will be completed to included but limited to: Examination and diagnosis, including radiographs, when indicated and detection of all manifestation of systemic disease, through cleaning, elimination of infection or life hazardous oral conditions, oral cancer, or cellulitis, treatment of injuries, restoration of decayed or fractured teeth, replacement of missing permanent teeth, when indicated, appropriate pain control procedures for optimal care of the individual, problems such as "bad breath" will be assessed for the cause and referred to other medical specialist as needed. Dental Services #5 read; The Dental Health Summary Form will be completed yearly by the dental professional and filed in the individual's Health Care record at the facility.	W 348		