STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G013	A. BUILDING _____ B. WING _____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLIDAY HOUSE OF PORTSMOUTH INC	4211 COUNTY STREET PORTSMOUTH, VA 23707

(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	{E 000}		
{W 000}	INITIAL COMMENTS An unannounced Fundamental Medicaid revisit survey to the re-certification survey conducted 4/23/19-4/26/19 & 4/29/19 was conducted 6/11/19 through 6/14/19. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). One complaint was investigated during the survey. The census in this 28 certified bed facility was 28 at the time of the survey. The survey sample consisted of 5 current Individual reviews (Individuals #101 through #105).	{W 000}	Point 1: How Corrective Action Taken for the Identified problem. The Maintenance Department removed all tree limbs, leaves, and steel rods along the fence area. The weeds and vines have been removed from around the fence area. The Maintenance Staff removed the wooden spoils that were by the fence area. All 15 Metal Storm shutter have been put into a recently purchased 10X12 storage shed. The metal pole and aluminum siding panels have also been put into the storage shed. The facility purchased a 20x12 storage shed on June 13, 2019 to keep items from lying around. Point #2 How will the facility identify similar occurrences. How corrective action taken for the identified problem. The Chief Administrative Officer and the Maintenance Supervisor met and did a physical walk through of the grounds. The Chief Administrative Officer inspected the grounds to assure that all things identified in Point #1 have been completed. Point #3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur. A 10X12 storage shed was purchased on June 13, 2019 to store items. This will keep items from being on grounds. The facility has signed a landscaping contract with East Cost and Enhancement. The company will complete the cutting and removing of tree limbs. Mowing and edging the yard bi-weekly. Replenishing mulch on the play ground and flowerbeds. Remove any weeds and vines.	
{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 observations and staff interview, the facility staff failed to ensure the environment remained in a safe and sanitary manner. The findings included: During an environmental inspection on 06/12/19 at 1:48 P.M., the facility's play ground area was observed to have tree limbs, leaves, and steel rods along the fence area. The fence area that encompassed the playground area was observed	{W 104}		7/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Chief Administrative Officer — (X6) DATE: 7/5/19

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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{W 104}	Continued From page 1 to have weeds and vines intertwined the fence. Five large wooden spoils measuring approximately 3 ft wide by 2 ft high were observed along the fence area next to a storage shed. A storage shed next to the playground was observed to have approximately 15 metal storm shutters metal sheets lying on the side of the shed. A metal pole and several aluminum siding panels were observed behind the storage shed. During an interview on 06/13/19 at 10:00 A.M. the Administrator stated he needed to order a storage shed to get the items placed in a secure location.	{W 104}	Point #4 How the facility plans to monitor its performance. Dates when the corrective action will be completed. The Chief Administrative Officer or designee will do a walk through of the physical property weekly. If any deficiency practices are identified, it will be corrected immediately and addressed monthly at the Risk Management meeting. Target Date: 7/5/19	7/5/19
W 187	DIRECT CARE STAFF CFR(s): 483.430(d)(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients: (i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2; (ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4; (iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4. This STANDARD is not met as evidenced by: Based on record review, complaint investigation and staff interview, the facility staff failed to provide staffing in minimum ratios of direct care	W 187	Point 1: Address how corrective action will be accomplished to address the issue(s), for <u>those individuals</u> found to have been affected by the deficient practice. The QIDP reviewed Individual #101 Individualized Support Plan and determined more supervision is needed during the night time hours. The IDT recommended that she receives level one supervision level 2 during the hours of 7pm-7am (Level 2 means staff must be visually focus and the individual #101 must be within eyesight of staff at all times). The QIDP will complete the ISP change note to reflect the change of supervision level. Evidence of ISP change note will be placed in the individual's medical record. The QIDP reviewed Individual #102 Individualized Support Plan and determined more supervision is needed during the night time hours. Individual #102 bedroom was moved from being adjacent from Individual #101. The IDT recommended that he receives level one supervision level 2 during the hours of 7pm-7am (Level 2 means staff must be visually focus and the individual #102 must be within eyesight of staff at all times). The QIDP will complete the ISP change note to reflect the change of supervision level. Evidence of ISP change note	

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W 187	Continued From page 2 staff to Individuals. The findings included: The facility failed to provide staff in ratios for Individuals with multiple disabilities, aggressive, assaultive and security risks who also manifest severely hyperactive or psychotic-like behaviors. A review of a facility provided video and a Facility Incident Report dated May 11, 2019 revealed: Individual #101, a female, dressed Individual #102, a male, in her clothing. Individual #101 had Individual #102 to take his shirt off and she put her bra on him. Individual #101 then took a belt and hit Individual #102. Individual #102 was found in Individual #101's closet fully dressed in her clothes and sandals. During an interview conducted by staff with Individual #101 on 5/11/19 staff were able to determine that she touched his chest and his private area. A review of the video indicated Individual #102 walked into Individual #101 bedroom at 6:26 A.M. and was not observed by staff until 6:53 A.M. A review of the as worked schedule for May 11, 2019 revealed: Six direct care staff worked the 11-7 shift on the Middle Unit were Individuals #101 and #102 resided. One staff served as Team Leader for the Middle, Right and Left Units. Two Individuals required Level 1 supervision, (requiring 1:1 supervision) with staff switching off every two hours. Twelve Individuals on the Middle Unit had aggressive and assaultive behaviors which included: headbutting, spitting scratching, hitting, biting, kicking, biting others, property destruction, grabbing others, throwing objects, and elopement. Five individuals were noted to be	W 187	will be placed in the individual's medical record. The QIDP reviewed Individual #102 Individualized Support Plan and determined more supervision is needed during the night time hours. Individual #102 bedroom was moved from being adjacent from Individual #101. The IDT recommended that he receives level one supervision level 2 during the hours of 7pm-7am (Level 2 means staff must be visually focus and the individual #102 must be within eyesight of staff at all times). The QIDP will complete the ISP change note to reflect the change of supervision level. Evidence of ISP change note will be placed in the individual's medical record. The QIDP reviewed Individual #103 Individualized Support Plan and determined more supervision is needed during waking hours. The IDT recommended that he receives Level 2 one to one supervision during waking hours. (Level 2 means staff must be visually focus and the individual #103 must be within eyesight of staff at all times). The QIDP will complete the ISP change note to reflect the change of supervision level. Evidence of ISP change note will be placed in the individual's medical record. The QIDP reviewed Individual #104 Individualized Support Plan and determined more supervision is needed during waking hours. The IDT recommended that she receives Level 2 one to one supervision during waking hours. (Level 2 means staff must be visually focus and the individual #104 must be within eyesight of staff at all times). The QIDP will complete the ISP change note to reflect the change of supervision level. Evidence of ISP change note will be placed in the individual's medical record. Point 2: Address how the facility will identify other individuals having the potential to be affected by the safe deficient practice. The Residential Management Team met to discuss the facility's census and each individual's support needs. It was determined that on a daily basis the schedule will be staffed with 25 Direct Support Professionals during the evening shift, and 13	7/25/19

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W 187	Continued From page 3 under 12 years old. A review of a facility provided video and a Facility Incident Report dated May 19, 2019 indicated: Individual #104 was physically abused by a direct care staff. Individual #104 was observed on the video on May 19, 2019 at 8:12 P.M. being escorted to the bathroom for evening hygiene. The direct care staff was observed pushing Individual #104 down and dragging her into the bathroom. A review of the as work schedule for May 19, 2019 indicated: Seven direct care staff worked on the Right Wing evening shift where Individual #104 resided. Three staff worked from 7:00 A.M. until 7:00 P.M. and one was also assigned Level 1 supervision for one individual. One direct care staff worked from 1 P.M. until 9 P.M.. Two direct care staff worked from 3 :00 P.M. until 7:00 P.M. and one direct care staff worked from 8:00 A.M. until 8 P.M.. Two staff worked from 3:00 P.M. until 11:00 P.M. The incident occurred at 8:12 P.M. with three staff on duty. One staff was assigned 1:1 duties for level 1 Supervision. Fourteen Individuals resided on the Right Wing. Five Individuals on the right wing were noted to have aggressive behaviors of headbutting, spitting, scratching, hitting, kicking, kicking others, destruction of property and biting others. Two Individuals had behaviors requiring one to one supervision requiring level 2 supervision. A review of a facility provided video and a Facility Incident Report dated May 25, 2019 revealed: Individual #103 was physically assaulted by a	W 187	Direct Support Professionals during the overnight shift. ALL fulltime Direct Support Professionals positions have been filled. Point 3: Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur. The facility has entered a contract agreement with ARVON STAFFING. Arvon will assign its employees (Direct Support Professionals) to perform the type of work described by Holiday House of Portsmouth outlined in the job description provided to Arvon by Holiday House of Portsmouth, ICF/IID. In the event Holiday House of Portsmouth is short staffed the Residential Manager will contact Arvon staffing to provide the additional staff needed. Point 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Residential Services will be provided the staffing schedule on a daily basis to ensure the facility staffing is compliant with 25 Direct Support Professionals on the evening shift and 13 Direct Support Staff on the overnight shift. Completion Date: July 25, 2019	7/25/19

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W 187	Continued From page 4	W 187		

direct care staff. Direct care staff was observed walking over to Individual #103 and forcefully pushed him on his right upper shoulder while Individual #103 was sitting in a chair. The direct care staff was also observed to pick up a chair and walk towards Individual #103 and make a motion as if to hit Individual #103.

The Incident occurred at 6:50 A.M. on May 25, 2019. The incident occurred on the Right Wing of the living site.

A review of the as worked schedule for May 25, 2019 indicated: Seven direct care staff worked on the Right Wing evening shift where Individual #104 resided. Three staff worked from 7:00 A.M. until 7:00 P.M. and one was also assigned Level 1 supervision for one individual. One direct care staff worked from 1 P.M. until 9 P.M.. Two direct care staff worked from 3 :00 P.M. until 7:00 P.M. and one direct care staff worked from 8:00 A.M. until 8 P.M.. Two staff worked from 3:00 P.M. until 11:00 P.M.

One staff was assigned 1:1 duties for level 1 Supervision. Fourteen Individuals resided on the Right Wing.

Five Individuals on the right wing were noted to have aggressive behaviors of headbutting, spitting, scratching, hitting, kicking, kicking others, destruction of property and biting others. Two Individuals had behaviors requiring one to one supervision requiring level 2 supervision.

During an interview on 6/13/19 at 9:05 A.M. with the Residential Manager she stated, the facility was short of staff. The Residential Manager stated, the minimum staff needed was 16 full time

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W 187	Continued From page 5 staff per shift. During an interview on 6/14/19 at 1:25 P.M.. with the Administrator he stated, the facility was under staff. He stated, the facility was down 3 full time direct care staffs, and 15 part time direct care staff. The Administrator stated, staffing is a continuous problem or retaining. "It has been a struggle keeping staff." Many staff work over time to help with coverage. A facility Staffing Policy included: "It is the policy of the facility to provide staff in an adequate amount to ensure that the individuals are safe and provided support."	W 187		
{W 189}	Complaint Deficiency. STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide each employee with continuing training in accordance to the facility's Plan of Correction. The findings included: A review of the facility's Plan of Correction to the April 29, 2019 re-certification survey with a date of compliance of June 7, 2019, revealed direct care staff did not receive continuing training	{W 189}	Point 1: Address how corrective action will be accomplished to address the issue(s), for those individuals found to have been affected by the deficient practice. All Holiday House of Portsmouth staff will be trained on abuse, neglect, mistreatment policy and One to One supervision training upon initial orientation and annually thereafter. Point 2: Address how the facility will identify other individuals having the potential to be affected by the safe deficient practice. All Holiday House of Portsmouth staff will be trained on abuse, neglect, mistreatment policy and One to One supervision training upon initial orientation and annually thereafter. **ALL** Holiday House staff were trained on the abuse and neglect policies of this facility on June 19, 2019. ALL Staff signatures have been documented on the facility's training Roster. The QIDP will train ALL Holiday House of Portsmouth staff regarding one to one supervision policy at the ALL Staff Meeting scheduled for July 17, 2019. ALL staff signatures will be documented on the facility's training Roster.	

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{W 189}	Continued From page 6 involving one to one supervision of Individuals. A review of the Plan of Corrections documentation presented during the Revisit Survey indicated only supervisors received training on one to one supervision of Individuals. During an interview with the Administrator on 06/13/19 at 1:25 P.M. the Administrator stated, "He felt only the supervisors needed to be re-trained on one to one supervision." When asked who provided the one to one supervision, the Administrator stated the direct support staff. A facility policy and procedure indicated: "The assigned staff will follow the guidelines of One to One Supervision (LEVEL ONE), which means the assigned staff will be visually focused on the individual (individual must be with in eyesight of staff at all times), the staff person will be within one arms's length of Individual, this person will implement the schedule of activities for the day, the assigned staff will rotate every 2 hours with another designated staff person, the one to one staff will be responsible for implementing the individuals behavior support plan and document every 2 hours regarding engagement activities with the Individual. When asked about staff receiving training regarding the facility's Abuse and Neglect Policy he stated, "Only the supervisors were trained." A review of the documented training records provided during the survey did not indicate direct care staff received training in accordance with the Plan of Correction with a compliance date of June 7, 2019.	{W 189}	Point 3: Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur. The facility staff will be retrained every month at the facility's All Staff meeting in the areas of Mandated Reporting, Abuse, Neglect, and Mistreatment. Signatures of compliance will be on the facility's staff training Roster. The facility staff will be retrained every month at the facility's All Staff meeting in the areas of One to One Supervision Signatures of compliance will be on the facility's training Roster. Point 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. A copy of the staff signature roster addressing abuse, neglect, mistreatment policies and mandating reporter will be brought to the Risk Management Meeting every month to ensure compliance. A copy of the staff signature Roster addressing one to one supervision policies will be brought to the Risk Management Meeting every month to ensure compliance. Completion Date: July 25, 2019	7/25/19
W 239	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(vi)	W 239		

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W 239	Continued From page 7 Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to develop replacement program plans of inappropriate behaviors that is adaptive or appropriate for two of five individuals (Individuals #101 and #102) in the survey sample. The findings included: 1. Individual #101 was admitted to the facility on 08/15/16 with diagnoses of Down syndrome, oppositional defiant disorder, attention deficit with hyperactivity disorder, encopresis (repeatedly having bowel movements in places other than the toilet after the age when bowel control can normally be expected), and moderate intellectual disability. Behaviors for this individual included, aggression, inappropriate touching, masturbating and defecating on self. A review of a facility provided video and a Facility Incident Report dated May 11, 2019 indicated: Individual #101 a female dressed Individual #102 a male in her clothing. Individual #101 had Individual #102 to take his shirt off and she put her bra on him. Individual #101 then took a belt and hit Individual #102. Individual #102 was found in Individual #101's closet fully dressed in her clothes and sandals. During staff interview with	W 239	Point 1: Address how corrective action will be accomplished to address the issue(s), for those individuals found to have been affected by the deficient practice. The Facility QIDP spoke with Individual #101 to discover why she exhibited the behaviors dressing males in females clothing and beating them with belts. It is the response of Individual #101 that "(she liked individual# 102). Individual #101 Individualized Support Plan was amended and reads "Individual #101 will be provided the opportunity on a daily to read books about building healthy, respectful, and equable relationships. The QIDP will complete the ISP change note to reflect the new Individualized Support Plan Goal. Evidence of ISP change note will be placed in the individual's medical record. Individual #102 Individualized Support plan was amended and reads" Individual #102 will learn to advocate for himself to protect him for vulnerability to abuse daily (i.e. Use of social stories, books, internet (computer). Point 2: Address how the facility will identify other individuals having the potential to be affected by the safe deficient practice. If an individual is exhibiting an inappropriate behavior Holiday House staff will document the behavior on a behavior narrative form. The QIDP will call an Interdisciplinary Team Meeting to baseline the inappropriate behavior and to discover why the behavior is occurring. Upon discovering "why" the behavior is occurring the team will develop associated training objectives to help the individual develop more appropriate behaviors. The QIDP will amend the ISP and complete the ISP change note to reflect the change. Evidence of change note will be filed in the individual's medical record. Point 3: Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur. If the staff observes an individual exhibiting an inappropriate behavior the Direct Support	7/25/19

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W 239	Continued From page 8 Individual #101 on 5/11/19, staff were able to determine that she touched his chest and his private area. During an interview on 06/13/19 at 10:15 A.M. with the Director of Nursing (DON), Social Worker (SKW), and the designated Qualified Intellectual Disability Professional (QIDP), they were asked had program plans been developed for Individual #101 dressing males in females clothing and beating them with belts. Staff stated, no they had not thought that her behaviors needed to be addressed. She has a behavior program plan for inappropriate touching of others. Staff were asked if dressing males in her clothing and beating them was inappropriate? The staff stated, "Yes." The staff followed up by stating they would contact the Behavior Support Consultant. 2. The facility staff failed to develop program plans for Individual #102 who was placed in female clothes and beaten with a belt. Individual #102 was admitted to the facility on March 18, 2019 with diagnoses which included Autism Spectrum Disorder, seizure disorder, language disorder, and Moderate Intellectual Disability. Individual #102 had behaviors of self-Injury, disruptive behaviors, emotional outburst (yelling, screaming. crying, stomping his feet, slamming doors, falling to flour, ripping his clothing, and threatening others). In the area of self-injury this individual hits, punches, bites, scratches, pinches, steps on his own feet and pull his hair. A review of a facility provided video and a Facility Incident Report dated May 11, 2019 indicated:	W 239	Professional will document this information on a behavior narrative form and submit the form to the Residential Supervisor. Residential Supervisor will review the behavior narrative form and forward a copy of the behavior narrative form to the facility QIDP. The Facility QIDP will call an Interdisciplinary Team Meeting to baseline the inappropriate behavior and to discover why the behavior is occurring. Upon discovering "why" the behavior is occurring the team will develop associated training objectives to help the individual develop more appropriate behaviors. The QIDP will amend the ISP and complete the ISP change note to reflect the change. Evidence of change note will be filed in the individual's medical record. Point 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The QIDP will review the behavior narrative forms for all individuals weekly to determine if an individual exhibited an inappropriate behavior. If an individual is exhibiting an inappropriate behavior Holiday House staff will document the behavior on a behavior narrative form. The QIDP will call an Interdisciplinary Team Meeting to baseline the inappropriate behavior and to discover why the behavior is occurring. Upon discovering "why" the behavior is occurring the team will develop associated training objectives to help the individual develop more appropriate behaviors. The QIDP will amend the ISP and complete the ISP change note to reflect the change. Evidence of change note will be filed in the individual's medical record. Completion Date: July 25, 2019	7/25/19

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HOLIDAY HOUSE OF PORTSMOUTH INC	4211 COUNTY STREET PORTSMOUTH, VA 23707

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W 239	Continued From page 9 Individual #101 a female dressed Individual #102 a male in her clothing. Individual #101 had Individual #102 to take his shirt off and she put her bra on him. Individual #101 then took a belt and hit Individual #102. Individual #102 was found in Individual #101's closet fully dressed in her clothes and sandals. During an interview with Individual #101 on 5/11/19 staff were able to determine that she touched his chest and his private area. During an interview on 06/13/19 at 10:15 A.M. with the Director of Nursing (DON), Social Worker (SKW), and the designated Qualified Intellectual Disability Professional (QIDP), they were asked had program plans been developed for Individual #102 being dressed in females clothing and having a female beat him with a belt. Staff stated, no they had not thought that his behaviors needed to be addressed. Staff were asked if dressing Individual #102 in Individual #101 clothing and beating them was inappropriate? The staff stated, "Yes." A Program Implementation Policy (ACTIVE TREATMENT) dated 10/10/2016 indicated: "Individuals served at the facility shall receive active treatment as defined below. Active treatment means: daily participation, in accordance with an individualized plan of care, in a program of professionally developed and supervised therapies, activities, and experiences aimed at meeting the individual's needs." The facility staff failed to develop program plans that was adaptive or appropriate to meet the individuals needs.	W 239		
W 340	NURSING SERVICES	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G013	A. BUILDING _____ B. WING _____	R-C 06/14/2019

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W 340	Continued From page 10 CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to develop training appropriate for health (sexuality) program plans for one of five individuals (Individual #101) in the survey sample. The findings included: Individual #101 was admitted to the facility on 08/15/16 with diagnoses of Down syndrome, oppositional defiant disorder, attention deficit with hyperactivity disorder, encopresis (repeatedly having bowel movements in places other than the toilet after the age when bowel control can normally be expected), and moderate intellectual disability. Behaviors for this individual included, aggression, inappropriate touching, masturbating and defecating on self. A review of a facility provided video and a Facility Incident Report dated May 11, 2019 indicated: Individual #101 a female dressed Individual #102 a male in her clothing. Individual #101 had Individual #102 to take his shirt off and she put her bra on him. Individual #101 then took a belt and hit Individual #102. Individual #102 was found in Individual #101's closet fully dressed in her clothes and sandals. During an interview with Individual #101 on 5/11/19 staff were able to	W 340	**W340 Point #1: How corrective action will be accomplished for those individuals found to have been affected by the deficient practice.** The Director of Nursing will meet with the nursing department including agency nurses to review the current survey. It was reported that during an interview on May 11, 2019, individual # 101 inappropriately touch individual #102 on the chest and private area. On June 12, 2019 Individual # 101 was seen by the GYN for family planning services. Individual #101 will be routinely seen annually by GYN or as needed, and every 3 months for Depo Provera injections and education on appropriate health and hygiene by the nursing staff. Completion Date: July 25, 2019 **Point#2: How the facility will identify other individuals having the potential to be affected by the same deficient practice:** The Director of Nursing will meet with the nursing department including agency nurses to review the current survey. The Director of Nursing and Charge Nurse will train the nursing department on "Healthy Boundaries and Hygiene Education for Teens." In addition, the nursing department will review an educational training video (Introduction to Sex- Ed for Self- Advocates) to help them better understand how to educate individuals at Holiday House with disabilities on healthy relationships, and sexuality. Healthy Boundaries and Hygiene Education for Teens is a training created by Holiday House of Portsmouth which will include but is not limited to 11 training modules with pictures that illustrates the basic topics in sexuality education. Healthy Boundaries and Hygiene Education for Teens will be offer to all individuals with the cognitive ability to understand the program. This training will be offer annually or when inappropriate boundaries behaviors has occurred. The nurses will acknowledge understanding after watching the video by signing off on the training roster. Completion Date: July 25, 2019 **Point #3: What measures will be put into place or**	7/25/19

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W 340	Continued From page 11 determine that she touched his chest and his private area. During an interview on 06/13/19 at 10:15 A.M. with the Director of Nursing (DON), Social Worker (SKW), and the designated Qualified Intellectual Disability Professional (QIDP), they were asked had program plans been developed for Individual #101 sexuality (dressing a male in female clothing and beating them with belts). Staff stated, no they had not thought that her behaviors needed to be addressed. She has a behavior program plan for inappropriate touching of others. Staff were asked if dressing males in her clothing and beating them was inappropriate? The staff stated, "Yes." Staff were asked if any training needs involving Individual #101 sexuality to prevent sexually transmitted diseases, or family planning been addressed in her program plan. The staff stated, "No."	W 340	**systemic changes made to ensure that the deficient practice will not reoccur:** Healthy Boundaries and Hygiene Education for Teens will be offer to all individuals with the cognitive ability to understand the basic fundamental of the program. This training will be offer annually for individuals 15 years and older, or when inappropriate boundaries behaviors has occurred. Completion Date: July 25, 2019 **Point #4: How the facility plans to monitor it performance to make sure that solutions are sustained; Dates when the corrective action will be completed**. Inappropriate boundaries occurrences requiring additional training will be reviewed during the individual's quarterly meeting. Completion Date: July 25, 2019	7/25/19