STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VAICFID90	A. BUILDING _____ B. WING _____	09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOME ICF	999 LAKE VIEW ROAD LYNCHBURG, VA 24502

(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 09/04/19. 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 complaints were investigated during the survey.	E 000	1) Address the corrective action taken for the problem. a. Horizon BH's Health and Safety Officer will developed a policy and procedure for the provision of sewage and waste disposal services in the event of an emergency and added the policy and procedure to the Emergency Preparedness Plan on 9/16/19.	9/30/19
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 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):]	E 015	b. Horizon BH's Procurement and Facilities Manager will obtain a current, specific agreement provided by sewage and waste disposal services in regards to an emergency response contingency plan by 9/30/19. 2) Address how the facility will identify similar occurrences of the problem a. Horizon BH's Health and Safety Officer will review policies and procedures and contractor agreements in regards to sewage and waste disposal in the event of an emergency to ensure they are in place and up to date. 3) Identify measures/systemic changes to ensure deficient practices will not reoccur. a. Horizon BH's Health and Safety Officer will review all service provider agreements and policies and procedures at least annually in regards to sewage and waste disposal for our emergency response contingency plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie McClure — TITLE: Res. Mgr. — (X6) DATE: 9/19/19

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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E 015	Continued From page 1 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 systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on facility document review and staff interview, the facility staff failed to ensure policies and procedures were developed for the provision of sewage and waste disposal needs. Findings include: During the emergency preparedness review on 09/4/19 at approximately 12:15 p.m., an interview was conducted with the HSO (Health and Safety Officer). The facility's emergency preparedness policy and procedure for the sewage and waste disposal was not found within the emergency preparedness plan. The HSO stated that they did not have one listed in the policy, but stated he had a separate document.	E 015	4) Indicate how facility will monitor its performance. a. Horizon BH's Health and Safety Officer will monitor emergency preparedness procedures and service provider agreements at least annually to ensure they meet our emergency contingency plan.	9/30/19

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E 015	Continued From page 2 The HSO presented an agreement dated 11/01/17 through 06/30/19 for emergency response contingency plan request for waste removal. This agreement was not specific to the services to be provided, nor was part of the emergency preparedness plan and did not evidence an annual review. No further information and/or documentation was provided prior to the exit conference on 09/04/19 at 6:00 p.m.	E 015		9/30/19
W 000	INITIAL COMMENTS An unannounced full Medicaid initial survey was conducted on 09/04/2019. 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 four (4) bed facility was one (1) at the time of the survey. The survey sample consisted of one (1) Individual review (Individual #1).	W 000		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the	W 263	1) Address the corrective action taken for the problem. a. Horizon BH's QIDP will obtain an informed, written consent from the individual's authorized representative for a physical restraint. b. Horizon BH's Program Manager will revise policies to address when a device is identified as a restraint and that we will obtain informed, written consent prior to the use of the restraint. c. Horizon BH's ICF management team will provide training to Lakeview ICF staff on the revised restraint policy and record attendance of the training.	9/30/19

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W 263	Continued From page 3 facility staff failed to obtain a written informed consent from an authorized representative prior to the implementation of a physical restraint for one individual in the survey sample. Individual #1 was observed with a buckled seat belt across her lap and affixed to the wheelchair. Individual #1 was unable to release the seatbelt on her own. Findings were: Individual #1, was admitted to the facility on 07/31/2019. She had the following diagnoses, including but not limited to: Down's syndrome, dysphagia, osteoporosis, chronic kidney disease Stage III, Blindness with glaucoma, hearing loss, and profound intellectual disability. On 09/04/2019 at approximately 11:30 a.m. Individual #1 was observed sitting in her wheelchair. A buckled seatbelt was in place across her lap. Individual #1 was non-responsive to verbal stimulation and she made no eye contact. She did not self propel in her wheelchair. A meal observation was conducted at approximately 12:00 p.m. Individual #1 was seated in her wheelchair with the seatbelt in place. During the meal she made verbal sounds, but no words. She periodically arched her back and stretched in her chair. At approximately 1:30 p.m. Individual #1's medical record was reviewed. The physician orders contained orders for a seatbelt to be used for mechanical support on all seating surfaces. The resident manager was asked about the seatbelt. She stated, "She [Individual #1] came to us with it in place. It helps with positioning. Since she is unable to remove it we consider it to be a	W 263	2) Address how the facility will identify similar occurrences of the problem. a. Horizon BH's QIDP will identify any physical restraint and obtain written informed consent from an authorized representative or legal guardian prior to implementation. 3) Identify measures/systemic changes to ensure deficient practices will not reoccur. a. Prior to admission all devices used by an individual will be assessed by the QIDP to determine if they meet the definition of a physical restraint. b. Horizon BH's QIDP will identify any physical restraint and obtain written informed consent from an authorized representative or legal guardian prior to implementation. 4) Indicate how facility will monitor its performance. a. The review by the Specially Constituted Committee will assure written, informed consent is obtained prior to implementation of a physical restraint	9/30/19

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W 263	Continued From page 4 restraint. We discussed it at the SCC [specially constituted committee] meeting." The SCC minutes were reviewed and contained the following information: "...Interventions: n/a Seat belt while sitting in wheel chair and during shower in shower chair.; Alternatives considered: n/a None at this time.; Restraint Reduction Plan/Results: n/a Seat belt is not worn during her rest period and bed time hours.; ...Recommendations: n/a Continue with seat belt while sitting due to safety concerns." At approximately 3:30 p.m., the Residential Manager and the QIDP (Qualified Intellectual Disability Professional) were asked if a written informed consent from the authorized representative had been obtained for the use of the seatbelt for Individual #1. They stated they would look. At approximately 4:30 p.m., the QIDP stated, "We have a verbal consent and we will be getting the written one soon." She was asked when the verbal consent had been obtained. She stated, "Just a few minutes ago." She was asked why an informed written consent had not been obtained prior to implementing the seatbelt. She stated, "She came from the training center with it." She was asked if Individual #1 could remove the seatbelt. She stated, "No, that's why we are calling it a restraint." The policies regarding the use of restraints were requested and received. The policy "Specially Constituted Committee ICF" was reviewed and contained the following information: "Restraint-means the use of a mechanical device, medication, physical (hands-on-hold) intervention	W 263		9/30/19

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W 263	Continued From page 5 to prevent an individual from moving his body to engage in a behavior that places him or others at imminent risk...Mechanical Support - Allows greater freedom of movement or improves normal; body functioning and improvements not possible without the use of mechanical support. Mechanical supports are used to protect the individual form [sic] harm while at the same time, keeping them safe." An additional policy, "Response to Restraint ICF", contained the following: "A. Implementation of restraints... 5. The individual and/or his/her person legally acting on their behalf/authorized representative (AR) must give informed consent for the use of a restraint...B. Mechanical Devices as Restraint/Restriction 1. Mechanical devices for protective and supportive purposes are used on a long-term basis to assist individuals in achieving proper body alignment, to protect the individual from injury, and/or to compensate for specific physical deficits. These devices can be used for support and can still be considered a restraint if the individual cannot remove the device. 2....Examples of mechanical devices include, but are not limited to:...seatbelt..." No further information was obtained prior to the exit conference on 09/04/2019.	W 263		9/30/19
W 267	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. This STANDARD is not met as evidenced by:	W 267		

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W 267	Continued From page 6 Based on staff interview and facility document review, the facility staff failed to develop written policies and procedures for the management of conduct between staff and individuals at the facility. Findings include: During an initial survey on 9/4/19, a review of human rights was conducted, specifically related to a policy for staff conduct toward individuals. The policy was requested for review. The AA (assistant administrator) presented a copy of the 'agency's policy' (not facility specific) on conduct. The AA stated that they (the facility) did not have an actual policy for staff conduct. The AA presented a policy titled, "Ethics and Conflict of Interest", the policy did not address staff treatment of ICF (Intermediate Care Facility) individuals at this facility regarding language, actions, discipline, rules, order and other types of interactions between staff and individuals on a daily basis that affect or may affect the individual's quality of life. On 9/4/19 at 5:40 PM, the program director stated that there is not a specific policy for staff conduct toward individuals, that is an actual ICF policy. The review of the policies, prior to the initial survey was conducted was reviewed again for clarification. The review did not reveal an ICF policy for staff conduct toward individuals. No further information and/or documentation was presented prior to the exit conference on 9/4/19.	W 267	1) Address the corrective action taken for the problem. a. Horizon BH's Program Manager will develop a written policy and procedure for the management of the conduct between staff and individuals. This policy and procedure will promote the growth, development, and independence of the client. b. Horizon BH will provide training to Lakeview ICF staff on the revised staff to client conduct policy and record attendance of the training. 2) Address how the facility will identify similar occurrences of the problem. a. Horizon BH's ICF management team will review our current agency policies and procedures in regards to code of conduct and dual relationships and create an ICF policy and procedure specifically to address management of conduct between staff and individuals. 3) Identify measures/systemic changes to ensure deficient practices will not reoccur. a. Horizon BH's management team will review with staff our agency policies and procedures with regard to management of conduct between staff and individuals and notify staff that the policy will be included in the ICF policies and procedures. 4) Indicate how facility will monitor its performance. a. Horizon BH's ICF management team will review all policies and procedures in regards to management of conduct between staff and individuals annually.	9/30/19