STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G025	A. BUILDING _____ B. WING _____	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBOURS PLACE, THE	22501 THOMAS WOODS TRAIL ZUNI, VA 23898

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/18/19 through 6/20/19. The facility was in substantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS The unannounced Fundamental Medicaid re-certification survey was conducted on 06/18/19 through 06/20/19. The Life Safety Code report will follow. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). No complaints were investigated during the survey. The census in this 12 certified bed facility was 12 at the time of the survey. The survey sample consisted of 4 current Individual reviews (Individuals #1 through #4).	W 000		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to implement policies and procedures to prohibit mistreatment and neglect of one Individual (Individual #1) in the survey sample of four.	W 149	1) The facility has written policy #805 Abuse-Neglect-Serious Incident that was updated on 10/2017. This policy prohibits mistreatment neglect and abuse of individuals. In addition to this policy the program had established policy specifically regarding transportation that was developed in 7/2017. This addressed loading and unloading large vehicles, behaviors, vehicle accident/breakdowns. This policy was updated on 05/19 to include transfer procedures and a vehicle clear checklist. New Transfer procedures included:	5/1/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darlene Whelmes — TITLE: Clinical Director — (X6) DATE: 7/3/19

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 149	Continued From page 1 Individual #1 was transported to her Day Support Program and was left on the van from 7:30 A.M. until 12:48 P.M. in wet, rainy, cold weather conditions. The findings included: Individual #1 was admitted to the facility on 04/01/01 with diagnoses that included seizures, obesity, limited receptive language, uses a wheelchair for mobility, and profound Intellectual disability. A review of an Incident Report dated 02/20/19 indicated the following: "The Day Support Transportation driver picked up 9 individuals from the residential facility at approximately 7:00 A.M. and transported them to the Day Support Program. Weather conditions were wet, and rainy with a recorded low temperature of 35 degrees. The bus arrived at the Day Support Program at approximately 7:30 A.M. The driver was experiencing intense need to use the bathroom. Before the Day Support Staff came to assist the driver to unload the bus, she went to the back of the bus and released the wheelchair tie-downs and bus seat belt for Individual #1 and returned to the front of the bus to help control her bladder. Day Support Staff approached the bus and supported 8 individuals off via the front door and moved on to the assist other buses as the driver drove the bus to its designated parking area. The driver supported two other individuals from another bus into the building, where they all (three) went directly to use the bathroom. The driver left the bus without completing the	W 149	A. There will be a program staff "receiver". When a vehicle arrives to the Day Program, an appointed staff will be at the van to receive the individual (there will be other staff to assist unloading). B. The receiver will be responsible in coordinating the program staff who are unloading. C. Pathways staff will proceed to support the individuals off the van. If there are any absences, the designated staff will write the individual's name at the bottom of the vehicle clear checklist. D. Designated staff will complete a thorough check of the vehicle to ensure all individuals are off the van. E. The designated receiver will verify/co-sign with the transportation driver that the van is clear before the driver leaves unloading area. F. There will be only 1 - 2 vans unloading at one time. G. The vehicle clear checklist with co-signatures of the transportation driver and Pathways staff verifying all individuals arrived safely and received by a designated staff from the program. In addition to updating policy and developing a vehicle "clear" checklist now requiring double staff signature, the program assigned an attendant to ride in the van. Training on the updated Transportation policy and updated vehicle clear checklist was provided on 3/8/19, 5/16/19, and 6/19/19. 2) The investigation findings did not reveal any other individuals affected.	2/21/19 6/19/19 2/26/19

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W 149	Continued From page 2 Vehicle "Clear" Checklist. Individual #1 remained seated in the back of the bus in her wheelchair from 7:30 A.M. until 12:48 P.M. A Vehicle Clear Policy Indicated: "The driver should have completed the Vehicle "Clear" Checklist which consisted of the driver walking through the vehicle at the end of the route to ensure no person is left. Transportation Policy #114 Indicated: "It is the policy of the agency to provide safe transportation to the consumers they serve. Procedures: Loading and Unloading large vehicles: Larger vehicles, such as passenger vans and busses, should load individuals with adaptive equipment (wheelchairs/walkers) first, then load the ambulatory individuals based on physical needs in order of least to greatest independence. The unloading of the larger vehicles should be executed in the opposite order of loading the van, with individuals with the greatest independence exiting the vehicle first and the least independence exiting next to last, and the individual with adaptive equipment unloaded last to prevent injury and to increase the opportunity for supervision." Individual #1 was taken into the Day Support Program. Assessed by nursing staff. Nursing staff assessed Individual at 1:15 P.M. The assessment indicated: "Individual #1 was alert in the wheelchair and eating lunch. Noted both upper and lower extremities to be cold. Skin to hands bilaterally noted to be reddened in color. Respiration's even and non labored. Temperature obtained auxiliary at 94.4. Individual #1 has a history of having an average body temperature of 95.5. Blankets applied to Individual #1 to increase body temperature. Registered Nurse Supervisor	W 149	3) Transportation manager will review checklists monthly and trouble shoot issues with staff. In the event any staff fail to sign the checklist the Program manager will initiate another walk through and complete a new vehicle clear checklist. A Root Cause Analysis review was also completed on 3/21/19. 4) Systematically the Vehicle Clear Checklist now requires double staff signature to minimize human error. Pathways will monitor completion of vehicle clear checklists and submit them monthly and will be revised as new individuals are admitted.	5/1/19 3/21/19 5/1/19

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W 149	Continued From page 3 transported Individual to Emergency room at 2:20 P.M." During an interview with the Day Support Director on 6/19/19 at 11:40 A.M. she was asked, why was only one person on the bus to transport the individuals? The Day Support Director stated, the bus driver had always driven the bus route alone. The Day Support Director stated, she had re-trained staff on procedures for loading and unloading individuals. A review of the facility's abuse/neglect policy indicated: "It is a policy of the facility to prohibit any form of abuse/neglect of individuals. Abuse or mistreatment is defined as any act or omission inconsistent with prescribed treatment and care which results in physical or emotional pain or distress to individuals." The facility staff failed to implement policies and procedures to prohibit the mistreatment and neglect of Individual #1.	W 149		
W 189	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: The facility staff failed to provide staff training that enables the employee to perform their duties effectively and competently. The Day Support Program failed to educate all staff members after an incident of Individual neglect was identified.	W 189	1) Five staff persons received an in-service on the Vehicle "Clear" Checklist on 03/08/19. Policy #114 Transportation was revised 5/1/19 to include new transfer procedures. A review of the revised policy was included in the Vehicle "Clear" Checklist training provided by management. Six staff transportation drivers received the training on 5/16/19. All Pathways staff received the training on 6/19/19. 2) All pathways staff and transportation drivers who received training signed attendance sheets that are maintained in their personnel training records.	5/1/19 5/16/19 6/19/19 6/19/19

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W 189	Continued From page 4 The findings included: Individual #1 was transported to her Day Support Program and was left on the van from 7:30 A.M. until 12:48 P.M. in wet, rainy, cold weather conditions. A review of the Facility's Plan of Correction dated 02/21/19 indicated staff would be trained with loading and unloading the buses. A review of an Incident Report dated 02/20/19 indicated the following: "The Day Support Transportation driver picked up 9 individuals from the residential facility at approximately 7:00 A.M. and transported them to the Day Support Program. Weather conditions were wet, and rainy with a recorded low temperature of 35 degrees. The bus arrived at the Day Support Program at approximately 7:30 A.M. The driver was experiencing intense need to use the bathroom. Before the Day Support Staff came to assist the driver to unload the bus, she went to the back of the bus and released the wheelchair tie-downs and bus seat belt for Individual #1 and returned to the front of the bus to help control her bladder. Day Support Staff approached the bus and supported 8 individuals off via the front door and moved on the assist other buses as the driver drove the bus to its designated parking area. The driver supported two other individuals from another bus into the building, where they all (three) went directly to use the bathroom. The driver left the bus without completing the Vehicle "Clear" Checklist. Individual #1 remained seated in the back of the bus in her wheelchair from 7:30 A.M. until 12:48 P.M."	W 189	3) The Residential Supervisor participated in a Root Cause Analysis of the incident on 3/21/19 and will continue to review any and all corrective action plans that may be developed related to the facility and ensure that any training recommended in corrective action plans is facilitated in a timely manner and per the plan. 4) A review of Policy #941 Staff Orientation/Training determined that it continues to meet state and federal requirements for continuing in-service training to assure competence in the performance of their duties. This policy was updated 2/2019.	3/21/19 7/2/19

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W 189	Continued From page 5 A Vehicle Clear Policy Indicated: "The driver should have completed the Vehicle "Clear" Checklist which consisted of the driver walking through the vehicle at the end of the route to ensure no person is left. Transportation Policy #114 Indicated: " It is the policy of the agency to provide safe transportation to the consumers they serve. Procedures: Loading and Unloading large vehicles: Larger vehicles, such as passenger vans and busses, should load individuals with adaptive equipment (wheelchairs/walkers) first, then load the ambulatory individuals based on physical needs in order of least to greatest independence. The unloading of the larger vehicles should be executed in the opposite order of loading the van, with individuals with the greatest independence exiting the vehicle first and the least independence exiting next to last, and the individual with adaptive equipment unloaded last to prevent injury and to increase the opportunity for supervision." A review of a Action Plan Dated 02/21/19 Indicated: Day Support Staff initiated a receiving Individuals for unloading vehicles Action Plan which included: "One of three staff person's will always be either the Day Support Manager or one of the Day Support Team Leaders and will be designated as the official receiver. Other available staff assist with unloading and supporting individuals into the building, but the designated receiver verifies with the transportation driver that the vehicle is clear before the driver parks the vehicle, and before moving on to unload the next vehicle. Transportation Manager scheduled a mandatory all staff meeting to address the process for	W 189		

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W 189	Continued From page 6 unloading, review required forms, and varying with day Support staff that the vehicle is clear." A review of an In-service Vehicle "Clear" Checklist In-Service was dated 03/08/19. A review of the signature list indicated only five staff persons attended the training. A review of a Bus Assistance Schedule for the day Support Program indicated approximately 15 bus assistants. During an interview with the Day Support Director on 6/19/19 at 11:40 A.M. she was asked, why was only one person on the bus to transport the individuals? The Day Support Director Stated, the bus driver had always driven the bus route alone. The day Support Director stated, she had re-trained staff on procedures for loading and unloading individuals. The facility staff failed to retrain staff to enable the employee to perform their duties more effectively and competently.	W 189		