STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 08/13/2019 through 08/14/2019. Corrections are required for compliance with 42 CFR Part 483.73, 483.75, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	E 000	The person responsible for the completion of all parts of the POC is Jane M. Sellers, Director, ICF-IID Services, QDDP Harrison ICF-IID Pleasant View, Inc. 1631 VA Avenue Harrisonburg, VA 22802	
E 001	Establishment of the Emergency Program (EP) CFR(s): 483.475 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This CONDITION is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure emergency	E 001		

RECEIVED
AUG 28 2019
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jane M Sellers, Dir, QDDP	Director, ICF MR	8-26-19

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.

E 001 Establishment of the Emergency Program (EP) CFR(s): 483:475

Harrison ICF-IID will develop and maintain policies and procedures outlining the facility's Emergency Preparedness Plan. Copies of these policies will be kept within the facility, and will be available to the residence staff at all times.

The policies will address each of the Emergency regulations in detail, and shall be reviewed and updated annually or as necessary.

Completion Date: September 15, 2019

E 004 Develop EP Plan , Review and Update Annually CFR(s):438.475(a)

In order to be in compliance with all applicable Federal, State, and local emergency preparedness requirements, the Harrison ICF-IID will develop and maintain a Comprehensive Preparedness Plan.The plan will include the development of an Emergency Team, including the Program Director, the Program Coordinator, the Administrative Assistant, and one to two members of the direct service staff. This plan will be reviewed annually, or as needed by the Emergency Team, and will be revised as necessary.

This Plan will be maintained within the Program Coordinator's office, with a copy available to direct support staff at all times.

Completion Date: September 15, 2019

E 006 Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2)

Harrison ICF-IID will develop an Emergency Preparedness Plan (EPP) that will be maintained, reviewed, and updated annually or as may become necessary.

The EPP will be developed by the Emergency Team and will be based on the local community-based Risk Assessment and a facility risk assessment. The facility assessment will be formulated using an all-risk approach, including the risk of missing clients. Within the Plan will be included specific strategies for addressing each emergency that has been identified in the facility risk assessment.

This information will maintained in the Program Coordinator's office, with a copy available to direct support staff at all times. Additionally, a current copy of the Harrisonburg/Rockingham County Risk Assessment will be kept on site.

Completion Date: September 15, 2019

E 007 EP Program Patient Population CFR(s):483.475(a)(3)

Harrison ICF-IID will develop a specific plan to address the specific needs of the current population of the residence. This plan will include, but not be limited to, identifying specific individuals at risk and their individual needs and the type of services that Harrison can provide during the emergency. Each area will be addressed in full detail to ensure that each individual will have the specific services that he/she needs throughout the emergency period. The plan will also include steps for the continuity of operations, delegation of authority, and succession plans for Harrison ICF-IID and Pleasant View, Inc., as well as a complete communication plan with administration, direct support staff, families, and State and local emergency personnel.

This plan will be reviewed and updated annually or as necessary, and will be maintained in the Program Coordinator office; additionally, a copy will be available for all direct support staff.

Completion date: September 15, 2019

E 009 Local, State, Tribal Collaboration Process CFR(s) : 483.475(a)(4)

Harrison ICF-IID will maintain an Emergency Preparedness Plan(EPP) that sets out a process for working in close cooperation with the local and regional emergency agencies. The plan will include as well cooperation with State and Federal emergency preparedness officials' plans to maintain integrated responses during disasters or emergency situations.

The plan shall also include documentation of the facility's participation in collaborative and cooperative planning, as well as documentation of all efforts made to contact these agencies/individuals.

The EPP will reviewed and updated as needed on an annual basis. A copy of this plan will be maintained in the Program Coordinator office, and will be available for review by the facility direct support staff.

Completion Date: September 20, 2019

E 013 Development of EP Policies and Procedures CFR(s): 483.475(b)

Harrison IC-IID will maintain copies of all policies/procedures and the Emergency Preparedness Plan (EPP) within the facility at all times. This information is maintained in the Program Coordinator's office, and is available for examination or review by any interested individual(s), including direct support staff, at all times.

The facility's emergency policies and procedures and the EPP will be reviewed and updated annually or as necessary.

Completion Date: September 20, 2019

E 020 Policies for Evacuation and Primary/Alt. Communication CFR(s)483.475(b)(3)

Harrison ICF-IID will develop and thorough implement policies and procedures that address specific areas of need in the case of an emergency. These policies and procedures will include, but not be limited to the following:

~ Safe evacuation of all the individuals, including consideration of the continuity of treatment needs and services specific to each individual evacuated; tracking of the location of each individual, transportation needs, identification of evacuation locations, external sources of assistance, and all means of communication with those the external sources of assistance.

These policies and procedures will be maintained within the facility, and will be available to all direct service personnel. Each policy and procedure will be reviewed annually or as necessary, and revised as appropriate.

Completion Date: September 20, 2019

E 022 Policies and Procedures for Sheltering in Place CFR(s) 483.475(b)(4)

Harrison ICF-IID will develop and maintain emergency policies and procedures for maintaining an Emergency Preparedness Plan (EPP), including a risk assessment and a communication plan to address any emergencies that might arise. Included in the EPP will be a plan and means for each individual, including the direct support staff and any volunteers who may be present to shelter in place. These policies will also detail how the individuals will be supported and their needs meet during this time, as well as how communication will be maintained.

This information will be reviewed annually, or as the need may arise. The policies will be maintained within the facility, with copies accessible to each of the direct care staff.

Completion Date: September 20, 2019

E 023 Policies and Procedures for Medical Documentation CFR(s): 483.475(b)(5)

Harrison ICF-IID will develop policies and procedures within the Emergency Preparedness Plan (EPP) to address the maintenance and protection of each resident's medical information, and ensures that the information is secure while remaining available as needed.

These policies and procedures will be maintained onsite, and reviewed annually or as necessary. A copy of these will also be available for direct support personnel at all times.

Completion Date: September 20, 2019

E 024 Policies and Procedures –Volunteers and Staffing CFR(s): 483.475(b)(6)

The facility will develop and implement policies and procedures for the use of community volunteers in an emergency situation as part of the Emergency Preparedness Plan (EPP), including strategies for communicating with State and/or Federal emergency and health care professionals, and what the roles of these individuals should be.

This information will be maintained within the facility, and will be accessible to all direct support personnel.

Completion date: September 20, 2019

E 025 Arrangement with Other Facilities CFR(s): 483.475(b)(7)

Harrison ICF-IID will develop a policy as part of the facility's Emergency Preparedness Plan (EPP) regarding networking and planning with other facilities and/or hotels, evacuation centers, etc., for housing for the individuals and all support personnel during a period of evacuation from Harrison Residence. This policy/plan will document the steps needed and identify all involved personnel needed to ensure that agreements with alternate locations are made and are adequate enough to meet the needs of each individual and their support staff.

The EPP will maintain signed agreements, along with the specifics of each evacuation location available. This information will be maintained within the residence's administrative office and available to all support staff; additionally, this information shall be reviewed annually, or as needed, and updated as necessary.

Completion Date: September 20, 2019

E 026 Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8)

The facility will develop a policy and procedure as part of the Emergency Preparedness Plan (EPP) to address a Waiver declared in accordance with Section 1135 of the State's Emergency Response plan. This policy will address the provision of care and treatment at an alternate care site identified by emergency management officials.

This policy will be maintained with the facility's Administrative office, and a copy will be available to direct support personnel at all times. The policy and any supporting information will me reviewed annually and as needed, and updated or revised as necessary.

Completion Date: September 20, 2019

E 031 Emergency Officials Contact Information Plan CFR(s): 483.475(c)(2)

Harrison ICF-IID will develop and maintain an emergency preparedness communication plan that will be maintained, reviewed, and updated annually or as necessary in compliance with Federal, State, and local laws. The communication plan will include a list of outside emergency personnel numbers, as well as company and facility employee's contact information.

This information will be maintained in the Program Coordinator's office, with a copy available to direct support staff at all times.

Completion Date: September 20, 2019

E 033 Methods for Sharing Information CFR(s): 483.475(c)(4)-(6)

In order to be in compliance with all applicable Federal, State, and local emergency preparedness requirements, the Harrison ICF-IID will develop and maintain policies concerning the release of Individual information which will include general condition and location of the Individuals.

This Plan will be maintained within the Program Coordinator's office, with a copy available to direct support staff at all times.

Completion Date: September 20, 2019

E 034 Information on Occupancy/Needs CFR(s): 483.475(c)(7)

Harrison ICF-IID will develop and maintain information about the facility's needs, the ability to provide assistance, as well as information regarding current occupancy.

This information will be reviewed and updated annually or as necessary and will be located within the Program Coordinator's office, with a copy available to all direct support staff.

Completion Date: September 20, 2019

E 036 EP Training and Testing CFR(s): 483.475(d)

Harrison ICF-IID will maintain copies of all policies and procedures for the Emergency Preparedness Plan (EPP) training and testing program. These policies and procedures for this plan will be updated annually, or as necessary. It will be located within the Program Coordinator's office, with a copy available to direct staff at all times.

Completion Date: September 20, 2019

E 037 EP Training Program CFR(s): 483.475(d)(1)

In order to be in compliance with all applicable Federal, State, and local emergency preparedness requirements, the Harrison ICF-IID will maintain an Emergency Preparedness Plan (EPP) that will provide written training of emergency preparedness with staff. This plan and documentation of trainings will be maintained in the Program Coordinator's office, with a copy available to all direct support staff.

Completion Date: September 20, 2019

E 039 EP Testing Requirements CFR(s): 483.475(d)(2)

Harrison ICF-IID will maintain an Emergency Preparedness Plan (EPP) that provides documentation of exercises performed by staff to test the emergency plan annually, or as necessary. This plan shall include the facility's participation in collaborative and cooperative planning, as well as documentation of all efforts made to contact these agencies/individuals.

A copy of this plan will be maintained in the Program Coordinator's office, and will be available for review by the facility direct support staff.

Completion Date: September 20, 2019

W 000 Fundamental Survey

W341 Nursing Services CFR(s): 483.460(c0(5)(ii)

As it is essential to maintain a healthy and safe environment for each individual residing within Harrison ICF-IID, and to protect each from exposure to any infectious disease that has been indentified within the facility, all staff will be aware of and follow all facility and agency policies regarding infection control. In addition, the individual who has been identified as having an infectious disease will be handled following the same protocols in order to ensure good healing or recovery , and to prevent reinfection.

The facility staff shall be retrained in the appropriate responses for dealing with individuals with either a diagnosed infectious disease or infectious process, or an individual who is awaiting test results for diagnosis. Harrison ICF-IID's policy is to isolate the individual frim the other residents in his or her own private space, and to utilize all established infection control procedures, including, but not limited to the use of Personal Protection Equipment (PPE), the management of potential infectious waste and laundry, and the disinfection of all hard surfaces.

All Harrison ICF-IID will be retrained in an inservice on basic infection control procedures, and documentation of this training will be maintained in each employee's HR file.

Further, each employee of the facility is recertified in infection control procedures yearly as part of Pleasant View, Inc's annual recertification process, and this is also documented within his/her personnel file.

Completion Date: September 20, 2019

W455 Infection Control CFR(s): 483.470(l)(1)

In order to prevent the the spread of infectious diseases, such as viral pneumonia, influenza, and strep , as well as bacteria-borne infections such as C-Diff and MRSA, it is necessary for Harrison ICF-IID to develop a clear and concise system for preventing the spread of this. This is particularly essential for Harrison, as many of the individuals have fragile health issues that make them more prone to contracting illnesses. With some of these individuals, an infectious disease such as viral pneumonia or influenza could result in death.

Harrison ICF-IID will develop and maintain a program to address communicable diseases occurring within the facility. This program will provide a tracking system for any communicable disease(s) that occur, including names, dates of illness, and treatments. Any infections will be tracked as well, with the cause/source of the infection, treatments, and outcomes recorded. Direct support personnel will be reminded on an ongoing basis to use Personal Protective Equipment (PPE) during any encounter that could result in the spread of germs, and to follow the usual protocols for handwashing and disinfecting surfaces.

In the event of an infectious disease or process occurring with one of the individuals, the program staff will initiate all the appropriate actions, including isolation if necessary.

Completion Date: September 20, 2019

W 457 Infection Control CFR(s): 483.470(l)(1)

Harrison ICF-IID will develop a tracking and surveillance program for the investigation of infections and the control and management of communicable diseases. This tracking system will include information including, but not limited to, treatment notes, duration of illness or infection, plus and additional information available regarding that specific incident.

An additional tracking form will be established to provide information regarding any emergency visit by any individual to a hospital Emergency Room, an urgent care facility, or an emergency visit to his/her PCP.

Both of these tracking forms shall be used to discern patterns of disease or injuries occurring to an individual.

It is critical to maintain good infection control practices for the facility, as the many of the residents have health issues that make them more susceptible to infectious diseases, and have fragile health concerns that could result in death. Maintaining a tracking system can identify the sources of infection or disease, and help prevent exposure to the individuals.

Completion Date: September 20, 2019

W 458 Infection Control CFR(s): 438.470(l)(3)

As the residents of Harrison ICF-IID have health concerns that make the exposure to and, prevention of infectious diseases particularly critical, it is essential that there are guidelines in place for all Pleasant View staff and DSPs regarding sickness and exposing others to infectious diseases or other conditions that can cause infections in others.

Accordingly,Pleasant View, Inc.' s Human Resources Department will develop a policy specific to work restrictions for all employees who are ill or may be carrying a communicable disease that could be easily spread to the individuals in each program, including Harrison ICF-IID. This policy will not be limited to Harrison Residence's direct support personnel, as there is frequently contact with direct support personnel from other parts of the agency.

This policy will be implemented by the Program Coordinator for each program; additionally, the Human Resources will maintain information on possible communicable diseases currently occurring within the

agency.This policy will be reviewed annually and updated as necessary. A copy will be maintained in the Human Resources manual available at the residence.

Completion Date: September 20, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 08/13/2019 through 08/14/2019. Corrections are required for compliance with 42 CFR Part 483.73, 483.75, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	E 000		
E 001	Establishment of the Emergency Program (EP) CFR(s): 483.475 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This CONDITION is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure emergency	E 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 001	Continued From page 1 preparedness policies were located at the facility. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no specific emergency preparedness policies were located in the facility. An emergency preparedness book was presented, but included incomplete information. The PD stated, "We had the policies and information, but our former director of nursing either took them or destroyed them. I have searched everywhere and cannot find them." No further information was provided prior to exit on 08/14/2019.	E 001		
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 004	Continued From page 2 The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure an emergency preparedness plan was documented. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no specific emergency preparedness plan was documented. The PD stated, "We had a written plan, but I am unable to locate the specific documentation. I have searched everywhere and cannot find it." No further information was provided prior to exit on 08/14/2019.	E 004		
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	E 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 006	Continued From page 3 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 that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure a risk assessment was included in the emergency preparedness plan. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no risk assessment was located in the emergency preparedness plan. The PD stated,	E 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 006	Continued From page 4 "We did a risk assessment, but I am unable to locate the specific documentation. I have searched everywhere and cannot find it." No further information was provided prior to exit on 08/14/2019.	E 006		
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, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure the emergency preparedness plan included the facility's patient population, strategies for this population, services that would be and continued during an emergency and delegation of authority and succession plans. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed	E 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 007	Continued From page 5 with the Program Director (PD). During this review no documentation was located to include, the facility's patient population, strategies for this population, services that would be and continued during an emergency and delegation of authority and succession plans. The PD stated, "We had all of this, but I am unable to locate the specific documentation. I have searched everywhere and cannot find it." No further information was provided prior to exit on 08/14/2019.	E 007		
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(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:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its	E 009		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 009	Continued From page 6 participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure the emergency preparedness plan included the facility's efforts to contact Emergency officials for participation in a collaborative and cooperative planning effort. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no documentation was located regarding the facility's efforts to contact Emergency officials for participation in a collaborative and cooperative planning effort. The PD stated, "We have talked to the area fire department and schools, but none of their training was pertinent to our facility. The school said they would notify me if a training was scheduled that would benefit us. I have no documentation." No further information was provided prior to exit on 08/14/2019.	E 009		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (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	E 013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 013	Continued From page 7 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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by:	E 013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 013	Continued From page 8 Based on document review and staff interview, the facility failed to ensure the specific emergency preparedness policies or facility risk assessment was located in the facility. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no specific emergency preparedness policies or facility risk assessment was located in the facility. The PD stated, "We had the policies and information, but our former director of nursing either took them or destroyed them. I have searched everywhere and cannot find them." No further information was provided prior to exit on 08/14/2019.	E 013		
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(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:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and	E 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 020	Continued From page 9 primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure specific emergency preparedness policies for safe evacuation were located in the facility. The findings included: During the unannounced survey conducted	E 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 020	Continued From page 10 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no specific emergency preparedness policies for safe evacuation were located in the facility. However, the facility did have evidence of monthly evacuation drills on each shift. The PD stated, "We had the policies and information, but I cannot find them. I have looked everywhere." No further information was provided prior to exit on 08/14/2019.	E 020		
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:	E 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 022	Continued From page 11 (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 document review and staff interview, the facility failed to ensure specific emergency preparedness policies for sheltering in place were located in the facility. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no specific emergency preparedness policies for sheltering in place were located in the facility. The PD stated, "We do not have written policies persay, but we have the required equipment, generator, food, water and supplies for an emergency. We bought an out building to store everything in." The PD presented a list of said supplies with expiration dates listed. She stated, "We rotate supplies out as the expiration dates require." No further information was provided prior to exit on 08/14/2019.	E 022		
E 023	Policies/Procedures for Medical Documentation CFR(s): 483.475(b)(5) [(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	E 023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 023	Continued From page 12 minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[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. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure specific emergency preparedness policies for preserving patient information, confidentiality or availability of patient records was located in the facility. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this	E 023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 023	Continued From page 13 review no specific emergency preparedness policies for preserving patient information, confidentiality or availability of patient records was located in the facility. The PD stated, "We have emergency charts for each Individual that are kept in the medication room." No further information was provided prior to exit on 08/14/2019.	E 023		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.475(b)(6) [(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:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in	E 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 024	Continued From page 14 an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure specific emergency preparedness policies for staffing or use of volunteers were located in the facility. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no specific emergency preparedness policies for staffing or use of volunteers were located in the facility. The PD stated, "We don't have this." No further information was provided prior to exit on 08/14/2019.	E 024		
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:]	E 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 025	Continued From page 15 *[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. *[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 document review and staff interview, the facility failed to ensure specific emergency preparedness policies regarding arrangements with other facilities for care of Individuals during an emergency. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this	E 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 025	Continued From page 16 review no specific emergency preparedness policies were located regarding arrangements with other facilities for care of Individuals during an emergency. The PD stated, "We would only ever move our Individuals to the day program site. We have do not have arrangements with anyone else." No further information was provided prior to exit on 08/14/2019.	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:	E 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 026	Continued From page 17 Based on document review and staff interview, the facility failed to ensure an emergency preparedness policy regarding care of Individuals under the 1135 waiver. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no specific emergency preparedness policy was located regarding care of Individuals under the 1135 waiver. The PD stated, "I am not sure what the 1135 waiver even is. What is it exactly." No further information was provided prior to exit on 08/14/2019.	E 026		
E 031	Emergency Officials Contact Information CFR(s): 483.475(c)(2) [(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: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local	E 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 031	Continued From page 18 emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure a list of emergency officials was located in the emergency preparedness plan. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no list of emergency officials was located in the Emergency Preparedness plan. A list of company and facility employees was included, but no outside emergency personnel numbers. The PD stated, "I can see where all these numbers should be included." No further information was provided prior to exit on 08/14/2019.	E 031		
E 033	Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) [(c) The [facility] must develop and maintain an	E 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 033	Continued From page 19 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 §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (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 document review and staff interview, the facility failed to ensure the emergency	E 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 033	Continued From page 20 preparedness plan included policies regarding release of Individual information to include general condition and location of said Individuals. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no policies were located regarding release of Individual information to include general condition and location of said Individuals. The PD stated, "We do not have this." No further information was provided prior to exit on 08/14/2019.	E 033		
E 034	Information on Occupancy/Needs CFR(s): 483.475(c)(7) [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 034	Continued From page 21 *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure emergency preparedness policies regarding a means of providing information about the facility's needs, its ability to provide assistance, or means to provide information about their occupancy. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no policies were located regarding means of providing information about the facility's needs, its ability to provide assistance, or means to provide information about their occupancy. The PD stated, "We do not have this." No further information was provided prior to exit on 08/14/2019.	E 034		
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 036	Continued From page 22 procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure documentation of training or testing the facility emergency preparedness program. The findings included:	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 036	Continued From page 23 During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no written training or testing program was located for the facility. The PD stated, "We did recently complete a table top exercise." Documentation of this exercise was presented. No further information was provided prior to exit on 08/14/2019.	E 036		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 24 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 25 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 26	E 037		

personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This STANDARD is not met as evidenced by:
Based on document review and staff interview, the facility failed to ensure documentation of the initial training of the facility emergency preparedness program.

The findings included:

During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility Emergency Preparedness process was reviewed with the Program Director (PD). During this review no written training of the initial emergency preparedness was located. There was evidence of emergency preparedness training with staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 27 conducted in June 2019. The PD stated, "I cannot find the original emergency preparedness training documentation. We did recently complete a table top exercise." Documentation of this exercise was presented. No further information was provided prior to exit on 08/14/2019.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 039	Continued From page 28 (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure documentation regarding the facility's efforts to contact emergency officials for participation in a collaborative and cooperative planning effort. The findings included: During the unannounced survey conducted 08/13/2019 through 08/14/2019 the facility	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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 039	Continued From page 29 Emergency Preparedness process was reviewed with the Program Director (PD). During this review no documentation was located regarding the facility's efforts to contact emergency officials for participation in a collaborative and cooperative planning effort. The PD stated, "We have talked to the area fire department and schools, but none of their training was pertinent to our facility. The school said they would notify me if a training was scheduled that would benefit us. I have no documentation." No further information was provided prior to exit on 08/14/2019.	E 039		
W 000	INITIAL COMMENTS An unannounced annual 55 Fundamental Medicaid Certification survey was conducted 08/13/2019 through 08/14/2019. 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. The census in this 15 certified bed facility was 14 at the time of the survey. The survey sample consisted of four (04) Individual reviews (Individuals #1 through #4).	W 000		
W 341	NURSING SERVICES CFR(s): 483.460(c)(5)(ii) 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 control of communicable diseases and infections, including the instruction of other personnel imethods of infection control.	W 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 341	Continued From page 30	W 341		

This STANDARD is not met as evidenced by:
Based on medication pass and pour observation, staff interview, and facility document review, facility staff failed to demonstrate proper infection control practices while administering medication through a feeding tube, and failed to adhere to contact isolation practices for one of two individuals, Individual #4.

Findings included:

On arrival to the facility on 08/13/2019 at 12:00 noon, the Program Director (PD) stated that Individual #4 had just returned from the Emergency Room (ER) with a diagnosis of viral pneumonia and he would be placed on isolation.

Individual #4 was admitted to the facility on 01/20/1993 with diagnoses including, but not limited to: Intellectual Disability, Agitated Behavior Disorder, Organic Hallucinations, Seizures and a PEG (percutaneous endoscopic gastrostomy).

Individual #4 was observed sitting in the dining area of the facility with staff upon his return from the ER until approximately 2:30 p.m. No PPE (personal protective equipment) ie: masks, gloves, gowns were in place for the Individual or the staff present.

At 5:30 p.m. Individual #4 was observed out of his room and sitting with other Individuals and staff in the TV room. Again, no PPE was in use.

On 08/14/2019 at 7:10 a.m., Individual #4 was observed in his wheelchair, in the dining area of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 341	Continued From page 31	W 341		

the facility. There were approximately five other Individuals and four staff members present in the dining area. No PPE in place. The Program Director (PD) was interviewed regarding Individual #4's isolation status. The PD stated, "Yes, he is on isolation." She instructed staff to place Individual #4 back in his room.

At 7:20 a.m. Individual #4 was observed in his room. A large cardboard box with a red trash bag was observed sitting in front of the closet in Individual #4's room. There was no evidence of PPE or his isolation status evident anywhere around his room. DSP #1 (direct staff person) was interviewed regarding Individual #4's isolation. DSP #1 stated, "I didn't know he was on isolation. They just told me to take him back to his room, so I did. Normally, there is something on the door or outside the room with gloves, masks and stuff."

DSP #2 was interviewed at 8:30 a.m. regarding Individual #4's isolation status. DSP #2 stated, "I did not know he was on isolation. There is normally a cart or something outside of the room. Me and another DSP cleaned him up this morning and got him up. We took him to the dining room as usual."

During the medication pass and pour observation, conducted 08/13/2019 at 3:33 p.m., RN #1 (registered nurse) was observed administering a medication through an Individual's feeding tube without wearing gloves. RN #1 was interviewed at 4:00 p.m. and she stated, "I usually don't wear gloves when giving meds [medications] through a PEG [percutaneous endoscopic gastrostomy] because it has a clamp and the likelihood of reflux is slim. If I am messing with the stoma or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 341	Continued From page 32	W 341		

using a tube without a clamp, then I do wear gloves."

The PD was asked for a policy regarding administration of medications through a feeding tube. The PD stated, "We don't have a policy persay. Everyone who gives medications through a feeding tube are inserviced by our nurse consultant. The original training is about six hours long and then she does a follow-up training in six months. After each training she observes staff three times to check off their competency." A copy of the "Staff Competency Evaluation, Gastrostomy Tube and Medication Study Guide and Tube Feedings" preparation worksheet were received.

The Nurse Consultant (RN #2) was interviewed by telephone on 08/15/2019 at 8:51 a.m. RN #2 stated "I use the 'DHF Behavioral Sciences Manual' infection control section for training. The initial training is six hours and then a refresher every six months for one hour. I observe the staff three times after each training. I do teach to wash hands before starting, apply protective equipment, gloves, gowns, etc." After discussion of the observation of RN #1's technique during the medication pass on 08/13/2019, RN #2 stated, "Shut the door. Oh my, I am sorry you witnessed that, but thanks for letting me know. It is impossible for me to observe all staff, all the time. She is a contract nurse and I didn't train her. I spoke with someone at the Department of Behavioral Health regarding contract staff and their competencies. I was told if they are an RN or LPN [licensed practical nurse] the agency is responsible for ensuring staff competencies and they are okay. I wrote a policy for this. It should be at the house somewhere."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 341	Continued From page 33 The PD was unable to locate the above mentioned policy. Regarding contract staff competencies, the PD stated, "She is a registered nurse and should know proper procedure and infection control when working with a feeding tube." No further information was received prior to the exit conference on 08/14/2019.	W 341		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on staff interview, and facility document review, the facility failed to maintain an ongoing surveillance program of communicable disease control and investigation of infections. Findings included: During entrance conference on 08/13/2019 at approximately 12:00 noon, a list of Individual infections and treatments was requested from the Program Director (PD). The PD stated, "We do not formerly track this. It is recorded in the Individual's record, but is not tracked anywhere else. I see that is something we need to start doing right away." An infection manual was presented that included standards of care for specific infections, but did not include any tracking system for Individual infections.	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 34 No further information was received prior to the exit conference on 08/14/2019.	W 455		
W 457	INFECTION CONTROL CFR(s): 483.470(l)(3) The facility must maintain a record of incidents and corrective actions related to infections. This STANDARD is not met as evidenced by: Based on staff interview, and facility document review, the facility failed to maintain a record of incidents and corrective actions related to infections. Findings included: During entrance conference on 08/13/2019 at approximately 12:00 noon, a list of Individual infections and treatments was requested from the Program Director (PD). The PD stated, "We do not formerly track this. It is recorded in the Individual's record, but is not tracked anywhere else. I see that is something we need to start doing right away." An infection manual was presented that included standards of care for specific infections, but did not include any tracking system for Individual infections. No further information was received prior to the exit conference on 08/14/2019.	W 457		
W 458	INFECTION CONTROL CFR(s): 483.470(l)(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.	W 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 458	Continued From page 35 This STANDARD is not met as evidenced by: Based on staff interview, and facility document review, the facility failed to have and implement an infection control policy that clearly delineated signs and symptoms for which staff would not be allowed to work. Findings included: During the survey conducted 08/13/2019 through 08/14/2019 an employee infection control policy was requested from the Program Director (PD). On 08/14/2019 at approximately 11:55 a.m., the PD stated, "We do not definitely have an infection policy for staff. We would not allow staff to work if they were actively vomiting, had diarrhea or had a temperature of 100 degrees or greater." No further information was received prior to the exit conference on 08/14/2019.	W 458		