STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G054	A. BUILDING _____ B. WING _____	10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT ICF/ID HOME	26 BOOKER ROAD MARTINSVILLE, VA 24112

(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 10/08/19 through 10/09/19. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	E 000		
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 staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that addressed the specific population of the facility and the strategies the facility had in place to address the needs of the facility's specific population. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan addressed the	E 007	E 007 Piedmont ICF –IID Emergency Preparedness Plan (EPP) has been edited to reflect the current population within the facility, identify specific individual's needs and specifications of care during an emergency situation / event(s). EPP will be maintained and updated as status changes occur to ensure compliance with Emergency Preparedness Plan requirements. Piedmont ICF-IID staff will be educated and trained on the updates to the EPP plan by November 10, 2019. As changes occur to the EEP according to regulation a new training will occur to meet the EEP requirements.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn L. Underwood — TITLE: Administrator — (X6) DATE: 11-21-2019

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

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E 007	Continued From page 1 specific population of the facility and the strategies it had in place to address the individual needs of this population. On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. After reviewing the facility's emergency preparedness plan the administrator verbalized to the surveyor that the emergency preparedness plan did not include any information to indicate the specific population of this facility that would be at risk during an emergency or the strategies in place for this population. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.	E 007		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies	E 015	E 015 Piedmont ICF-IID Emergency Preparedness Plan (EPP) has been edited to reflect current MRE Supplies, water, medical supplies, and alternate sources to maintain the following: temperatures, emergency lighting, fire detection, and sewage. Emergency supplies will remain, maintained, and increase to meet the needs of client/staff. Effective as of November 10, 2019	

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E 015	Continued From page 2 (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that addressed the provision for food in the event of an emergency. The findings included:	E 015		

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E 015	Continued From page 3 The facility staff failed to ensure that the facility emergency preparedness plan addressed how the facility would provide food for staff and Individuals of the facility in the event of an emergency. On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. After reviewing the facility's emergency preparedness plan the administrator verbalized to the surveyor that the emergency preparedness plan did not include information to indicate how the facility would provide food for staff and the individuals of the facility in the event of an emergency. The administrtor stated they shopped for food weekly at a local grocery store and nothing was delivered to the facility. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.	E 015		
E 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff	E 018	E 018 Piedmont ICF-IID Emergency Preparedness Plan has been edited to reflect resident's location and needs of placement type in the event of an emergency. The EPP will be able to show communication tracking system used to maintain knowledge of all on-duty staff as well as residents during an emergency event. Piedmont ICF-IID staff will has been advised (November 10, 2019) and upcoming all staff training will take place December 11th, 2019 (due to rescheduling) be educated and trained on changes. Piedmont ICF-IID's documentation and records of trainings will be on site.	

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E 018	Continued From page 4 and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff	E 018		

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E 018	Continued From page 5	E 018		

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

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

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

The findings included:

The facility staff failed to ensure that the facility emergency preparedness plan addressed how the facility would track the staff and individuals of the facility in the event of an emergency.

On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. After reviewing the facility's emergency preparedness plan the administrator verbalized to the surveyor that the emergency preparedness plan did not include any information on how the facility would track the location of staff and the

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E 018	Continued From page 6 individuals of the facility in the event of an emergency. The administrator stated, "I don't see that." No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.	E 018		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on staff interview and facility document	E 022	E 022 Piedmont ICF-IID Emergency Preparedness Plan (EPP) has been edited to include Piedmont ICF-IID Shelter Evacuations Policy and Procedure which reflects shelter in place protocol and options for sheltering 10 miles to 100 mile radius. Protocol and options will be edited to reflect staffing and volunteers which maybe within the facility at the time of an emergency event. Piedmont ICF-IID staff will has been advised (November 10, 2019) and upcoming all staff training will take place December 11th, 2019 (due to rescheduling) to be educated and trained on changes. Piedmont ICF-IID's documentation and records of trainings will be on site. The EPP will be accessible within the Emergency Preparedness Kit and as well in the Emergency Facility Book, which is housed within the facility. EPP has been edited to reflect volunteers when needed in the event of an emergency.	

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E 022	Continued From page 7 review, the facility staff failed to develop an emergency preparedness plan that addressed how the facility would provide a shelter in place for any volunteers during the event of an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan addressed how the facility would provide shelter in place for any volunteers in the event of an emergency. On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. After reviewing the facility's emergency preparedness plan the administrator verbalized to the surveyor that the emergency preparedness plan did not include any information on how the facility would provide for sheltering in place for volunteers. The administrator stated they did not have any volunteers and anyone that was at the facility would have to go through the human resource department and would be treated as an employee. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.	E 022		
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	E 024		

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

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E 024	Continued From page 8 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 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 staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that addressed how the facility would use volunteers during the event of an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan addressed how the facility would use volunteers in the event of an	E 024		

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E 024	Continued From page 9 emergency. On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. After reviewing the facility's emergency preparedness plan the administrator verbalized to the surveyor that the emergency preparedness plan did not include any information on how the facility would utilize volunteers. The administrator stated they did not have any volunteers and anyone that was at the facility would have to go through the human resource department and would be treated as an employee. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.	E 024		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and	E 032	E 032 Piedmont ICF-IID Emergency Preparedness Plan (EPP) has been edited to reflect primary and alternative means of communication during an emergency. The EPP will reflect protocols for communicating with entitles of a need to know status. The EPP has been edited to reflect clear contact information (land lines, mobile radios, cell phones, text alters, emails, DBH/ on call system) of ICF-IID staffing, local, state, and regional emergency management entitles which may have a need to know of the emergency event that has taken place. Piedmont ICF-IID staff will has been advised (November 10, 2019) and upcoming all staff training will take place December 11th, 2019 (due to rescheduling) to be educated and trained on changes.	

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E 032	Continued From page 10	E 032		

local emergency management agencies.
This STANDARD is not met as evidenced by:
Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that documented how the facility would use alternate communications with facility staff, federal, state, regional and/or local emergency management agencies in the event of an emergency.

The findings included:

The facility staff failed to ensure that the facility emergency preparedness included documentation to indicate how the facility would use alternate communications with facility staff, federal, state, regional and/or local emergency management agencies in the event of an emergency.

On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. After reviewing the facility's emergency preparedness plan the administrator verbalized to the surveyor that the emergency preparedness plan did not include any documentation to indicate how the facility would use alternate communications with facility staff, federal, state, regional and/or local emergency management agencies in the event of an emergency. The administrator then added that they had a landline phone, cell phones, and mobile radios.

No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.

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E 034	Continued From page 11 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. *[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 staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included a means of providing information about the facility's needs, and its ability to provide assistance in the event of an emergency and how it would provide information about their occupancy in an event of an emergency. The findings included:	E 034 E 034	E 034 Piedmont ICF-IID Emergency Preparedness Plan Piedmont ICF-IID staff will has been advised (November 10, 2019) and upcoming all staff training will take place December 11th, 2019 (due to rescheduling) to be educated and trained on changes.	

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E 034	Continued From page 12 The facility staff failed to ensure that the facility emergency preparedness included a means of providing information about the facility's needs, its ability to provide assistance in the event of an emergency, and how it would provide information about their occupancy in an event of an emergency. On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. After reviewing the facility's emergency preparedness plan the administrator verbalized to the surveyor that they tried to have whatever they needed in the facility. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.	E 034		
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	E 039	E 039 Piedmont ICF-IID Emergency Preparedness Plan (EPP) testing was set to be completed by November 15, 2019, due to scheduling and sickness of staff. A full scale facility based exercise has been scheduled for December 11, 2019. Exercise will be conducted on an annual basis or as needed basis going forward to meet and maintain compliance of regulations of the EPP	

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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.
(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

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E 039	Continued From page 14 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 staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included participation in community based, non-community based, or a table top exercise to test the effectiveness of the emergency plan. The findings included: The facility staff failed to participate in a full-scale exercise that was community based, non-community based, or a table top exercise to test the effectiveness of the their emergency plan. On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. During this review the administrator verbalized to the surveyor that they had not had any type of exercises to test the effectiveness of their emergency plan since she had been employed at the facility (11/2018). No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.	E 039		
E 042	Integrated EP Program CFR(s): 483.475(e) (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated	E 042		

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E 042	Continued From page 15 emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures	E 042	E 042 Piedmont ICF-IID Emergency Preparedness Plan (EPP) has been edited to reflect to be part of a healthcare system. Piedmont ICF-IID Emergency Preparedness is a part of DBHDS, Emergency Network. Piedmont contact would be Carolyn Whiting per Piedmont ICF-IID. Also, affiliated with Near Southwest Preparedness Alliance located 1944 Peters Creek Road, Roanoke, VA. 24107.	

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E 042	Continued From page 16 that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included documentation to indicate that the facility had or had not opted to be part of a healthcare systems unified and integrated emergency preparedness program. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included documentation to indicate that the facility had or had not opted to be part of a healthcare systems unified and integrated emergency preparedness program. On 10/09/19 beginning at approximately 8:30 a.m., the surveyor and the facility administrator reviewed the facility's emergency preparedness plan. After reviewing the facility's emergency preparedness plan the administrator verbalized to the surveyor that she did not think they belonged to any healthcare alert systems/programs. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19 at approximately 12:15 p.m.	E 042		
W 000	INITIAL COMMENTS An unannounced Medicaid re-certification survey	W 000		

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W 000	Continued From page 17 was conducted on 10/08/19 through 10/09/19. The facility was not in compliance with the following Federal ICF/ID regulations. The Life Safety Code will follow. The census in this 8 certified bed facility was 8 clients at the time of survey. The survey sample consisted of 3 current Client reviews (Clients #1 through #3).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a recordkeeping system by ensuring a complete and accurate clinical record for 1 of 3 Individuals (Individual #2). The findings included: The "PHYSICIAN CONSULTATION" sheet dated 08/30/19 indicated Individual #2 should have been receiving clonazepam 1 mg three times a day and lorazepam 1 mg every day. The October 2019 MAR (medication administration record) revealed that the staff were administering the clonazepam 1 mg twice a day and the lorazepam was being administered PRN (as needed). The clinical record review revealed that this Individual had been admitted to the facility on	W 111	W 111 Piedmont ICF-IID residents records were reviewed for consistency of all medication prescribed. All current medications orders were reviewed to ensure consistency in documentation within all documentation are reflecting all medication orders as set for by Primary Care Physician and Medical Director. A review has been completed of Medication Administration Record (MAR), current prescriptions and all documentation to yield current status approved by prescribing physician and Medical Director of Piedmont ICF-IID. Completed by October 29, 2019. Specially Constituted Committee (SCC) to reflect on physician orders and any changes to record. SCC meeting was held November 21, 2019.	

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W 111	Continued From page 18 09/25/2012. The "Essential Information" sheet included the diagnoses mild intellectual disability and schizophrenia. Individuals #2 clinical record review was completed on 10/09/19. This clinical record included an "Individualized Program Plan" dated 10/18/18 that included the medications clonazepam and lorazepam. The lorazepam was documented as being administered PRN. The "Specially Constituted Committee Review" dated 07/19/2019 included approval for the medications clonazepam and lorazepam PRN. The "PHYSICIAN CONSULTATION" sheet dated 08/30/19 included a "Patient Care Summary" that was electronically signed by the physician. This summary indicated the Individual should be receiving clonazepam 1 mg three times a day and lorazepam 1 mg every day. However, the August 2019 MAR's that accompanied this paperwork was clearly marked to indicate the Individual was being administered clonazepam 1 mg twice a day and lorazepam 1 mg PRN. The physician had transcribed on page 2 of the physician consultation sheet "No New Orders." The physician, Residential Manager, and facility nurse had signed page 2 of this sheet. On 10/08/19 Residential Tech #1 reviewed the medication orders with the surveyor and stated Individual #2 had been receiving the medication the way it was printed on the October 2019 MAR's for a long period of time. A review of the medication labels on 10/08/19	W 111		

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W 111	Continued From page 19 revealed that the label on the lorazepam read 1 mg everyday prn for agitation. The label on the clonazepam read two times a day. This information corresponded with the current (October 2019) MAR's. On 10/09/19 at 9:45 a.m., the contracting pharmacy faxed prescription for the lorazepam and clonazepam to the facility. The hard script for the lorazepam was dated 05/09/2019 read "lorazepam 1 mg take 1/day PRN agitation." The hard script for the clonazepam read "BID (twice a day) for anxiety" and was dated 09/03/2019. On 10/09/19, the facility nurse went to the physician's office and returned with a copy of a "Medicare Annual Wellness Visit" dated 10/07/19. A review of this form-included documentation to indicate the Individual should be receiving lorazepam 1 mg everyday and clonazepam 1 mg three times a day. Under the heading, "Anxiety/Depression" the physician documented that the Individual "...is currently stable..." After reviewing this document with the surveyor, the nurse verbalized that the medication orders would need clarifying. Residential Tech #1 stated more than one physician saw this Individual and that could be the issue. The administrator was notified of the conflicting information regarding Individual #2's clonazepam and lorazepam prior to the exit conference on 10/09/19 at approximately 12:00 p.m. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19.	W 111		
W 159	QIDP	W 159		

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W 159	Continued From page 20 CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the QIDP (qualified intellectual disability professional) failed to identify and correct discrepancies in the clinical record for 1 of 3 Individuals. (Individual #2). The findings included: Individual #2's clinical record included discrepancies's in how the Individuals lorazepam and clonazepam was to be administered. The clinical record review revealed that this Individual had been admitted to the facility on 09/25/2012. The "Essential Information" sheet included the diagnoses mild intellectual disability and schizophrenia. The Individuals clinical record review was completed on 10/09/19. This clinical record included an "Individualized Program Plan" dated 10/18/18 that included the medications clonazepam and lorazepam. The lorazepam was documented as being administered PRN (as needed). The "Specially Constituted Committee Review" dated 07/19/2019 included approval for the medications clonazepam and lorazepam PRN. The QIDP was listed on this document as being the ICF administrator.	W 159	W 159 Piedmont ICF-IDD QIDP / ICF Administrator edited and reviewed all client records in order to be free of any discrepancies as identified within site review as of October 31, 2019. ICF Administrator will monthly conduct reviews of all medications for necessity and accuracy of medical orders to maintain consistency and oversight as QIDP of the facility is in accordance to regulations.	

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W 159	Continued From page 21 The "PHYSICIAN CONSULTATION" sheet dated 08/30/19 included a "Patient Care Summary" that was electronically signed by the physician. This summary indicated the Individual should be receiving clonazepam 1 mg three times a day and lorazepam 1 mg every day. However, the August 2019 MAR's that accompanied this paperwork was clearly marked to indicate the Individual was being administered clonazepam 1 mg twice a day and lorazepam 1 mg PRN. The physician had transcribed on page 2 of the physician consultation sheet "No New Orders." The physician, Residential Manager, and facility nurse had signed page 2 of this sheet. On 10/08/19 Residential Tech #1 reviewed the medication orders with the surveyor and stated the Individual had been receiving the medication the way it was printed on the October 2019 MAR's for a long period of time. A review of the medication labels on 10/08/19 revealed that the label on the lorazepam read 1 mg everyday prn for agitation. The label on the clonazepam read two times a day. This information corresponded with the current (October 2019) MAR's. On 10/09/19 at 9:45 a.m., the contracting pharmacy faxed prescription for the lorazepam and clonazepam to the facility. The hard script for the lorazepam was dated 05/09/2019 read "lorazepam 1 mg take 1/day PRN agitation." The hard script for the clonazepam read "BID (twice a day) for anxiety" and was dated 09/03/2019. On 10/09/19, the facility nurse went to the physician's office and returned with a copy of a "Medicare Annual Wellness Visit" dated 10/07/19.	W 159		

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W 159	Continued From page 22 A review of this form-included documentation to indicate the Individual should be receiving lorazepam 1 mg everyday and clonazepam 1 mg three times a day. Under the heading, "Anxiety/Depression" the physician documented that the Individual "...is currently stable..." After reviewing this document with the surveyor, the nurse verbalized that the medication orders would need clarifying. Residential Tech #1 stated more than one physician saw this Individual and that could be the issue. The ICF administrator was notified of the conflicting information regarding Individual #2's clonazepam and lorazepam prior to the exit conference on 10/09/19 at approximately 12:00 p.m. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19.	W 159		
W 363	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the pharmacy failed to identify irregularities in the clinical record in regards to medications for 1 of 3 Individuals. (Individual #2). The findings included: Individual #2's clinical record included	W 363	W 363 Piedmont ICF –IID Pharmacist contractor conducted a Drug Regimen Review on October 22, 2019 which included systematic cross check protocol to ensure medication orders are free of any irregularities. Piedmont ICF-IID QIDP edited the Pharmacy Review Form to meet the required regulations. (forms is attached)	

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W 363	Continued From page 23	W 363		

discrepancies in how the Individuals lorazepam and clonazepam were to be administered. The pharmacy reviews failed to identify these discrepancies during the drug regimen reviews.

The clinical record review revealed that this Individual had been admitted to the facility on 09/25/2012. The "Essential Information" sheet included the diagnoses mild intellectual disability and schizophrenia.

The Individuals clinical record review was completed on 10/09/19.

This clinical record included an "Individualized Program Plan" dated 10/18/18 that included the medications clonazepam and lorazepam. The lorazepam was documented as being administered PRN (as needed).

The "Specially Constituted Committee Review" dated 07/19/2019 included approval for the medications clonazepam and lorazepam PRN.

The "PHYSICIAN CONSULTATION" sheet dated 08/30/19 included a "Patient Care Summary" that was electronically signed by the physician. This summary indicated the Individual should be receiving clonazepam 1 mg three times a day and lorazepam 1 mg every day. However, the August 2019 MAR's that accompanied this paperwork was clearly marked to indicate the Individual was being administered clonazepam 1 mg twice a day and lorazepam 1 mg PRN. The physician had transcribed on page 2 of the physician consultation sheet "No New Orders." The physician, Residential Manager, and facility nurse had signed page 2 of this sheet.

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W 363	Continued From page 24 On 10/08/19 Residential Tech #1 reviewed the medication orders with the surveyor and stated the Individual had been receiving the medication the way it was printed on the October 2019 MAR's for a long period of time. A review of the medication labels on 10/08/19 revealed that the label on the lorazepam read 1 mg everyday prn for agitation. The label on the clonazepam read two times a day. This information corresponded with the current (October 2019) MAR's. On 10/09/19 at 9:45 a.m., the contracting pharmacy faxed prescription for the lorazepam and clonazepam to the facility. The hard script for the lorazepam was dated 05/09/2019 read "lorazepam 1 mg take 1/day PRN agitation." The hard script for the clonazepam read "BID (twice a day) for anxiety" and was dated 09/03/2019. On 10/09/19, the facility nurse went to the physician's office and returned with a copy of a "Medicare Annual Wellness Visit" dated 10/07/19. A review of this form-included documentation to indicate the Individual should be receiving lorazepam 1 mg everyday and clonazepam 1 mg three times a day. Under the heading, "Anxiety/Depression" the physician documented that the Individual "...is currently stable..." After reviewing this document with the surveyor, the nurse verbalized that the medication orders would need clarifying. Residential Tech #1 stated more than one physician saw this Individual and that could be the issue. The surveyor reviewed the drug regimen reviews for July/August/September 2019. These drug regimen reviews were completed by the same	W 363		

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PIEDMONT ICF/ID HOME	26 BOOKER ROAD MARTINSVILLE, VA 24112

(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 363	Continued From page 25 pharmacy company and did not identify any irregularities. For the months of July and September 2019, the pharmacist had checked the box that read, "No potential problems were found." The ICF administrator was notified of the conflicting information regarding Individual #2's clonazepam and lorazepam prior to the exit conference on 10/09/19 at approximately 12:00 p.m. No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/19.	W 363		