STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G013	A. BUILDING _____ B. WING _____	01/30/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/28/2020 through 1/30/2020. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000		03/10/2020
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 every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015	Holiday House of Portsmouth has determined the best method for fire detection and has created a Fire Watch Program as a part of the facility's Emergency Operation Plan. In the event the facility's sprinkler system, fire warning system, fire suppression system, fail to work properly Holiday House of Portsmouth will implement the facility's Fire Safety plan. A sprinkler system could include but is not limited to: sprinklers, sprinkler heads, branch lines, water mains and water supply. A **power outage** (also called a **power** cut, a **power** blackout, **power** failure or a blackout) is a short-term or a long-term loss of the electric **power** to a particular area.This plan will be available for all Holiday House of Portsmouth staff in writing at all staff stations. Training will be conducted at initial orientation and annually. The Facility Safety Officer will be responsible for conducting the training at initial orientation and annually for ALL STAFF. All Holiday House of Portsmouth staff will be trained in the fire watch program and how to conduct a (**FIRE WATCH TOUR**). **Every fire watch tour will require documentation of the date, time, and staff initials of a person performing the watch. A fire watch tour is a continuous activity performed by having one or more assigned/trained staff walking the entire affected area of the system outage. The tour monitors the facility through direct observation for possible signs of fire.** Fire watches shall be performed by the person designated solely to the fire watch and no other facility related activities of events. Sprinkler system outages can occur during construction, renovations storms or other planned or unplanned events which eliminate part or all of the sprinkler system's functioning ability. Observation of fire or smoke during this fire watch the Residential Supervisor should immediately initiate the facility's fire safety plan.	

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

CLO Chief Administrative Officer 2/13/2020

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

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E 015	Continued From page 1 *[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 record review and staff interview, the facility staff failed to have a fire detection system and provide documentation that the emergency preparedness plan addressed alternate sources for sewage and waste disposal services. The findings included: During an interview with the Administrator on 01/30/20 at 11:00 AM the Administrator was asked if the facility had a Fire Watch Program for fire detection and he stated no. During a review of the emergency preparedness plan with the Administrator on 01/30/20 at 11:03 A.M. he was asked for documentation for sewage and waste disposal services. The administrator	E 015	Evacuate and (Call 911) The Residential Supervisor will designate staff to conduct fire watch tours in the event of sprinkler failure or power outages. This person will not be responsible for resident care and be designated solely to the fire watch tour. Residential Supervisor shall Contact the facility Administrators and the Safety Officer when problems are encountered with the sprinkler system operations/ and or power outages. In the event the administrators and Safety officer can't be reached. The Residential Supervisor will contact the sprinkler company. The sprinkler company shall respond to site until the system is repaired, replaced and/or working. Information shall be posted in staff stations. The Residential Supervisor will notify the Fire Department that the sprinkler alarm system is not working correctly. The fire watch tour shall inspect all wings, floors and or buildings for fires. Fire watch tours shall occur continuously. **30 minute intervals 24 hours a day until the system is repaired, replaced and/or working.** Fire watches shall be performed by the person designated solely to the fire watch and no other facility related activities of events. A fire watch should check and document the following in all rooms including: Resident rooms (removing materials extension cords) Dietary and Laundry rooms (remove lint from dryers and soiled linen. Mechanical and Electrical rooms (remove combustible/flammable materials) Fire Department access to the facility (remove snow or ice from exits) Fire Department access to hydrants, sprinkler connections, standpipes and fire extinguishers Exit accesses, exits and exit discharge are unobstructed Storage of combustible or flammable materials shall be in approved containers or designated storage areas Identify temporary heating devices and have them removed (if applicable)Ensure fire and smoke doors close properly unnecessary machinery which is running continuously is turned off Sprinkler valves shall be open and sealed; gauges	03/10/20

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E 015	Continued From page 2 stated he did not have documentation of the facility having contract agreements for sewage and waste disposal services. The Administrator was also asked for the facility's emergency fire detection system; facility staff failed to determine the best method for emergency fire detection.	E 015	should indicate normal pressures and sprinkler heads shall be unobstructed. Construction or renovation work areas shall be monitored closely. Maintenance staff shall be available on call or on site for equipment emergency issues or shut down situations. All staff shall be aware of locations of all fire extinguishers. The Chief Administrative Officer met with a representative Andrew Augustine from SERVPRO Water Damage Solutions and entered a written agreement 2/10/2020. The Contract addresses that during an emergency that requires **sewage and waste** services. SERVEPRO will come to the facility and address water damage restoration services, mold remediation services, crawl space clean up services to help with water damage repairs. The Contract address that the certified professionals are immediately dispatched to the facility and arrive to Holiday House with the appropriate equipment within 90 minutes or less of the call to start the damage cleanup process.	3/10/20
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 every 2 years (annually for LTC).] 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 local emergency management agencies. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have all facility contact information in the communication plan. The findings included: During an interview on 01/30/20 at 11: 33 a.m. with the Administrator, he was asked for names and contact information for all facility staff, as well as entities providing services under agreement	E 032	The Chief Administrative Officer updated the facility communication plan. This update includes ALL Holiday House of Portsmouth staff, current names, titles, and accurate and current contact information. This update also included adding **Federal Emergency Management Agency (FEMA)** in the communication plan. The Chief Administrative Officer also updated the contact list for vendors utilized during an emergency for accuracy. All vendors contact information has been included in the communication plan. Updates will be conducted by the Chief Administrative Officer as needed when changes occur and annually.	

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E 032	Continued From page 3 during an emergency. A review of the communications plan did not include the name of all staff and their contact information, nor did the plan include vendors providing services to the facility during an emergency.	E 032		
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 every 2 years (annually for LTC).] 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(c):] (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 record review and staff interview, the facility staff failed to have all facility information about the facility's occupancy needs and its ability to provide assistance, to the authority having	E 034	Holiday House of Portsmouth Chief Administrative Officer has updated the emergency preparedness plan to identity the facility's occupancy needs and the ability to provide assistance during an emergency. The following services will be offered by Holiday House of Portsmouth in the event of an Emergency. The facility has identified that all 28 individuals are at risk during any emergency event that occurs **"SHELTER IN PLACE"** the following emergency services will be available to the residents of this facility during emergency events. **Room and Board**: The individual is provided to shelter in their own home and own room to be comfortable as possible during the emergency situation. **Residential Services**: 24 Supervision by trained staff and monitors individuals for safety at all times **Dietary Needs**: this includes specialized diets with feeding equipment and specialized utensils as needed during the emergency. Special dietary supplements used for tube feedings or oral feedings if applicable **Personal Hygiene items**-this includes personal soaps, lotions, etc. as items indicated per physician **Ancillary Services** covered by physical, speech, occupational, or other therapy, and appropriate medically necessary supplies **Therapeutic Recreation Services**: Holiday House of Portsmouth provides for an ongoing program of activities designed to meet in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial wellbeing of each individual. **Nursing Services:** **Food Supply**-extensive food supply a seven day supply of staple foods and a four day supply of perishable goods are maintained in the Kitchen Department. Any additional food supplies will be obtained from local vendors and supplies as needed **Water Supply**=excess water supply **Items stocked in gross supply** (e.g. flashlights, batteries etc.) Facility is equipped with Generator: Thornton Electrical – Provides services to the facility such as the backup generator and all electrical equipment. Maintenance and Grounds: Support from maintenance staff to help clean debris around facility for safety. Laundry Services; environmental technicians on staff to perform laundry duties Telephone Access-landline and cellular Project Lifesaver	3/10/20

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E 034	Continued From page 4 jurisdiction, the Incident Command center, or designee. The findings included: During an interview on 01/30/20 at 11:40 A.M. with the Administrator, he was asked for information about the facility's occupancy needs and its ability to provide assistance. The administrator stated the Emergency Preparedness plan did not contain information about the facility's occupancy needs and its ability to provide assistance during an emergency.	E 034	**VICOM** – Provide IT and computer technical services during an emergency. Omnicare Pharmacy will provided medication and other pharmacy services during an emergency Cox Business will provide internet and phone service during an emergency. VSC will provide emergency services for our fire detection system and the fire extinguisher in the time of an emergency. Home Care will provide gloves, wipes, diapers and underwear in the event an officially declared State of Emergency or manmade emergency. ALSCO will provide laundry bags, soil laundry carts, bath towels, sheets, pillow cases, wash cloths, paper towels, toilet paper, hand soap, and hand sanitizer during an emergency. Omnicare Pharmacy will provided medication and other pharmacy services during an emergency Sysco will provide food and water in the event of an emergency or a man-made disaster. **Services Offered during Evacuation Emergencies** There is a Memorandum of Understanding with the following programs to provide mutual assistance and temporary use of facilities on a short term basis, as necessary in response to an emergency event or disaster: Saint Mary's Home for Disables Children in Norfolk, VA Westhaven Baptist Church in Portsmouth, VA Westminster Reformed Presbyterian Church in Suffolk, VA Candlewood Suites in Richmond, VA Transportation: 6 vehicles to transport to the evacuation destination; trailer to carry surplus of supplies VSC will provide emergency services for our fire detection system and the fire extinguisher in the time of an emergency. Project Lifesaver ServPro: Fire and Water Cleanup and Restoration Services to provide clean up services before returning to the facility. The Chief Administrative Officer or designee will collaborate with the Eastern Virginia Healthcare coalition on a quarterly basis to provide info about the facility's occupancy needs and its ability to provide assistance to the authority having jurisdiction, and the incident command center or designee. The first meeting has been scheduled for March 5, 2020.	3/10/20
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) 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 its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least			

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E 039	Continued From page 5 every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039	The Chief Administrative has reviewed and updated the Education and Training Policy in the Emergency Operations Plan. This policy identifies that the Holiday House of Portsmouth will conduct exercises to test the emergency plan at least twice per year including unannounced staff drills using the emergency procedures established by the facility. This policy addresses that the facility will conduct drills such as fire drills, evacuation drills, mock disaster drills, table top activities, and community based exercises. Each exercise will be accompanied by an after action review report to analyze the facility's response to and maintain documentation of all drills, table top exercises and emergency events. On February 7, 2020 The Chief Administrative Officer met with Captain Joseph M. Rubino, Response and Recovery Specialist from the Office of Emergency Management, and David Topczynski Emergency Planner at Office of Emergency Management to discuss a full scale community based exercise for the facility to participate in. The participants from the Emergency Management Office has agreed to assists the facility to conduct full scale community based exercises annually. In the event the community based exercise is not accessible Holiday House of Portsmouth will conduct a facility based functional exercise. On February 19, 2020 the Chief Administrative Officer/Maintenance Supervisor will conduct the table top exercise on HVAC Failure. This table top will be led by the Chief Administrative Officer as the facilitator. The Chief Administrative Officer will ensure the appropriate after action report to analyze the table top activity.	3/10/20

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E 039	Continued From page 6 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or	E 039		

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E 039	Continued From page 7 (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or	E 039		

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E 039	Continued From page 8 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 9 (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,	E 039		

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E 039	Continued From page 10 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the 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: The facility staff failed to provide documentation of a full scale community based table top exercise and analysis and to conduct an exercise to test the emergency plan annually. . The findings included: During an interview on 01/30/20 at 11:45 AM with the Administrator he was asked for	E 039		

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E 039	Continued From page 11 documentation regarding the facility's community based full scale exercise. The Administrator stated he did not participate in a community based exercise nor did the facility participate in a table top exercise.	E 039		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 1/28/2020 through 1/30/2020. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 28 certified bed facility was 28 at the time of the survey. The survey sample consisted of 5 Individual reviews.	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review, review of facility documentation and staff interviews, the facility staff failed to implement Individual Program Plan for a right arm brace for 1 of 5	W 249	Program Implementation- The facility staff failed to implement Individual Program Plan for a right arm brace for Individual #4. **Point 1: Address how corrective action will be accomplished to address the issue(s), for those individuals found to have been affected by the deficient practice.** The Nursing staff will provide the school nurse at Individual #4's school a copy of the physician's orders for the right arm brace. The physician's orders for the right arm brace states for it to be worn at all times but may be removed as needed when Individual #4 refuses to keep it on. The right arm brace must be reapplied immediately if Individual #4 starts picking at his arm. The right arm brace will be used until self-inflicted wounds heal (nursing staff to check brace every 2 hours for proper fitting and check skin integrity for redness and swelling, check radial pulse every 2 hours to ensure positive circulation, brace will be removed for dressing changes and as needed by nursing only). The Director of Nursing, Charge Nurse or appointed designee will provide the school nurse for Individual #4's Right Arm Splint Documentation Form. This form documents every 2 hours for skin	3/10/20

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W 249	Continued From page 12 individuals (Individual #4) in the survey sample. The findings included; Individual #4 was admitted to the facility on 8/1/15 with diagnoses of moderate intellectual disability, an autistic disorder, an expressive language disorder, epilepsy and a recurrent seizure disorder. Individual #4 had a physician's order dated 7/30/19, for use of a right arm brace to be worn at all times until self-inflicted wounds were healed. The order further stated for nursing to check the brace every 2 hours for proper fitting and to check skin integrity. Review of facility's documentation revealed the facility's staff were assessing the brace every 2 hours but the school staff had no documentation the brace was assessed every 2 hours while the individual was in school. An interview was conducted with Licensed Practical Nurse (LPN) #1 on 1/30/20, at approximately 12:10 p.m. LPN #1 stated the facility had no documentation to support that the nurse at Individual #4's school was assessing the right arm brace every 2 hours as ordered. LPN #4 further stated the nurse was fairly new to the school system. An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) also on 1/30/20 at approximately 12:15 p.m. The QIDP stated representatives are invited from the school to Individual #4's quarterly and annual meetings but they never attend and that is when important information would be exchanged. The QIDP	W 249	integrity and circulation (no redness, no swelling, capillary refill < 3). The Facility QIDP will provide the teacher a copy of Individual #4's copy of the physician's orders for the right arm brace. The Facility QIDP will add to Individual #4's Individualized Program Plan the use of the right arm brace. Individual #4's use of the right arm brace will be monitored quarterly and information and updates will be noted on Individual #4's Schedule of Supports until the use of the right arm brace is discontinued. **Completion Date: February 7, 2020** **Point #2: Address how the facility will identify other individuals having the potential to be affected by the same deficient practice.** The Nursing staff will ask the medical providers to write PRN orders for restrictive equipment for the individuals for school hours. The Nursing staff will provide the school nurse at the Individual's school a copy of the physician's orders for the restrictive equipment. The Director of Nursing, Charge Nurse or appointed designee will provide the school nurse the Individual's use of restrictive equipment information and any form associated with documentation of the restrictive equipment if it is needed. The Nursing staff will communicate and provide a copy of the physician's orders and any form associated with documentation of the restrictive equipment if it is needed to the Facility QIDP. The Facility QIDP will notify the teachers of restrictive equipment and provide the individuals' teacher a copy the physician's orders for the restrictive equipment. The Facility QIDP will add to Individual's Individualized Program Plan for the restrictive equipment. The Individual's use of the restrictive equipment will be monitored quarterly and information and updates will be noted on the Individual's Schedule of Supports until the use of the restrictive equipment is discontinued. **Point #3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** The Coordination and Monitoring of Educational Services Policy will be updated to include the procedures of nursing staff asking the medical providers to write PRN orders for restrictive equipment for the individuals for school hours. The Nursing staff will provide the school nurse at the Individual's school a copy of the physician's orders for the restrictive equipment. The Director of Nursing, Charge Nurse or appointed designee will provide the school nurse the Individual's use of restrictive equipment information and any form associated with documentation of the restrictive equipment if it is needed. The Nursing staff will communicate and provide a copy of the physician's orders and any form associated with documentation of the restrictive equipment if it is needed to the Facility QIDP. The Facility QIDP will notify the teachers of restrictive equipment and provide the	3/10/20

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W 249	Continued From page 13 further stated the facility communicates with the school staff via a communication book which is sent and return with the individual each school day. An interview was conducted with the school nurse 1/30/20 at approximately 1:30 p.m. The school nurse acknowledged awareness of Individual #4 wearing a right arm brace and stated there were no instructions available to provided services to the arm or brace while attending school. The school nurse denied assessing the right arm and/or brace. On 1/30/20 at approximately 2:30 p.m., the above information was shared with the Administrator, Director of Nursing, Social Worker and QIDP. The Administrator stated the liaison between the facility and the school would be ensuring all pertinent information is communicated to the school staff.	W 249	individuals' teacher a copy the physician's orders for the restrictive equipment and documentation of the restrictive equipment if applicable. The Facility QIDP will update the Education Collaboration Form to include the use of restrictive equipment at school. **Point #4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The Facility QIDP will complete the Education Collaboration Form for the individuals monthly to include the use of restrictive equipment at school if applicable. The Facility QIDP will provide a sample of the Education Collaboration Form for the individuals to the Risk Management Committee monthly for review.	
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to ensure medications were administered to one individual (Individual #3) in the survey sample of five individuals as ordered by the physician. The findings included:	W 368	**Point #1: How the corrective action will be accomplished for those individuals found to have been affected by the deficient practice.** The Director of Nursing will meet with the nursing department including agency nurses to review the current survey. It was reported that during an interview on 01/30/2020, individual # 3 received medications that were ordered for another individual on 09/13/2019. On 09/13/2019 Individual # 3 was given medication that was ordered for a different individual. Poison control, medical providers and parents were notified. Individual # 3 vital signs, mental status change and GI issues (nausea or vomiting) were monitored every 2 hours for 8 hours for 24 hours and call 911 if needed per Physician orders. **Point#2: How the facility will identify other individuals having the potential to be affected by the same deficient practice:** The Director of Nursing will meet with the nursing department including agency nurses to review the current survey. The Director of Nursing will review the medication error involving Individual #3 with the nursing department. The Director of Nursing and Charge Nurse will retrain the nursing department on the 5 Rights of Medication Administration which will include Right Individual, Right drugs, Right dose, Right route and Right time. In addition to a post medication test and a medication administration observation (This was	3/10/20

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W 368	Continued From page 14 Individual #3 was admitted to the facility on 08/15/16 with diagnoses that included moderate intellectual disability, anemia, Attention Deficit Hyperactivity Disorder (ADHD) and Down's Syndrome. A facility Medication Error Report dated 09/13/19 indicated that Individual #3 received medications that were ordered for another Individual and included: "Nurse administering medication failed to properly identify individual at 6:50 PM administered keppra 750 mg, clonidine 0.2 mg and Seroquel 400 mg by mouth to Individual #3. Individual was monitored for adverse reactions. Informed Primary Care Physician, Poison Control and family." A review of the physician orders dated 08/22/19 indicated the Individual was supposed to receive: "Polyethylene Glycol powder, give 8.5 gram by mouth one time a day for constipation mixed in 4 oz of water, Depakote Sprinkles capsule 125 mg give 8 capsules by mouth two times a day." During an interview on 01/30/20 at 10:00 AM with the Director of Nursing (DON) she stated the nurse was new and had been distracted. The nurse was re-trained and tested on medication administration. A review of the facility Drug Administration policy indicated: Policy-When administering drugs, always protect the person's safety. To ensure patient safety follow the "Rights of Drug Administration" D. The Right Person: Make sure you can identify the person. Compare information to the (MAR) medication administration record against the person's identity. Know your agency's policy regarding patient identification."	W 368	(This was implemented on September 18, 2019 immediately after the medication error occurrence). Completion Date: September 18, 2019 **Point #3: What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur:** The Don will generate a "New Nurse Medication Administration Observation" (NNMO) check list procedure. The NNMO will be completed before the new nurse can administer medication without supervision. The NNMO check list procedure will included, but is not limited to the 5 rights of medication administration and the nurse ability to prioritize to avoid distraction during medication administration. •The new nurse will complete a medication test and medication administration observation given by the DON, CN or Designated nurse trainer at the end of the nurse 90 days probation. The medication test will then be given quarterly and medication administration observation annually. •The DON will amend The Annual Medication Administration Observation check list procedure to include the nurse ability to prioritize to avoid distraction during medication administration. **Point #4: How the facility plans to monitor it performance to make sure that solutions are sustained; Dates when the corrective action will be completed.** The nursing department will complete medication administration test quarterly and medication administration observation annually. The Director of Nursing will complete the medication error report as incidence occurs and present medication errors to the risk management committees.	3/10/20

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W 476	MEAL SERVICES CFR(s): 483.480(b)(3) Food served to clients individually and uneaten must be discarded. This STANDARD is not met as evidenced by: Based on observation and staff interviews the facility staff failed to discard compromised food which was stored in the refrigerator. During observation of the kitchen and temperatures of food on 1/28/20 at approximately 4:50 p.m.; a gallon bag of celery stalks were observed in the refrigerator dated 12/20/19. The celery stalks were whitish and mushy on both ends of the stalks and a large amount of brownish liquid was observed in the bottom of the bag. An interview was conducted with the Kitchen Manager, who stated they probably should have been thrown out but she thought they could trim around the stalks and save some of the celery. The Kitchen Manager removed the bag from the refrigerator. On 1/29/20, the Kitchen Manager was observed bringing the same bag of celery stalks dated 12/20/19, out of the refrigerator putting the gallon bag of celery inside a white plastic shopping bag and placed the shopping bag on top of a garbage can. On 1/30/20 at approximately 2:30 p.m., the above information was shared with the Administrator, Director of Nursing, Social Worker and QIDP. The Administrator stated the celery should have been discarded when it was recognized not fresh.	W 476	**W476Point #1: How the corrective action will be accomplished for those individuals found to have been affected by the deficient practice**. The Director of Nursing and Kitchen Manager will meet with the kitchen department to review the current survey. It was reported that during an interview on 01/28/2020 a gallon bag of celery stalks were observed in the refrigerator dated 12/20/2019. The celery stalks were whitish and mushy on both ends. The kitchen manager will immediately inspect and discard all produce that are not correctly labeled. Completion Date: February 8, 2020 **Point#2: How the facility will identify other individuals having the potential to be affected by the same deficient practice**: The Director of Nursing and Kitchen Manager will meet with the Kitchen department to review the current survey. The Kitchen Manager and Kitchen team leader will train the kitchen department on how to correctly storage fresh produce and the procedure for the Fresh Produce Inventory Sheet. The Fresh Produce Inventory Sheet will be used as a tracking system for all produce received from the food suppliers. **Point #3: What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur:** The Fresh Produce Inventory Sheet will include but is not limited to the date produce were received and expiration dates. The kitchen staff will date and place all cut/used produce in a plastic Ziploc bag with the first day the produce was cut/used. The produce will be discard 7 days from the date on the bag. **Point #4: How the facility plans to monitor it performance to make sure that solutions are sustained;**. The Kitchen manager or designated kitchen staff will complete an inspections on the fresh produce and monitor the Fresh Produce Inventory Sheet weekly. Any produce that have expired or is overly ripe will be discarded immediately.	3/10/20

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