STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G050	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI SNOWFLAKE DRIVE	4541 SNOWFLAKE DRIVE RICHMOND, VA 23237

(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 A COVID-19 Focused Emergency Preparedness Survey was conducted offsite 06/02/2020 through 06/03/2020 and onsite 07/01/2020. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 6 certified bed facility was 6 at the time of the onsite survey.	E 000	1) CRi has developed a COVID-19 focused infection control Visitors questionnaire and temperature log to support staff in assessing each other and screening visitors to prevent, control and contain the spread of the Corona Virus 2) The Program Manager and Program Nurse will during the next virtual staff meeting review the importance of using the temperature logs and visitor's questionnaire to screen and ask staff/visitors COVID-19 related questions on a daily basis before granting them access to the Program. 3) Program staff will, using proper infection control protocols, take temperatures/Oxygen saturation levels and ask questions related to travel and exposure to COVID-19 before granting anyone access to the program. Staff and visitors who do not meet the threshold will be denied access to the program and advised to seek medical attention from their Personal Care Providers.	7/30/2020
W 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted offsite 06/02/2020 through 06/03/2020 and onsite 07/01/2020. Corrections are required for compliance with 42 CFR Part 483.470(l)(1) infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 6 certified bed facility was 6 at the time of the onsite survey.	W 000		
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 Observation, staff interview, and facility document review, the facility staff failed to	W 455		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Valerie Tansinda — TITLE: Clinical Director — (X6) DATE: 07/17/2020

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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W 455	Continued From page 1 implement an active infection control program to prevent the spread of COVID-19. The findings included; The facility staff failed to screen all staff prior to obtaining entrance to the facility. On 7/1/2020 at approximately 10:45 AM Surveyor A entered the facility. Surveyor A underwent no screening, no temperature check, no questions regarding travel or COVID-19 symptoms. Employee A (Program Director) stated they stopped screening employees. Employee B (direct service personnel) confirmed the surveillance of staff ended about 2 weeks ago. The facility Corporate policy, as stated in a letter from the Chief Executive Officer (CEO) was reviewed and stated: "We will continue to follow guidance provided by the Governor, local health departments, and the CDC. A Ready Team has been appointed to assess and begin planning our path forward to address when and how CRi will begin to relax the emergency policies currently in place for both the programs and administrative offices. As I mentioned, we will continue to discourage all visitors to the homes. While we understand this policy is not ideal, we are committed to limiting the risk of exposure to and transmission of the COVID-19 virus to those we support as well as staff, families, guardians, and the community at large. The use of technology to conduct virtual visits is highly encouraged during this time." On 7-1-2020, at the end of day debriefing and survey exit, the facility staff were made aware of	W 455	4) The Program Manager, Program Nurse, QIDP or designated weekend staff will review the temperature logs and Visitor questionnaires on a daily basis to ensure that this standard is being met in order to maintain the health and safety of all the individuals and staff we support at the Program.	7/30/2020

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W 455	Continued From page 2 the deficient practice. The facility staff failed to protect the individuals in the facility from incoming infectious disease by way of failure to screen staff and provide surveillance. The facility policy to restrict visitation indicated the understanding that potential vectors of COVID-19 would likely come from the community, which includes staff. No further information was provided by the facility.	W 455	1)	