STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G043	A. BUILDING ______ B. WING ______	09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES FAIRMONT HOUSE	124 FAIRMONT DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/26/20 through 08/28/20 and 08/31/20 through 09/01/20. The facility was in substantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000	W114 Facility failed to ensure the Physicians Order Summary (POS) was legible for staff to read for Individual #1. 1. LPN#1 highlighted and copied the POS which resulted in having a hue over the name of the medications and facility staff (DSP#1) was unable to read it. LPN#1 replaced the illegible copy of the POS with a legible copy. (Reference Attachment #1: Physician Orders for Individual #1 dated 8/20/20, 2pgs).	9/10/20
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 08/26/20 through 08/28/20 and 08/31/20 through 09/01/20. 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 four certified bed facility was three at the time of the survey. The survey sample consisted of two Individual reviews (Individuals #1 and #2).	W 000	2. LPN #1 conducted an audit of all Fairmont individuals medical records and discovered the similar deficient practice. Legible orders were obtained from the Physician to replace the illegible orders. All other ICF-IID facilities will conduct audits to ensure this practice is not occurring and make corrections as warranted. 3. A meeting was held with the Chief Community Living Officer and all ICF-IID Nursing staff (LPNs/RNs) on 9/4/20 They were instructed to discontinue making copies of documents that include highlights or other markings which could creating illegibility. This practice will be used conistently across all ICF-IID programs operated by VersAbility Resources.	9/10/20 9/15/20 9/4/20
W 114	CLIENT RECORDS CFR(s): 483.410(c)(4) Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. 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 ensure the Physician Order Summary (POS) was legible for staff to read for	W 114	4. Medication Audits will be conducted at random, monthly, and the Medication Audit form (Reference Attachment #2: Medication Audit Checklist, 2pgs.) was updated to include monitoring of whether or not Physician Orders Summaries are legible.	9/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda K. Kuna, LCSW	Chief Community Living Officer	09/11/2020

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 114	Continued From page 1	W 114		

one of two individuals (Individual #1) in the survey sample.

The findings included;

Individual #1 was admitted to the facility on 12/18/18 with diagnoses of severe intellectual disability, Down's syndrome, stroke, pulmonary fibrosis, arthritis in joints and poor vision in the right eye.

Individual #1's Physician Order Summary signed by the physician 6/2/20, revealed all medications had an opaque hue over the drug name, making it extremely difficult to read.

An interview was conducted 8/27/20, at approximately 11:30 a.m., with Direct Support Specialist (DSP) #1. DSP #1 stated she doesn't review the Physician's Order Summary (POS) for she was trained to follow the order on the MAR. DSP #1 was unable to read some of the opaque hues on the POS when asked what it read.

An interview was conducted with Licensed Practical Nurse (LPN) #1, on 8/27/20, at approximately 12:40 p.m. LPN #1 stated on the original MAR the drug names were highlighted and the opaque hue on the copy in front of the MAR was a result of the highlight. LPN #1 stated the highlighted MAR was in front of the MAR to be referenced by the direct care staff but, she didn't realize how difficult it was to read it until it was brought to her attention.

On 9/1/20 at approximately 10:15 a.m., the above information was shared with the Program Director, the Registered Nurse (RN) and the Residential Manager. The RN stated to highlight

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W 114	Continued From page 2 the medications was something new LPN #1 was implementing but; since they realize the problem it created the practice would be discontinued.	W 114		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interviews, the facility staff failed to ensure privacy during toileting for one of two individuals (Individual #1) in the survey sample. The findings included; Individual #1 was admitted to the facility on 12/18/18 with diagnoses of severe intellectual disability, Down's syndrome, stroke, pulmonary fibrosis, arthritis in joints and poor vision in the right eye. Individual #1 was assisted to toilet after receiving a respiratory treatment on 8/28/20 at approximately 11:35 a.m. DSP (Direct Support Specialist) #4 assisted Individual #1 in to the bathroom and to sit on the commode. DSP #4 stepped out the bathroom but left the door open where the Individual was viewable to anyone near the bathroom door. DSP moved between the Individual's room and the bathroom never closing the bathroom door to provide privacy during toileting. An interview was conducted 8/28/20, at	W 130	W130 Facility failed to ensure privacy during toileting for Individual #1. 1. DSP #4 did not ensure privacy by leaving the bathroom door ajar while Individual #1 was toileting on 9/1/20. As a result, the Residential Manager met 1:1 with DSP #4 to discuss the situation and provide guidance to ensure privacy for Individual #1 on the day the deficent practice was observed. DSP #4 was instructed to stay inside the bathroom with Individual #1 while toileting and close the door for privacy. Policy #85 (Physical Environment)was updated to include bathroom doors remaining closed while toileting to ensure privacy of the individuals at all ICF-IID facilities operated by VersAbility Resources. 2. Individual #1 was the only individual affected by this deficient practice. However, all ICF-IID facility staff must adhere to policy updates. Email was sent to all ICF-IID Managers requesting notification and training of facility staff on Policy #85 update. 3. The Residential Manager met with all Fairmont staff to discuss proper procedures while toileting for Individual #1, as well as, all other Fairmont residents. The revised policy, Policy #85: Physical Environment, was reviewed with staff and signatures were obtained. (Reference Attachment #3 , Policy #85 Physical Environment; and Attachment # 4, Policy #85 Review and Insight Supervision and Privacy training signature sheet).	9/1/20 9/6/20 9/8/20 9/8/20 and 9/10/20

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W 130	Continued From page 3 approximately 11:50 a.m., with Direct Support Specialist (DSP) #4. DSP #4 stated the Individual requires supervision. On 9/1/20 at approximately 10:15 a.m., the above information was shared with the Program Director, the Registered Nurse (RN) and the Residential Manager. The Residential Manager stated Individual #1 must have in sight supervision but the bathroom door shouldn't be left open for others to view the individual during toileting.	W 130	W 130 continued 4. The Managers of all ICF-IID facilities will conduct, at random, observations of this practice to ensure compliance at least monthly.	9/10/20
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. 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 notify the physician and the Authorized Representative of their administration of the medication Albuterol three times daily without a physician's order, to one of two individuals (Individual #1) in the survey sample. The findings included; Individual #1 was admitted to the facility on 12/18/18 with diagnoses of severe intellectual disability, Down's syndrome, stroke, pulmonary fibrosis, arthritis in joints and poor vision in the	W 148		

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

PRINTED: 09/04/2020
FORM APPROVED
OMB NO. 0938-0391

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W 148	Continued From page 4 right eye. Individual #1's medication administration record (MAR), revealed an order for Albuterol 2.5 milligrams (mg)/3 milliliter (ml). Take 2.5 mg total by nebulization three time a day (6:00 a.m., 12:00 p.m., 6:00 p.m.), for wheezing. Albuterol sulfate inhalation solution is indicated for the relief of bronchospasm in patients 2 years of age and older with reversible obstructive airway disease and acute attacks of bronchospasm. (https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=7e2e2a9d-3e90-4ff3-8661-4a88005186e9&version=2) Review of the clinical record revealed an order from the physician date 3/12/20, which read start Albuterol 2.5 mg/3 ml nebulizer treatment three times a day and as needed. The current physician order summary signed by the physician on 6/2/20 read, discontinue all previous orders and continue with... Albuterol 2.5 mg/3 ml. Take 3 ml by nebulization every 6 hours as needed for wheezing. An interview was conducted 8/27/20, at approximately 11:30 a.m., with Direct Support Specialist (DSP) #1. DSP #1 stated she doesn't review the Physician's Order Summary (POS) for she was trained to follow the order on the MAR and the MAR stated Individual #1 should receive Albuterol 2.5 mg/3 ml by nebulization three times a day and she had just administered the 12:00 p.m., dose. An interview was conducted with Licensed	W 148	W 148 The facility failed to notify the Physicain and the Authorized Representative of their administration of the medication Albuterol three times daily without a Physician's Order for Individual #1. 1. The Physician and Authorized Representative were notified of the error found with the Physician Order for Albuterol on 9/8/20. LPN #1 noted at time of Survey that it was the intent of the Physician that the Albuterol meds for Individual #1 would continue as written and had not changed. A PO was obtained from the Physician noting this info. was correct. (See Attachment #5, Physician Order dated Sept. 10, 2020.) Also, the RN, once notified of the error on 9/1/20, obtained a Physician Order to assure a current order was in place to continue administering the medication. An Incident Report was completed by LPN #1, per agency policy recording discovery of error. (Reference Attachment #6 : VersAbility Resources, Inc. Community Living Incident/Injury Report form). 2. This deficient practice was discovered to relate only to Individual #1 and not the other residents within the home. All other residents of ICF-IID facilities physician orders will also be reviewed to ensure accuracy as well.	9/8/20 9/10/20 9/1/20 9/8/20 9/10/10

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W 148	Continued From page 5 Practical Nurse (LPN) #1, on 8/27/20, at approximately 12:40 p.m. LPN #1 stated after reviewing of the 6/2/20, POS and the 8/1/20 MAR, the order wasn't correct but it had been corrected on the 8/20/20 POS to be signed by the physician for the next 90 days beginning 9/1/20. Review of the MAR on 8/27/20, revealed the erroneous order was still in place and staff was continuing to sign indicating they administered the medication Albuterol without a physician's order. Documentation wasn't available stating the physician and the Authorized representative were notified of the Albuterol discrepancy. On 8/28/20, at approximately 11:15 a.m., administration of Albuterol 2.5 mg/3 ml by nebulization to Individual #1 was observed. On 9/1/20 at approximately 10:15 a.m., the above information was shared with the Program Director, the Registered Nurse (RN) and the Residential Manager. No additional information was provided by the facility's staff.	W 148	(W148 continued) 3. A meeting was held with the Chief Community Living Officer and all ICF-IID Facility Nurses on 9/4/20 to discuss the expectations and adherence to Policy #52 (Physician Orders and Physician Progress Notes) regarding the need to review orders and update every 90 days. Also, when a new orders is obtained by a new prescriber, other than the individual's PCP, the Nurse assigned to the home, or substitute, will ensure orders are current and correct. 4. The facility's assigned Nurse (LPNs, or designee) will provide documentation related to Physician Orders to the RN within 48 hours to review for errors. If an order changes, they must notify RN immediately to review and prevent any discrepancy in the order and/or possible delay of treatment.	9/4/20 9/10/20
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.	W 242		

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W 242 Continued From page 6

This STANDARD is not met as evidenced by:
Based on observation, record review and staff interviews, the facility staff failed to implement the Individual Program Plan (IPP) for the use of compensatory strategies secondary to loss of vision of the right eye for one of two individuals (Individual #1) in the survey sample.

The findings included;

Individual #1 was admitted to the facility on 12/18/18 with diagnoses of severe intellectual disability, Down's syndrome, stroke, pulmonary fibrosis, arthritis in joints and poor vision in the right eye.

Individual #1 was observed on 8/27/20, at approximately 3:35 p.m., working a table top puzzle which required matching and placing fruit shapes in the puzzle at the kitchen table. Individual #1 had one puzzle piece not placed therefore; he looked below to the floor and before him on the table to locate the missing puzzle piece. The missing puzzle piece was actually to his right but assistance was necessary for Individual #1 to locate it. Individual #1 began to frown for he was unable to locate the last puzzle piece. When Direct Support Specialist (DSP) #4 returned to the kitchen she moved the puzzle piece within his visual field, Individual #1 picked it up, placed it in the puzzle and began to clap his hand and smile broadly.

An interview was conducted 8/27/20, at approximately 3:50 p.m., with DSP #4. DSP #4 stated the Individual #1 has poor vision but she wasn't aware if there was an plan to compensate for the loss of vision.

W 242

W242
Facility failed to implement the IPP for the use of compensatory strategies secondary to loss of vision of the right eye for Individual #1.

1. An updated OT Assessment was requested for Individual #1 by the Occupational Therapy Consultant to evaluate current needs. The OT Assessment was completed on 9/9/20 and report received on 9/10/20. ISP will be updated to reflect recommendations from the OT related to vision and hearing deficits. (Reference Attachment #7: Occupational Therapy Assessment Update Report). — 9/11/20; 9/11/20

The Physical Therapy Consultant will also conduct an assessment on 9/15/20 to address vision and hearing deficits. The PT recommendations will also be incorporated into the ISP. — 9/15/20

2. It was determined that this deficiency would be applicable to all residents of Fairmont House, as well as, all other VersAbility Resources ICF-IID facilities, therefore assessments will be conducted by the Occupational Therapy Consultant and Physical Consultant for all residents to ensure proper support is being provided to individuals with hearing and vision difficulties. — 9/15/20

3. All ICF-IID facility residents will receive assessments and staff will be provided training if recommendations by the OT and PT are warranted to improve vision and hearing. Training will provided to staff in — 9/15/20

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W 242	Continued From page 7 Review of the clinical record revealed an Occupational Therapy Consult Report dated 12/31/19. The report read; (name of Individual) "is challenged to secure items on the table top on the right and left side of the midline (due to a reported diagnosis of hemianopsia) with verbal cues to scan his entire visual field as well as upper extremity strengthening of proximal and distal musculature. Compensatory strategies include elevating table top activities to 30 degrees to increase visibility of objects for manipulation". On 9/1/20 at approximately 10:15 a.m., the above information was shared with the Program Director, the Registered Nurse (RN) and the Residential Manager. No additional information was offered by the facility's staff.	W 242	W242 continued person/virtually, or by use of video. Support instructions will be provided to staff accordingly. 4. The ISP will be monitored during IDT Meetings to ensure the team is addressing deficits for hearing and vision. The Support Coordinator, Envisions Day Program and Nursing staff will follow procedures as outlined by the OT and/or PT as well. The ISP/Nursing Care Plans will incorporate recommendations as necessary. The Manager of the home will conduct monthly observations, at random, to determine compliance with recommendations from the OT/PT.	9/11/20 9/15/20
W 244	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iv) The individual program plan must identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the situations in which each is to be applied. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, the facility staff failed to implement the Individual Program Plan (IPP) for use of a gait belt while walking for one of two individuals (Individual #1) in the survey sample. The findings included; Individual #1 was admitted to the facility on 12/18/18 with diagnoses of severe intellectual	W 244	W 244 Facility failed to use a gait belt while walking for Individual #1 1. DSP #4 failed to follow guidance provided to staff as to how to use the gait belt with Individual #1 while also using a rollator. The Physical Therapy Consultant was contacted and a gait belt training for	9/15/20

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W 244	Continued From page 8 disability, Down's syndrome, stroke, pulmonary fibrosis, arthritis in joints and poor vision in the right eye.	W 244	W244 Individual #1 will be conducted on 9/15/20 for all staff at Fairmont House ICF-IID. The training will be recorded for future use as well.	
	Individual #1 was observed on 8/28/20, at approximately 11:10 a.m., walking to his bedroom to receive a respiratory treatment. Individual #1 was wearing a gait belt and utilizing a rollator walker. Direct Support Specialist (DSP) #4 was observed walking in front of Individual #1 walker and holding on to the center of the walker's frame. Again at approximately 11:30 a.m., Individual #1 was observed walking from his room to the bathroom and again DSP #4 was observed in front of the walker guiding the individual to the bathroom door and eventually into the bathroom without the walker as the Individual held onto the door frame to enter the bathroom.		2. This deficiency practice only referenced Individual #1, however, it is the agency practice to ensure all ICF-IID facilities receive training regarding this deficiency. 3. All ICF-IID facility staff will receive training on use of gait belts by the Physical Therapy Consultant. The training will be recorded for future use at the site. 4. Manager of the program will conduct random observations monthly to ensure proper use of the gait belt is occurring.	9/10/20 9/15/20 9/10/20
	An interview was conducted 8/27/20, at approximately 11:35 a.m., with DSP #4. DSP #4 stated Individual #1 has poor vision therefore she guides the walker from the front. DSP #4 wasn't able to stated if Individual #1 lost his balance while walking how standing before the walker she would be able to assist the Individual. DSP #4 further stated sometimes she utilizes the gait belt but from now on she would assist Individual #1 when walking utilizing the gait belt. Review of the Physician's Order summary signed 6/2/20, revealed the following orders; May use rollator walker with seat for safety. May use gait belt when ambulating and transferring to different surfaces. Review of the clinical record revealed an Occupational Therapy Consult Report dated 12/31/19. The report read; functional mobility			

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W 244	Continued From page 9 activities include ambulating with contact guard assistance while wearing a gait belt and support staff to maneuver rollator walker directionally. On 9/1/20 at approximately 10:15 a.m., the above information was shared with the Program Director, the Registered Nurse (RN) and the Residential Manager. The Residential Manager stated staff should be assisting Individual #1 to walk by using the gait belt not by manipulating the walker. The Residential Manager further stated the staff is constantly educated on their role in assisting Individual #1 with walking and use of his devices.	W 244		
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 observation, record review, review of facility documentation and staff interviews, the facility staff failed to obtain a physician's order for the drug Albuterol prior to administration to one of two individuals (Individual #1) in the survey sample. The findings included; Individual #1 was admitted to the facility on 12/18/18 with diagnoses of severe intellectual disability, Down's syndrome, stroke, pulmonary fibrosis, arthritis in joints and poor vision in the right eye.	W 368	W368 Facility failed to obtain Physician's Order for the drug Albuterol prior to administration to Individual #1. 1. LPN #1 obtained Physician Order indicating that administration of the drug Albuterol was not an error, however, the physician's order was incorrect. On 9/1/20 the RN obtained a copy of the correct order so that the Albuterol could continue to be administered. LPN #1 obtained a note from the Physician indicating that the drug Albuterol should have been continued as administered prior to the 6/2/20 order which neglected to state this information. (See Attachment #5: Physician Order dated Sept. 10, 2020.) An Incident Report was completed by LPN #1, per agency policy recording discover of error. (Reference Attachment #6: VersAbility Resources, Inc. Community Living Incident/Injury Report form).	9/1/20 9/10/20 9/8/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G043	A. BUILDING ____ B. WING ____	09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES FAIRMONT HOUSE	124 FAIRMONT DRIVE HAMPTON, VA 23666

(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 368	Continued From page 10	W 368	W368 continued	
	Individual #1's medication administration record (MAR), revealed an order for Albuterol 2.5 milligrams (mg)/3 milliliter (ml). Take 2.5 mg total by nebulization three time a day (6:00 a.m., 12:00 p.m., 6:00 p.m.), for wheezing.		2. This deficient practice was discovered to relate only to Individual #1 and not the other residents within the home.	9/10/20
	Albuterol sulfate inhalation solution is indicated for the relief of bronchospasm in patients 2 years of age and older with reversible obstructive airway disease and acute attacks of bronchospasm. (https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=7e2e2a9d-3e90-4ff3-8661-4a88005186e9&version=2)		3. A meeting was held with the Chief Community Living Officer and all ICF-IID Facility Nurses on 9/4/20 to discuss the expectations and adherence to Policy #52 (Physician Orders and Physician Progress Notes) regarding the need to review orders and update every 90 days. Also, when a new orders is obtained by a new prescriber, other than the individual's PCP, the Nurse assigned to the home, or substitute, will ensure orders are current and correct.	9/4/20
	Review of the clinical record revealed an order from the physician date 3/12/20, which read start Albuterol 2.5 mg/3 ml nebulizer treatment three times a day and as needed.		4. The facility's assigned Nurse (LPNs, or designee) will provide documentation related to Physician Orders to the RN within 48 hours to review for errors. If an order changes, they must notify RN immediately to review and prevent any discrepancy in the order and/or possible delay of treatment.	9/10/20
	The current physician order summary signed by the physician on 6/2/20 read, discontinue all previous orders and continue with... Albuterol 2.5 mg/3 ml. Take 3 ml by nebulization every 6 hours as needed for wheezing.			
	Further review of the Medication Administration Record revealed three times each day from 8/1/20 through 8/28/20, Individual #1 had received Albuterol Albuterol 2.5 mg/3 ml, without a current physician's order.			
	An interview was conducted 8/27/20, at approximately 11:30 a.m., with Direct Support Specialist (DSP) #1. DSP #1 stated she doesn't review the Physician's Order Summary (POS) for she was trained to follow the order on the MAR and the MAR stated Individual #1 should receive Albuterol 2.5 mg/3 ml by nebulization three times			

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	49G043	A. BUILDING ______ B. WING ______	09/01/2020

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W 368	Continued From page 11 a day and she had just administered the 12:00 p.m., dose. An interview was conducted with Licensed Practical Nurse (LPN) #1, on 8/27/20, at approximately 12:40 p.m. LPN #1 stated after reviewing of the 6/2/20, POS and the 8/1/20 MAR the order wasn't correct but it had been corrected on the 8/20/20 POS to be signed by the physician for the next 90 days beginning 9/1/20. Review of the MAR on 8/27/20, revealed the erroneous order was still in place and staff was continuing to sign indicating they administered the medication Albuterol without a physician's order. Documentation wasn't available stating the physician and the Authorized representative were notified of the Albuterol discrepancy. On 8/28/20, at approximately 11:15 a.m., administration of Albuterol 2.5 mg/3 ml by nebulization to Individual #1 was observed. On 9/1/20 at approximately 10:15 a.m., the above information was shared with the Program Director, the Registered Nurse (RN) and the Residential Manager. No additional information was provided by the facility's staff.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation during the medication	W 369		

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W 369	Continued From page 12 pass on 8/28/20, record review, review of facility documentation and staff interviews, the facility staff failed to have a current scheduled physician's order for the drug Albuterol prior to administration to one of two individuals (Individual #1) in the survey sample. The findings included; Individual #1 was admitted to the facility on 12/18/18 with diagnoses of severe intellectual disability, Down's syndrome, stroke, pulmonary fibrosis, arthritis in joints and poor vision in the right eye. Individual #1's medication administration record (MAR), revealed an order for Albuterol 2.5 milligrams (mg)/3 milliliter (ml). Take 2.5 mg total by nebulization three time a day (6:00 a.m., 12:00 p.m., 6:00 p.m.), for wheezing. Albuterol sulfate inhalation solution is indicated for the relief of bronchospasm in patients 2 years of age and older with reversible obstructive airway disease and acute attacks of bronchospasm. (https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=7e2e2a9d-3e90-4ff3-8661-4a88005186e9&version=2) Review of the clinical record revealed an order from the physician date 3/12/20, which read start Albuterol 2.5 mg/3 ml nebulizer treatment three times a day and as needed. The current physician order summary signed by the physician on 6/2/20 read, discontinue all previous orders and continue with... Albuterol 2.5 mg/3 ml. Take 3 ml by nebulization every 6 hours	W 369	W 369 Facililty failed to have a current scheduled physician's order for the drug Albuterol prior to administration to Individual #1. 1. LPN #1 obtained Physician Order indicating that administration of the drug Albuterol was not an error, however, the physician's order was incorrect. On 9/1/20 the RN obtained a copy of the correct order so that the Albuterol could continue to be administered. (See Attachment #8 : Physician Order dated 9/1/20) LPN #1 obtained a note from the Physician indicating that the drug Albuterol should have been continued as administered prior to 6/2/20 physician order and afterwards until current. (See Attachment #5:, Physician Order dated Sept. 10, 2020.) Also note that the incorrect physician order for Albuterol was provided to Surveyor also during the review by the LPN, however, the correct physician order was located in the medical binder with the Physician's signature. An Incident Report was completed by LPN #1, per agency policy referencing discover of errors and explaining what happened. (Reference Attachment #6: VersAbility Resources, Inc. Community Living Incident/Injury Report form). 2. This deficient practice only relate only to Individual #1 and did not relate to the other residents within the home.	9/1/20 9/10/20 9/8/20 9/10/20

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W 369	Continued From page 13 as needed for wheezing. An interview was conducted 8/27/20, at approximately 11:30 a.m., with Direct Support Specialist (DSP) #1. DSP #1 stated she doesn't review the Physician's Order Summary (POS) for she was trained to follow the order on the MAR and the MAR stated Individual #1 should receive Albuterol 2.5 mg/3 ml by nebulization three times a day and she had just administered the 12:00 p.m., dose. An interview was conducted with Licensed Practical Nurse (LPN) #1, on 8/27/20, at approximately 12:40 p.m. LPN #1 stated after reviewing of the 6/2/20, POS and the 8/1/20 MAR the order wasn't correct but it had been corrected on the 8/20/20 POS to be signed by the physician for the next 90 days beginning 9/1/20. Review of the MAR on 8/27/20, revealed the erroneous order was still in place and staff was continuing to sign indicating they administered the medication Albuterol without a physician's order. Documentation wasn't available stating the physician and the Authorized representative were notified of the Albuterol discrepancy. On 8/28/20, at approximately 11:15 a.m., administration of Albuterol 2.5 mg/3 ml by nebulization to Individual #1 was observed. On 9/1/20 at approximately 10:15 a.m., the above information was shared with the Program Director, the Registered Nurse (RN) and the Residential Manager. No additional information was provided by the facility's staff.	W 369	W369 continued 3. A meeting was held with the Chief Community Living Officer all ICF-IID Facility Nurses on 9/4/20 to discuss the expectations and adherence to Policy #52 (Physician Orders and Physician Progress Notes) regarding the need to review orders and update every 90 days. Also, when a new orders is obtained by a new prescriber, other than the individual's PCP, the Nurse assigned to the home, or substitute, will ensure orders are current and correct. 4. The facility's assigned Nurse (LPNs, or designee) will provide documentation related to Physician Orders to the RN within 48 hours to review for errors. If an order changes, they must notify RN immediately to review and prevent any discrepancy in the order and/or possible delay of treatment.	9/4/20 9/10/20