STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 onsite 09/30/20, 10/01/20 and 10/05/20 and continued with offsite review through 10/06/20. 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.			
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 09/30/20, 10/01/20 and 10/05/20 and continued with offsite review through 10/06/20. 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 4 bed certified facility was 4 at the time of the survey. The survey sample consisted of 2 Individual reviews (Individuals #1 and #2).			
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's staff failed to develop a plan consisting of relevant interventions to	W240 E 000 W 000 W 240	Facility staff failed to develop a plan consisting of relevant interventions to support swishing and spitting during oral hygiene for Individual #1. 1. Nurse (LPN)#1 re-assessed Individual #1's ability to swish and spit as outlined in oral hygiene intervention. Individual #1 continued to have difficulty swishing and spitting and as a result, a Physician's Order was obtained to use toothettes instead of administering Listerine mouth wash. (Reference Attachment #1: Individual #1's Physician Order) In addition, both the Nursing Care Plan and ISP were updated to reflect this change. 2. All other individuals within the facility were assessed and only Individual #1 was affected by this deficiency. ***3. This deficiency was isolated to Individual #1, however, Hollywood House Manager reminded facility staff to report all difficulty the individuals may have with interventions or strategies developed for them and to document such occurrences in their ID Notes. 4. Managers of all ICF-IID facilities operated by VersAbility Resources will conduct monthly staff observations at random to ensure individuals, as well as facility staff, are responding well to goals/objectives and interventions identified in their ISP and Nursing Care Plan Any concerns will be brought to the attention of the Nurse (LPN or RN) and the Support Coordinator to determine if revisions are warranted or additional supports or assessments are necessary.	10/15/20 10/7/20 10/6/20 10/6/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda K. Kuna, LCSW	Chief Community Living Officer	10/27/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 240	Continued From page 1	W 240		

support swishing and spitting during oral hygiene for 1 of 2 Individuals (Individual #1) in the survey sample.

The findings included:

Individual #1 was admitted to the facility on 4/3/17. The primary diagnoses included; severe intellectual disability, a seizure disorder, and periodontal disease.

The Physician Order Summary for 10/2020 revealed an undated order for Listerine mouth wash 15 milliliters, swish and spit by mouth twice daily (oral hygiene).

The nursing care plan dated 7/14/20, under Oral Hygiene read, Brush teeth at least 4 times daily with electric tooth brush (staff to offer assistance). Concentrate on the gum line for two minutes when brushing teeth. Listerine mouth wash 15 milliliters swish and spit by mouth twice daily.

On 10/1/20 at approximately 12:55 p.m., Individual #1 was assisted to the bathroom to brush his teeth. Individual #1 started brushing his teeth but experienced difficulty staying focused and completing the task therefore Direct Support Personnel #1 brushed Individual #1's teeth. Afterwards a cup of water was handed to Individual #3 to rinse his mouth but instead the water was swallowed. Another cup of water was handed to Individual #1 and again the water was swallowed instead of the Individual swishing and spitting.

On 10/8/20 at approximately 6:20 p.m., Individual #1 was observed in the medication room receiving Listerine mouth wash for oral hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 240	Continued From page 2 The cup of Listerine was handed to Individual #1 who took the antiseptic in his mouth, wasting some on his shirt and noted swallowing some. When directed to spit the Listerine there was nothing to spit. The Listerine had been swallowed by Individual #1. Direct Support Personnel #4 was interviewed 10/5/20 at approximately 6:28 p.m., he stated sometimes he spits most of the Listerine out but today he didn't. On 10/6/20 at approximately 6:00 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1, who stated the direct support staff had not expressed the inability of Individual #1 to perform the swish and spit instructions and she felt the individual was capable of swishing and spitting. On 10/6/20 at approximately 6:00 p.m., the above information was shared with the Program Director, Registered Nurse, Licensed Practical Nurse and the Residential Manager. The Residential Manager stated they would reassess supports for Individual #1's oral hygiene program to determine the most appropriate interventions.	W 240		
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	W 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 242	Continued From page 3 acquiring them. This STANDARD is not met as evidenced by: Based on observations, staff interviews, record review, and facility documentation review, the facility staff failed to implement individual program supports to prevent falls for 2 of 2 Individuals (Individual #1 and #2) in the survey sample. The findings included; Individual #1 was admitted to the facility on 4/3/17. The primary diagnoses included; severe intellectual disability, a seizure disorder, and periodontal disease. On 9/30/20 at approximately 7:45 a.m., Individual #1 was observed in his room in a recliner with a Direct Support Professional (DSP) #3 seated nearby. DSP #3 stated Individual #1 required a staff member to remain with him due to his high fall risk. On 9/30/20 at approximately 9:00 a.m., Individual #1 was assisted to the bathroom using a gait belt, a rollator and one person assistance, afterwards the individual was observed working with the physical therapist on ambulation skills. On 9/30/20 at approximately 9:40 a.m., Individual #1 was observed in bed asleep with DSP #3 present in the room. A bed alarm was attached to the bed but it wasn't engaged to alarm with the individual's positional changes. DSP #3 stated the bed alarm wasn't engaged because she was present. Review of an incident report revealed Individual	W 242	W242 Facility staff failed to implement individual program supports to prevent falls for Individual #1 and #2. 1. Immediately on 9/30/20, Individual #1 was evaluated by the Physical Therapy Consultant and instructions for post-fall interventions were provided. (Reference Attachment #2: Physical Therapy Progress Note for Individual #1, 2pgs.) It was recommended that staff maintain their focus on Individual #1 while toileting and not perform any other tasks. Staff should also provide "Stand-by assistance" at arms length whenever toileting, showering, and for all transfers--including ambulating with walker. The Physical Therapy Consultant provided training on 10/5/20 with staff to review these recommendations and procedures. (Reference Attachment #3: PT Training Signature Sheet dated 10/5/20 for Individual #1). The training was videotaped and captured use of gait belt, rollator, and supervision level. Staff will be able to access video at any time for refresher. The PT also reviewed support needed for Individual #2 during this training. (Reference Attachment #4: PT Training Signature Sheet dated 10/5/20 for Individual #2 and Attachment #5: Physical Therapy Progress Note for Individual #2). A video was made showing staff how to properly ambulate Individual #2 and provide "Insight Supervision" when transferring to his wheelchair. The Physical Therapy Consultant assessment revealed that Individual #2 was able to independently and safely transfer to his wheelchair, however, he doesn't always make sure his brakes are locked prior to transfer. It was recommended that	9/30/20 10/5/20 10/5/20 10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 242	Continued From page 4 #1 had a fall from the toilet to the floor when the staff member turned to pick his clothing from the floor on 9/30/20 at approximately 6:00 a.m., resulting in head trauma. Individual #1 nursing care plan dated 7/14/20 revealed a problem of Fall Risk (High Risk). The interventions included; assistance with walking support as needed. Use gait belt as needed for safety during ambulation, rollator walker for ambulation as needed. A 8/31/20 Physical Therapy consult read Individual #1 requires use of a gait belt to assist with standing and contact guard assistance of one whenever he weight bears or ambulates due to his compromised balance. Observation on 9/30/20 at approximately 11:54 a.m., revealed Individual #1 receiving staff assistance to come to a standing position and grasping the rollator which was unlocked and rolling away from him. An observation on 10/1/20 at approximately 12:17 p.m., revealed Individual #1 transferring from the dining table with staff assistance but again the rollator locks were not engaged to prevent the rollator from rolling away from the Individual. A Physical Therapy consult dated 9/30/20 read as a result of the 9/30/20 fall the individual's balance was assessed with him scoring 13 out of 28. This score indicated Individual #1 was a high fall risk. The Physical Therapy assessment further revealed the individual's immediate standing balance was fair to poor and his overall standing balance was poor. The consult also stated staff should perform no other activities when toileting, showering or ambulating Individual #1. The	W 242	"Standby assistance" be provided to ensure he transfers safely and that Individual #2's chair be removed from his reach. Facility staff will bring wheelchair to Individual #2 upon his request in order to assure the brakes are locked prior to use. In addition, tracking logs were developed for facility staff to indicate whether or not they checked the wheelchair brakes for Individual #2. (Reference Attachment #6: Wheelchair Brakes Log). Also tracking logs were developed to assure facility staff provide standby assistance while toileting for Individual #1 (Reference Attachment #7: Stand-By Assistance Toileting Log and support using the rollator (Reference Attachment #8: Rollator Use.) A tracking log was already in place foruse of the Gait Belt. A log was created to track staff providing Standby Assistance at arms length while showering and/or using the shower chair also. (Reference Attachment #9: Standby Assistance at arms length while showering/using shower chair log for Individual #1). All tracking sheets will be completed daily by facility staff. 2. All ICF-IID facilities operated by VersAbility Resources could be affected by this deficient practice, therefore, the Physical Therapy Consultant was asked to conduct similar training at all ICF-IID facilities operated by VersAbility Resources to identify fall risks and provide training and recommendations based upon needs of the facilities. The trainings were recorded and can be accessed by all facility staff as needed. 3. Hollywood House ICF-IID facility staff received training from the Physical Therapy	10/5/20 10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 242	Continued From page 5 Physical Therapist note then stated in-service training would be provided for the staff. On 10/6/20 at approximately 6:00 p.m., the above information was shared with the Program Director, Registered Nurse, Licensed Practical Nurse #1 and the Residential Manager. The Registered Nurse stated the Physical Therapist had developed an individualized video specifically related to Individual #1 high fall risk and the Physical Therapist had begun staff education. The facility staff failed to ensure Individual #2's wheel chair was locked prior to transfers to reduce the risk of falls and or injury. Individual #2 was originally admitted to the facility 05/02/06. The current diagnoses included but not limited to, severe intellectual disability and Cerebral Palsy. Review of Individual #2's Plan for Supports included but not limited to the following: Fall Monitoring (High Fall Risk) and will receive the following professional services (Physical Therapy Services 2 times a week.) On 09/30/20 at approximately 8:15 a.m., Surveyor #1 observed Individual #2 sitting in his wheel chair; the wheel chair was not locked. The Individual jumped up, Direct Support Professional (DSP) #1 was standing near the Individual who stated, "He can walk." On 10/01/20 at approximately 12:30 p.m., Surveyor #1 observed Individual #2 sitting in a regular chair eating his lunch. After, Individual #2 finished eating his lunch; he went to self-transfer into his wheel chair, which was not locked. The wheel chair rolled backwards and the Individual fell back into the regular chair. The Individual was not cued or informed by the DSP to lock his wheel chair prior	W 242	Consultant on 10/5/20. All other ICF-IID facilities also received training specific to their programs from the Physical Therapy Consultant. They all were completed by by 10/15/20. 4. All ICF-IID Managers will conduct monthly observations of the facility staff at random to ensure appropriate procedures are being followed as recommended and demonstrated by the Physical Therapy Consultant.	10/6/20 10/15/20 10/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 242	Continued From page 6	W 242		

to his transfer. The DSP assisted Individual #2 into his wheel chair.

A phone interview was conducted with DSP #1 on 10/06/20 at approximately 8:15 a.m. The DSP said Individual #2's wheel chair should be locked at all times prior to his transfer. The DSP said Individual #2's wheel chair has a lock break that locks both wheels at the same time. When asked, "What is the purpose of locking Individual #2's wheel chair prior to transfers," she replied, "So the wheel chair won't move during his transfers."

On 10/06/20 at approximately 8:30 a.m., a phone interview was conducted with the Physical Therapist (PT). PT said (Individual #2) is a fall risk and his wheel chair must be locked at all times prior to all transfers. He said the staff must make sure (Individual #2's) wheel chair is locked because if the wheel chair is not locked and Individual #2 goes to stand up or sit in his chair, the chair can slide backwards putting him at risk for falls. PT stated, "(Individual #2) does need reminders at times to lock his wheel chair."

A phone interview was conducted with the House Manager on 10/01/20 at approximately 10:06 a.m., who stated, "If staff is around, they are to ensure (Individual #2's) wheel chair is locked at all times." She said the wheel chair must be locked so the wheel chair does not move if the Individual attempts transfer unassisted. She said (Individual #2) can lock his wheel chair but does need reminders. The House Manager stated, "If (Individual #2) attempts to transfer without his wheel chair not being locked, the wheel chair can roll backward and the Individual could fall."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 242	Continued From page 7 A debriefing was held with the Program Director, House Manager, Registered Nurse and License Practical Nurse on 10/06/20 at approximately 6:00 p.m. The facility did not present any further information about the findings.	W 242		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, staff interviews and clinical record review, the facility staff failed to ensure 1 of 2 Individuals in the survey sample (Individual #2) received adequate nutrition to maintain his body weight. The findings included: Individual #2 was originally admitted to the facility 05/02/06. The current diagnoses included but not limited to, severe intellectual disability and Cerebral Palsy. Review of Individual #2's Physician Orders (PO) signed and dated by the physician on 09/21/20 included the following: regular pureed diet. Individual #2's care plan included to monitor weights. Some of the interventions the staff would use to accomplish these goals are to weigh Individual #2 monthly or sooner if needed; weights will be recorded monthly in the chart and will notify the physician of any problems or concerns.	W 460	W460 Facility staff failed to ensure Individual #2 received adequate nutrition to maintain his body weight. 1. Individual #2 was taken to another ICF-IID facility to get weighed on 10/8/20 and weighed 125lbs. The Dietitian Consultant was contacted by Nurse #1 and assessed the situation. The Dietitian determined Individual #2's weight loss was not a concern at this time. (Reference Attachment #10: Dietitian Report for Individual #2). The report noted that Individual #2 is currently at 6% weight loss from last quarter and a weight loss of 7.5% is considered significant according to ASPEN guidelines. However, the Manager of Hollywood House ICF-IID revised the Nutrition Data Sheet for the home so that staff could measure and track excess food that was not being consumed by the individual during meals. (Reference Attachment #11: Nutrition Data Sheet for Individual #2). In addition, the scale used to weigh the individuals from Hollywood ICF-IID was inspected, tested and calibrated on 10/12/20. (Reference Attachment #12: The Scale People, Inc. Certificate of Calibration dated 10/12/20). The Speech Language Pathology Consultant was contacted by the facility Nurse to conduct an assessment due to Individual #2 having lots of spillage during meals. It was determined by	10/8/20 10/21/20 10/8/20 10/12/20 10/8/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 460	Continued From page 8 On 09/20/20 at approximately 12:15 p.m., Surveyor #1 observed meal prep. DSP #1 pureed the following food items for Individual #2: turkey and squash but did not use a fork to skim through the pureed turkey or squash for small pieces that were not completely pureed. The pureed food was given to Individual #2 but the staff did not do a second check for small pieces. Individual #2 was able to feed himself using a regular spoon, high-sided plate and drinking from a sippy cup. Individual #2 had spilled 50% of his food on his clothing and table protector. While Individual #2 was eating his pureed diet, he had a coughing episode. Review of an incident/injury report was completed on 07/11/20 read in part: staff observed Individual #2 throwing up his breakfast with small (sic) of food then started throwing up a clear substance. Review of Individual #2's Plan for Supports included but not limited to the following: Individual #2 will receive the following supports informally: Dining Plan (may have seconds) 1:1 & food pureed and second staff will re-check (puree) for small pieces. Individual #2 to use a high-sided plate and spill proof cup. Review of Individual #2 weights revealed the following: 01/21/20=124.2 (pounds) 02/28/20=123.8 03/25/20 - unable to access the scale due to COVID 04/22/20 - unable to access the scale due to COVID 05/25/20 - unable to access the scale due to COVID	W 460	the Speech Pathology Consultant that Individual #2 was eating and swallowing at baseline levels of functioning and recommend no changes to his modified diet. Also recommended was purchase of another adaptive plate (high sided) for Individual #2 in order to help reduce spillage. (Reference Attachment #13: Speech Language Pathology Report dated 10/20/20). Two of the plates recommended in the Speech Pathology Consultant were ordered by the Manager of the facility and are scheduled to be delivered to the facility by 10/24/20. 2. The deficiency was relative only to Individual #2. All other individuals in the home were not experiencing significant weight loss. 3. This was determined not to be a systemic concern and deficiency is isolated to Hollywood House ICF-IID. Facility staff were trained to measure the spillage and document amount on the Nutritional data form by the Manager of the program. 4. The facility Nurse will continue to monitor monthly, or as needed, to ensure significant weight loss is identified and assessed for additional treatment.	10/6/20 10/6/20 10/20/20 10/6/20 10/6/20 10/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 460	Continued From page 9 06/26/20=117.2 07/14/20=116.1 08/31/20=117.0 09/30/20 - the scale is broken - scale people contacted for maintenance. A phone interview was conducted with the House Manager on 10/01/20 at approximately 10:06 a.m., who stated, "I was not aware that Individual #2 had weight loss until his weights were requested by the surveyor." The House Manager said Individual #2's weights were being taken at (Name of day program) and nursing is responsible for tracking the Individual weights. She said, (Name of day program) was closed during the months of March, April and May 2020, because of COVID-19, and during that time, Individual #2's weights were not taken. The House Manager was asked, if there was a wheel chair scale at the facility. The House Manager stated, "Yes, there is one in the shed, but it has not been used in years and it needed to be calibrated." On 10/01/20 at approximately 12:38 p.m., a phone interview was conducted with the Licensed Practical Nurse (LPN) #1 who stated, "Individual #2's weight is obtained using a weight scale at (Name of day program)." The LPN said Individual #2's weights were not obtained in March, April and May 2020 because of COVID-19. The LPN said a plan was put in place at that point to open up (Name of day program) so weights could be obtained. The LPN said, we could have gotten the wheel chair scale out of storage and had it calibrated for those three months. The LPN stated, The Dietitian was informed of Individual #2's weight loss."	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 460	Continued From page 10 Review of Individual #2's Dietitian Progress Note dated 05/09/20 included but not limited to the following: Unable to obtain weights in March and April 2020. Review of Individual #2's Dietitian Progress Note dated 09/09/20 included but not limited to the following information: Under assessment: Individual #2's average weight this quarter (117 lbs.) is 94% as compared to last quarter's average weight (123 lbs.), unintended weight loss noted. Nutritional status needs to be monitored due to unintended weight loss. A debriefing was held with the Program Director, House Manager, Registered Nurse and Licensed Practical Nurse on 10/06/20 at approximately 6:00 p.m. The facility did not present any further information about the findings.	W 460		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and clinical record review, the facility staff failed to ensure an appropriate pureed diet was provided to 1 of 2 Individuals in the survey sample (Individual #2). The findings included: The facility staff failed to ensure Individual #2's pureed diet was initially checked by the staff who prepared the food. The second staff member	W 474	W474 Facility staff failed to ensure an appropriate pureed diet was provided to Individual #2. 1. Facility staff did not follow procedure to have 2nd person check to assure Individual #2 food was pureed properly. The Manager of Hollywood House provided training for all facility staff on 10/2/20 to ensure procedures for pureeing food were being followed. (Reference Attachment #14: Individual #2's Pureed Diet Guidelines training signature sheet). The Manager also conducted a random observation on 10/22/20 post training to assure procedures were being implemented and staff followed procedures. (Reference Attachment #15: Food Handling Observation form)	10/2/20 10/22/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 474	Continued From page 11 failed to re-check the pureed food for unpureed chunks of food prior to being served. Individual #2 was originally admitted to the facility 05/02/06. The current diagnoses included but not limited to, severe intellectual disability and Cerebral Palsy. Review of Individual #2's Plan for Supports included but not limited to the following: Individual #2 will receive the following supports informally: Dining Plan (may have seconds) 1:1 & food pureed and second staff will re-check (puree) for small pieces. Individual #2 to use a high-sided plate and spill proof cup. Review of Individual #2's Physician Orders signed and dated by the physician on 09/21/20 included the following: Regular Pureed Diet. On 09/20/20 at approximately 12:15 p.m., meal prep observation was made by Surveyor #1. Direct Support Professional (DSP) #1 pureed the following food items for Individual #2; turkey and squash but did not use a fork to skim through the pureed turkey or squash for small pieces that were not completely pureed. The pureed food was given to Individual #2 but the staff did not check for small pieces. A phone interview was conducted with the House Manager on 10/01/20 at approximately 10:06 a.m. The House Manager said the staff puree Individual #2's food. She stated once Individual #2's food has been pureed, the staff is to take a fork and check, for large chunks ensure all of his food has been fully pureed. She said prior to serving Individual #2 his pureed diet, a second staff member is to use a fork and examine his	W 474	2. All individuals could have been affected by this deficient practice, therefore, re-training was provided by the Manager of the facility. 3. This was an isolated incident and did not appear to be systemic. 4. The Manager of Hollywood House ICF-IID, as well as all ICF-IID facility Managers, will continue to conduct random observations of staff administering meals to assure diets are being followed and meals prepared according to the individual's diet plan.	10/2/20 10/2/20 10/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G041	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES HOLLYWOOD HOUSE	41 HOLLYWOOD AVENUE HAMPTON, VA 23661

(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 474	Continued From page 12	W 474		

food again to make sure the person who pureed the food did not miss any unblended food (double check the checker.) She said there is a sign posted in the kitchen on how to prepare Individual #2's pureed diet. A copy of the signage was requested.

On 10/01/20, a document was received with the following instructions on how to prepare a pureed diet for Individual #2: Please take your time when pureeing the food, use a fork to go through the food looking for any particles that didn't puree well, whoever is assigned to Individual #2, must recheck his food before serving, using a fork to skim the food, do not take for granted that the Ninja (blender) did everything - use juice from the food to help soften if available.

A debriefing was held with the Program Director, House Manager, Registered Nurse and Licensed Practical Nurse on 10/06/20 at approximately 6:00 p.m. The facility did not present any further information about the findings.