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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

(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 9/21/20 through 9/24/20. The facility was not 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		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Cardo DS	Division Director	10/19/20

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 006	Continued From page 1 Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility staff failed to identify Active Screening strategies for outside visitors and vendors to address COVID-19 as an emergency event. The findings included: The following observations were conducted, during the survey, by Surveyor #2: On 9/21/20 at approximately 4:00 p.m., upon entry into the residential home, DSP (Direct	E 006	On 9/24/20, the Supervisor II instituted a procedure for actively screening visitors who must enter the facility, including vendors, contracted custodial personnel and repair persons, for symptoms of COVID. The Sign-In/ Screening procedure was emailed to all facility staff, who were asked to review the procedure and were given an opportunity to ask questions. A copy of the Sign-In/ Screening procedure was placed in the facility's Communication Binder, with a signature page for all staff to sign, indicating that they read and understood the procedure. All facility staff completed the procedure review and sign-off, indicating their understanding.	9/30/20

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E 006	Continued From page 2 Support Personnel) #5 obtained this surveyor's temperature. The temperature was not recorded and the DSP did not ask any further screening questions. This surveyor was asked to sign the visitor's sign in log. Upon inspection of the visitor's log from 3/31/20 to 9/21/20, 36 visitors signed the log. Among the visitors included janitorial services, delivery persons, bed repairmen, heating and air conditioning repairmen, fire inspector, wheelchair repairmen and maintenance. Upon entry the following day (9/22/20), the Residential Supervisor II asked if I needed to sign the visitor's log or have temperature taken, to which this surveyor responded that they should follow their procedures. The Supervisor II obtained this surveyor's temperature, but did not record the temperature or ask any further screening questions. She stated they did not record any temperatures of those on the visitor's log or ask any screening questions of any vendors entering the home because they did not come to visit an individual. She stated there would be a process for screening family visiting the individuals in the courtyard with a record of temperatures and further screening questions, but that procedure was not in place for vendors. She stated, "About two weeks ago, we re-instated visitation for the family and set up a screening procedure with a record of the screening for family visitors, but we have not had any family member call to set up any visits as of yet. We stopped visitation on 3/31/20, but did not consider others coming in the home as visitors, so no process or record of screening. We make sure they are wearing a mask though." On 9/23/20 from 10:00 a.m. through 1:30 p.m., a janitorial vendor was frequently observed walking	E 006	The Emergency Preparedness policy was updated to include this screening process. The Sign-In/ Screening procedure includes having the visitor: 1) Wear a mask at all times while in the facility; 2) Clean their hands with alcohol-based hand sanitizer upon entry; 3) Complete a temperature check upon entry; 4) Sign the Visitor's Log; 5) Complete a Screening form for symptoms of COVID; and 6) Maintain social distancing from residents and staff while in the facility. Any visitor answering "yes" to any of the questions on the Screening form for symptoms of COVID-19 will be asked to immediately leave the facility. Additionally, the Program Patient Population section of Emergency Preparedness policy was updated to include information about individuals with respiratory compromise who may be at increased risk for COVID-19 or other infectious respiratory disease. Strategies for addressing COVID-19 were also added to the "Strategies to Provide Support During an Emergency" form referenced in the policy. On 9/24/20, the Supervisor II contacted the contracted custodial vendor and informed the supervisor of the custodial staff that one of the of the custodial staff had been observed walking through the facility multiple times on 9/23/20 with her mask hanging from her ear. The supervisor of the custodial staff was asked to immediately inform all custodial staff who work at Indian River ICF/IID that they must wear their mask at all times while in the facility.	9/24/2020

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

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E 006	Continued From page 3	E 006	All facility staff will receive their annual emergency preparedness training and testing during the month of November. This training will include review of the above-stated policy revisions.	11/8/2020
	down hallways and throughout the home with her facemask hanging off her left ear. On 9/23/20 at approximately 2:30 p.m., this aforementioned observation was brought to the attention of the Residential Supervisor II. She stated the practice of not wearing a mask in the home was unacceptable and she would address it with the janitorial vendor.			
	On 9/23/20 at approximately 3:30 p.m., Surveyor 2 was present during an inservice that was conducted by the Residential Supervisor II with 9 staff attending, to go over the screening process going forward for all persons that entered the home. The screening process included obtaining the vendors temperature and asking if they experienced a cough, shortness of breath/difficulty breathing, sore throat, new loss of taste or smell, chills, head or muscle aches and or nausea, diarrhea or vomiting.		Effective immediately, in order to ensure the Sign-In/ Screening process is being properly implemented, the House Manager will observe staff completing the Sign-In/ Screening procedure with vendors/visitors at least twice per week. In addition, the Supervisor II will complete spot-checks of documentation at least monthly, comparing names on the Visitor Sign-In Log with completed Screening forms.	ongoing
	During Emergency Preparedness review at 11:00 A.M. on 9/23/20 with the Supervisor II and ICF (Intermediate Care Facility) Administrator, the ICF Administrator stated the Emergency Preparedness Plan was up dated in August 2020.			
	A review of a risk assessment dated 3/16/20 indicated: Alert Type- Infectious Disease Outbreak - Event Summary: "Due to the COVID-19 pandemic all visitation and community outings have been suspended starting 3/17/20. Day Support was suspended starting 3/2/20. Resident's vitals will be monitored daily. All staff will take their temperature prior to their shift to ensure they do not have a temperature greater than 100 degree F. Letters have been mailed to AR/LG (authorized representatives)/ (legal guardians) informing them of the pandemic, or			

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E 006	Continued From page 4	E 006		

precautions and our restrictions. Updated letters are sent on a regular basis. This restrictions will remain in place and will be reviewed on a regular basis in accordance with the recommendations from our regulatory agencies, CDC (Center for
Disease Control) and VDH Virginia Department of Health."

A review of a Visitors sign in/out form indicated: Various outside vendors were entering the facility from 03/20/20 until 09/24/20. There was no Active Screening guidance per CDC recommendations.

During an interview at 11:18 A.M. on 9/23/20 with the ICF Administrator, he stated the agency attorney had sent out an email indicating that the facility could not take and record temperatures of visitors or outside vendors.
A review of an email document dated March 27, 2020 indicated: Temperature Checks- "We cannot take staff temperatures."

CDC recommendation for Active Screening included: Screen everyone entering the healthcare facility for symptoms consistent with COVID-19.
Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature > 100.0 F or subjective fever.
Ask them if they have been advised to self-quarantine because of exposure to someone with COVID-19.
Properly manage anyone with symptoms of COVID-19 or who has been advised to self- quarantine. According to the CDC, COVID-19 symptoms may include, but are not limited to the following: fever, cough, shortness of breath, headache, new loss

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E 006	Continued From page 5 of taste or smell, congestion or runny nose, sore throat, diarrhea, myaliga (muscle aches, body aches) tiredness or fatigue. A review of the facility's Infection Control Procedures: Pandemic Influenza - indicated: Implement visitor restrictions, per CDC guidelines: wear a mask when visiting the ICF. Upon arrival temperatures will be taken and recorded. The facility ICF Administrator was asked why the facility's Infection control procedures were not implemented, he stated they were following the guidance of there legal advisor.	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and	E 013		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 013	Continued From page 6 procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to implement Active Screening strategies for outside visitors and vendors to address COVID-19 as an emergency event. The findings included: The following observations and interviews were conducted, during the survey, by Surveyor #2: On 9/21/20 at approximately 4:00 p.m., upon entry into the residential home, Direct Support Professional (DSP) #5 obtained this surveyor's temperature. The temperature was not recorded and the DSP did not ask any further screening questions. This surveyor was asked to sign the visitor's sign in log. Upon inspection of the visitor's log from 3/31/20 to 9/21/20, 36 visitors signed the log. Among the visitors included janitorial services, delivery persons, bed repairmen, heating and air conditioning repairmen, fire inspector, wheelchair repairmen and maintenance. Upon entry the following day (9/22/20), the Residential Supervisor II asked if	E 013	During afternoon shift change on 9/23/20, the Supervisor II verbally reviewed the Sign-In/ Screening procedure to be used going forward for actively screening visitors entering the facility with the nine staff who were present. On 9/24/20, the Supervisor II instituted the written procedure for actively screening visitors, including vendors, contracted custodial personnel and repair persons, for symptoms of COVID. The Sign-In/ Screening procedure was emailed to all facility staff, who were asked to review the procedure and were given an opportunity to ask questions. A copy of the Sign-In/ Screening procedure was placed in the facility's Communication Binder, with a signature page for all staff to sign, indicating that they read and understood the procedure. All facility staff reviewed and signed-off on the procedure, indicating their understanding.	9/30/2020

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E 013	Continued From page 7 Surveyor #2 needed to sign the visitor's log or have temperature taken, to which this surveyor responded that they should follow their procedures. The Supervisor II obtained this surveyor's temperature, but did not record the temperature or ask any further screening questions. She stated they did not record any temperatures of those on the visitor's log or ask any screening questions of any vendors entering the home because they did not come to visit an individual. She stated there would be a process for screening family visiting the individuals in the courtyard with a record of temperatures and further screening questions, but that procedure was not in place for vendors. She stated, "About two weeks ago, we re-instated visitation for the family and set up a screening procedure with a record of the screening for family visitors, but we have not had any family member call to set up any visits as of yet. We stopped visitation on 3/31/20, but did not consider others coming in the home as visitors, so no process or record of screening. We make sure they are wearing a mask though." On 9/23/20 from 10:00 a.m. through 1:30 p.m., a janitorial vendor was frequently observed walking down hallways and throughout the home with her facemask hanging off her left ear. On 9/23/20 at approximately 2:30 p.m., this aforementioned observation was brought to the attention of the Residential Supervisor II. She stated the practice of not wearing a mask in the home was unacceptable and she would address it with the janitorial vendor. On 9/23/20 at approximately 3:30 p.m., Surveyor #2 was present during an inservice that was conducted by the Residential Supervisor II with 9	E 013	. The Emergency Preparedness policy was updated to include this screening process. The Sign-In/ Screening procedure includes having the visitor: 1) Wear a mask at all times while in the facility; 2) Clean their hands with alcohol-based hand sanitizer upon entry; 3) Complete a temperature check upon entry; 4) Sign the Visitor's Log; 5) Complete a Screening form for symptoms of COVID; and 6) Maintain social distancing from residents and staff while in the facility. Any visitor answering "yes" to any of the questions on the Screening form for symptoms of COVID-19 will be asked to immediately leave the facility. On 9/24/20, the Supervisor II contacted the contracted custodial vendor and informed the supervisor of the custodial staff that one of the of the custodial staff had been observed walking through the facility multiple times on 9/23/20 with her mask hanging from her ear. The supervisor of the custodial staff was asked to immediately inform all custodial staff who work at Indian River ICF/IID that they must wear their mask at all times while in the facility. The Emergency Preparedness policy was updated to state that ICF staff will ensure visitors follow guidelines for wearing a mask at all times while in the facility; any facility staff who observes that a visitor/vendor has removed their mask while in the facility will immediately ask the visitor to put their mask back on and remind them that it must be worn at all times while in the facility. All facility staff will receive their annual emergency preparedness training and testing during the month of November. This training will include review of the above-stated policy revisions.	9/24/2020 11/8/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED
	49G060		09/24/2020

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INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

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E 013	Continued From page 8 staff attending to go over the screening process going forward for all persons that entered the home. The screening process included obtaining the vendor's temperature and asking if they experienced a cough, shortness of breath/difficulty breathing, sore throat, new loss of taste or smell, chills, head or muscle aches and or nausea, diarrhea or vomiting. During Emergency Preparedness review at 11:00 A.M. on 9/23/20 with the Supervisor II and ICF (Intermediate Care Facility Administrator, the ICF Administrator stated the Emergency Preparedness Plan was up dated in August 2020. A review of a risk assessment dated 3/16/20 indicated: Alert Type- Infectious Disease Outbreak - Event Summary: "Due to the COVID-19 pandemic all visitation and community outings have been suspended starting 3/17/20. Day Support was suspended starting 3/2/20. Resident's vitals will be monitored daily. All staff will take their temperature prior to their shift to ensure they do not have a temperature greater than 100 degree F. Letters have been mailed to AR/LG (authorized representatives)/ (legal guardians) informing them of the pandemic, or precautions and our restrictions. Updated letters are sent on a regular basis. This restrictions will remain in place and will be reviewed on a regular basis in accordance with the recommendations from our regulatory agencies, CDC (Center for Disease Control) and VDH Virginia Department of Health." A review of a Visitors sign in/out form indicated: Various outside vendors were entering the facility from 03/20/20 until 09/24/20. There was no Active Screening guidance per CDC recommendations.	E 013	Effective immediately, in order to ensure the Sign-In/ Screening process is being properly implemented, the House Manager will observe staff completing the Sign-In/ Screening procedure with vendors at least twice per week. In addition, the Supervisor II will complete spot-checks of documentation at least monthly, comparing names on the Visitor Sign-In Log with completed Screening forms.	ongoing

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

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E 013		E 013		

Continued From page 9

During an interview at 11:18 A.M. on 9/23/20 with the ICF Administrator he stated the agency attorney had sent out an email indicating that the facility could not take and record temperatures of visitors or outside vendors.
A review of an email document dated March 27, 2020 indicated: Temperature Checks- "We cannot take staff/visitors temperatures."

CDC recommendation for Active Screening included: Screen everyone entering the healthcare facility for symptoms consistent with COVID-19.
Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature > 100.0 F or subjective fever.
Ask them if they have been advised to self-quarantine because of exposure to someone with COVID-19.
Properly manage anyone with symptoms of COVID-19 or who has been advised to self- quarantine.
According to the CDC, COVID-19 symptoms may include, but are not limited to the following: fever, cough, shortness of breath, headache, new loss of taste or smell, congestion or runny nose, sore throat, diarrhea, myaliga (muscle aches, body aches) tiredness or fatigue.

A review of the facility's Infection Control Procedures: Pandemic Influenza - indicated: Implement visitor restrictions, per CDC guidelines: wear a mask when visiting the ICF. Upon arrival temperatures will be taken and recorded, they will be instructed to wash their hands, complete a temperature check, and self-report if they have symptoms of the emerging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 013	Continued From page 10 infectious disease. If asymptomactic, the visitor will be offered an area distance from remainder of residents, such visitor must sign in in case contact tracing becomes necessary. Any approved visitor that is symptomatic or has an elevated temperature of 100.0 F for higher when they arrive will be turned away. If the ICF's are under a 'No visitation and no community outing" status, this will include no home visits. Delivery persons will be instructed to unload supplies outside of the facility entrance and vendors will be instructed to complete their work outside, whenever possible. For vendors or repair persons who must enter the facility, the above process will used. The facility ICF Administrator was asked why the facility's Infection control procedures were not implemented, he stated they were following the guidance of there legal advisor.	E 013		
E 036	EP Training and Testing CFR(s): 483.475(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

(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 036	Continued From page 11 procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of	E 036		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

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E 036	Continued From page 12 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on staff interview and three random staff record reviews, the facility staff failed to ensure a contracted staff member (Staff #3) was trained and tested on the Emergency Preparedness Plan. The findings included: During the Emergency Preparedness Plan review at 11:40 A.M. on 9/23/20 with the ICF Administrator and the Supervisor II, a random list of employees identification numbers were selected for testing and training. Employees were noted to sign in daily by their respective employee identification number. One such employee number was identified by the ICF Administrator as an outside vendor employee who was contracted for cleaning services. The ICF Administrator was asked if this person worked at the facility on a weekly schedule and he stated, "Yes." A review of the employee sign in form for the previous 6 months indicated this employee had worked at the facility on a weekly schedule. The ICF Administrator stated, this employee was not tested nor trained in the facility's Emergency Preparedness Plan because she was an outside vendor employee. The ICF Administrator was asked if this employee	E 036	On 9/28/20, the Supervisor II reviewed the Sign-In/ Screening procedure with the contracted custodian staff who is routinely assigned to the facility. This review included the requirement to wear a mask at all times while in the facility. Contracted custodian staff who are routinely assigned to the facility will receive training and testing on the Emergency Preparedness policy and the Infection Control policy, focusing on COVID 19 and the use of appropriate PPE. Initial training and testing will occur by 11/18/20 and then annually thereafter.	9/28/2020 11/8/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

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E 036	Continued From page 13 would be responsible for ensuring COVID-19 recommended guidance was being followed. He stated, "Yes." The ICF Administrator was asked who trained the employee of the facility's policy and procedures for Infection Control as it related to COVID - 19. The ICF Administrator stated he did not know. When asked who trained this employee of handwashing and the process for use and storage of masks, he stated, he did not know. The facility staff failed to train and test employees based on the Emergency Preparedne	E 036	New contracted custodian staff will be informed of any infection control protocols that must be immediately adhered to when they begin work at the facility and will receive training and testing on emergency preparedness within 15 days of being routinely assigned to the facility, with their annual training then occurring each year in November. Throughout the year, contracted custodian staff will receive an in-service on any significant revisions to the plan applicable to them, which will be documented on a Training Attendance Roster.	11/8/2020
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 9/21/20 through 9/24/20. 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 5 certified bed facility was 5 at the time of the survey. The survey sample consisted of 4 Individual reviews (Individuals #1 through #4).	W 000		
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	W 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ____ B. WING ____	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

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W 242	Continued From page 14 that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based observations, record review, staff interviews and review of facility documents, the facility staff failed to implement 1 of 4 Individual's (Individual #3) program plan during administration of medications. The findings included: Individual #3 was admitted to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) on 9/11/13 with diagnoses that included profound intellectual disability and seizure disability. The most recent Comprehensive Functional Assessment (CFA) dated 7/1/2020 assessed Individual #3 with the gross/fine motor skills able to grasp and/or release objects with both hands and able to perform this skill well. Cognitive assessment included she was able to follow simple one step instructions and requests and learned by verbal prompts, imitation and physical assistance. The treatment plan dated 8/1/20 through 7/31/21 identified a residential active treatment during the medication administration process. The staff will hand Individual #3 her medication spoon and ask her to hold it while staff gently put their hand around her hand or wrist. The individual will hold the spoon without dropping it and it will be recorded if she held or dropped the spoon. The trash can lid will be open and when she is next to it, staff will guide the individual's hand over the	W 242	The QIDP will meet with DSP #1 to review the active treatment objective to be implemented during the medication administration process for Individual #3. The QIDP will also review objectives to be implemented during the medication administration process for all other residents of the facility. This will include a review of the method to be implemented for each of the objectives. On 9/30/20 and 10/1/20, the QIDPs met with all facility staff to review the active treatment objective to be implemented during the medication administration process for Individual #3, as well as those objectives to be implemented during the medication administration process for all other residents of the facility. This included a review of the method to be implemented for each of the objectives. All staff signed the Training Attendance Roster.	10/30/2020 10/01/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ____ B. WING ____	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

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W 242	Continued From page 15 trash can by holding her hand or wrist. The staff will then ask Individual #3 to drop the spoon into the trash with physical assistance and will document whether or not the task was completed. During observation of the 7:00 p.m. medication pass on 9/21/20, the Direct Support Professional (DSP) #1 assigned to administer Individual #3 her medications did not follow the active treatment plan, but instead spooned the scheduled medication crushed in yogurt without active involvement from Individual #3. On 9/24/20 at 1:30 p.m., the aforementioned observation was shared with the Residential Supervisor II and assigned Qualified Intellectual Disability Professional (QIDP). The QIDP stated it was the responsibility of the staff to prompt Individual #3, during the medication pass, to hold her spoon hand over hand, consume her medication and drop the spoon it in the trash can afterwards. The facility's policy and procedures titled Individual Program Plan dated 11/1/16 indicated that based on the assessments completed during Interdisciplinary Team (IDT) Meeting, continuous active treatment is implemented to allow clients to function with as much independence and self-determination as possible and to prevent or minimize regression.	W 242	Currently, each night, overnight DSP staff completes a review of the day's documentation, including documentation on objectives implemented during the medication administration process. If there is any missed documentation, the overnight staff informs the House Manager who follows-up with the assigned staff to make sure the staff is aware of the objective or service to be provided, when it is scheduled to be implemented, and the documentation required. Additionally, the QIDP reviews each residents' documentation at least monthly. Any concerns with documentation identified by the QIDP are addressed with the involved staff.	Ongoing Ongoing
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.	W 260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

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W 260	Continued From page 16 This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, the facility staff failed to revise one Individual's (Individual #1) Individual Program Plans in the survey sample of 4 Individuals. The facility staff failed to revise Individual #1's medication administration program plan to include refusal of medication. The findings included: Individual #1 was admitted to the facility on 4/15/13 with diagnoses which included Spastic Quadriplegia, legally blind secondary to Optic atrophy (both eyes), Profound Intellectual Disability (ID), Lennox-Gastaut syndrome/seizures. hyperlipidemia, Osteoporosis, major depression,, generalized anxiety and other Compulsive related disorders. During observation of medication administration on 9/21/20. Individual #1 was observed by Surveyor #2 refusing his medications. A review of the Individual Treatment Plan Objective #1.1.1 indicated: It is important for Individual #1 to: take his medication and he would like his seizures managed. It is important for Individual #1 to maintain good health and be well. Objective: Individual #1 will take his medication when placed into a cup with one verbal prompt. Intervention: Method- staff will place each of Individual #1's medication into a cup. Staff will hand Individual #1 the cup and verbally prompt	W 260	A review of the Medication Administration Record for Individual #1 indicated that he had not missed any medication due to refusal in the last year, from September 2019 through September 21, 2020, when the observation of medication administration took place. Documentation on Individual #1's Weekly Review Forms during that period also indicated that Individual #1 was consistently completing his supportive medication objective as written. The QIDP will meet with DSP #1 to review the supportive medication objective for Individual #1, as well as his Behavioral Support Plan, to ensure her understanding of each. The QIDP will stress the importance of informing her immediately if anything in the individual's Treatment Plan or Behavioral Support Plan is not working effectively for the individual or if the plan(s) need to be revised to address a new need. The QIDP will also stress the importance of accurately documenting any changes in the individual's ability to complete objectives as written, so that the QIDP has information needed to revise the plan(s).	10/30/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 260	Continued From page 17 him to take his medication. Individual #1 will take the cup and swallow each of his pills. Ask him to either throw his cup away or hand the cup to staff. Assist with medication according to physicians orders. Inform Individual #1 what each medication is for/any side effects and verbally prompt him to take his medication. Verbal prompts will be followed by gesture prompts, modeling and assistance if needed. Individual #1 was noted to receive the medications Tegretol and Onfi for seizure control and Lexapro for Depression. Documentation reviewed: weekly review form and daily schedule of supports. During an interview at 8:44 a.m. on 9/24/20 with Direct Support Professional (DSP) she was asked if Individual #1 refused his medications. The DSP stated, "Yes he frequently refuses his medications and staff have to constantly to go back to him and request that he take his medications." The DSP was asked if Individual #1 had a program plan for refusing to take medications and she stated, no. A review of Individual #1's Behavior Support Plan Indicated: Target Behaviors: Aggressive behavior: hitting objects, ramming his wheelchair into doors, walls, or objects or attempting to hit or kick others. Self Injurious Behavior: Hitting himself Disruptive Behavior: shouting, throwing objects During an interview at 2:20 P.M. on 9/24/20 with the Supervisor II she stated that staff are use to	W 260	On 9/30/20 and 10/1/20, the QIDPs met with all facility staff to review the supportive medication objective for Individual #1, as well as his Behavioral Support Plan (BSP). They stressed the importance of immediately informing the QIDP if anything in the Treatment Plan or BSP for Individual #1 or for any other resident of the facility is not working effectively for the individual or if the plan(s) need to be revised to address a new need. They also stressed the importance of accurately documenting any changes in the individual's ability to complete objectives as written, so that the QIDP has information needed to revise the plan(s).	10/01/2020
			The QIDP will contact the Psychologist to discuss the report from DSP #1 that Individual #1 has been frequently refusing to take his medication. The Psychologist, with input from the QIDP, will update the BSP to include strategies to use when Individual #1 is refusing to take his medications. All facility staff will be trained on the revised BSP.	11/8/2020
			To ensure changes are sustained, at the end of each month, the QIDP will continue to review documentation related to the individuals' Behavioral Support Plans to ensure the plans are adequately meeting the individuals' needs.	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 260	Continued From page 18 Individual #1 behaviors for refusing medications. He eventually will come around and take them.	W 260		
W 362	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to obtain input from the pharmacist on each individuals drug regimen review at least quarterly for four Individuals (Individual #1, #2, #3 and #4) in the survey sample of four Individuals. The findings included: 1. The facility staff failed to ensure the pharmacist reviewed the drug regimen at least quarterly for Individual #1. Individual #1 was admitted to the facility on 4/15/13 with diagnoses which included Spastic Quadriplegia, legally blind secondary to Optic atrophy (both eyes), Profound Intellectual Disability (ID), Lennox-Gastaut syndrome/seizures. hyperlipidemia, Osteoporosis, major depression,, generalized anxiety and other Compulsive related disorders. The facility staff failed to ensure a drug regimen review was conducted at least quarterly. The review of the Pharmacist Record of Medication Regimen Review dated 2/13/20 was the last quarterly review.	W 362	On 10/10/20, copies of documentation required for the Consultant Pharmacist to complete Pharmacy Reviews for all residents of the facility were delivered to his office. The Consultant Pharmacist completed the drug regimen reviews for all residents of the facility on 10/12/20. Going forward, drug regimen reviews will be completed quarterly for all residents of the facility. If visitor restrictions remain in place or are put in place in the future, documentation required by the Consultant Pharmacist to complete the quarterly Pharmacy Reviews will be faxed or hand-delivered to his office to be completed off-site. To prevent reoccurrence, two weeks prior to each quarterly due date, the RN Supervisor or designee will email the Consultant Pharmacist, reminding him of the due date and requesting a reply to inform the facility of the date he intends to visit. If visitation restrictions are in place, the RN Supervisor or designee will confirm when required documentation will be faxed or hand-delivered to him. On or immediately following the intended completion date, the RN Supervisor will check each chart to ensure that the quarterly drug regimen review has been completed.	10/12/2020 Ongoing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

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W 362	Continued From page 19 Individual #1 was noted to receive the medications Tegretol and Onfi for seizure control and Lexapro for Depression. During an interview at 2:15 P.M. on 9/24/20 with the ID-Supervisor II, she stated, due to the COVID-19 Pandemic the pharmacist had not visited the facility or reviewed the drug regimens. 2. The facility staff failed to ensure the pharmacist reviewed the drug regimen at least quarterly for Individual #2. Individual #2 was admitted to the facility on 4/18/13. Diagnoses for this individual included Spastic Quadriplegia, Profound ID, seizures, hypothyroidism, Thoracic Scoliosis, dysphagia, blind right eye, glaucoma of left eye, and major depression. The facility staff failed to ensure a drug regimen review was conducted at least quarterly. The review of the Pharmacist Record of Medication Regimen Review dated 2/13/20 was the last quarterly review. Individual #2 was noted to receive the medication Depakote and Dilantin for seizure control. The medications Celexa and Remeron for Depression. During an interview at 2:15 P.M. on 9/24/20 with the ID-Supervisor II, she stated, due to the COVID-19 Pandemic the pharmacist had not visited the facility or reviewed the drug regimens. A review of the facility's Health Care Services	W 362	If the review has not been completed by the intended date, the RN Supervisor will contact the Consultant Pharmacist to confirm an alternate date within the required timeframe. She will again check the charts and continue to communicate with the pharmacist as needed to ensure the review takes place within required timeframe.	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

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W 362		W 362		

Continued From page 20
pharmacy Consultant Services Policy:
indicated- 3. Drug Regimen Review (a). The Consultant Pharmacist will complete a written quarterly review of the client's medication regimen. Reviews may occur more often when an individual's response indicates problems with drug therapy.
3. The facility staff failed to complete a written quarterly review of the individual's medication regimen for Individual #3.

Individual #3 was admitted to the ICF/IID on 9/11/13 with diagnoses that included profound intellectual disability and seizure disorder.

Upon review of the Individual's Record of Medication Regiment Reviews, the last record of the review of medications was 2/13/20, thus the May 2020 and August 2020 medication regimen reviews by the pharmacy consultant were not conducted as required,

On 7/7/20, Individual #3 was ordered Keppra 100 milligrams (mg) twice a day (BID) and on 4/26/15 ordered Dilantin 125 mg three times a day (TID).

On 9/24/20 at 10:00 a.m., the Residential Supervisor II stated due to the Global Pandemic and restriction of visitor, they had not considered making arrangements for the consultant pharmacist to review any of the individual's medication regimens onsite or remotely.

4. The facility staff failed to complete a written quarterly review of the individual's medication regimen for Individual #4.

Individual #4 was admitted to the ICF/IID on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 362	Continued From page 21 4/1/15 with diagnoses that included profound intellectual disability, seizures, diabetes, autism and depressive disorder. Upon review of the Individual's Record of Medication Regiment Reviews, the last record of the review of medications was 2/13/20, thus the May 2020 and August 2020 medication regimen reviews by the pharmacy consultant were not conducted as required. On 5/1/15, Individual #4 was ordered the anti-depressant Prozac 40 milligrams (mg) once a day (QD) for the treatment of depression, and an additional 20 mg QD of Prozac on 11/2/18. The individual was also ordered Trazodone 50 mg (anti-depressant) on 12/6/19 at bedtime for sleep. For the management of his diabetes, Individual #4 was ordered Metformin 500 mg twice a day (BID) with breakfast and dinner. On 5/27/16, Individual #4 was ordered the anti-convulsant Vimpat 200 mg BID for the control of his seizure disorder. On 9/24/20 at 10:00 a.m., the Residential Supervisor II stated due to the Global Pandemic and restriction of visitor, they had not considered making arrangements for the consultant pharmacist to review any of the individual's medication regimens onsite or remotely.	W 362		
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.	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G060	A. BUILDING ______ B. WING ______	09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN RIVER RESIDENCE - A	2525 LIFETIME CIRCLE VIRGINIA BEACH, VA 23456

(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 22 This STANDARD is not met as evidenced by: Based observations, record review, staff interviews and review of facility documents, the facility staff failed to follow the physician orders for 1 of 4 Individuals (Individual #3) during administration of medications. The findings included: Individual #3 was admitted to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) on 9/11/13 with diagnoses that included profound intellectual disability and seizure disability. The most recent Comprehensive Functional Assessment (CFA) dated 7/1/2020 assessed Individual #3 to use food at all times to administer medications and nectar thickened liquids in a glass as needed, and was very cooperative during the medication administration process. Individual #3 had current physician orders dated 9/1/20 for nectar thickened liquids. During observation of a medication pass on 9/21/20 at 7:00 p.m., Individual #3 was observed holding crushed medication mixed in yogurt in her mouth. Direct Support Professional (DSP)#1 did not offer additional yogurt or a thickened liquid to ensure the individual swallowed the medication. When DSP #1 asked the individual to open her mouth, she expelled the yogurt down her lips and side of her mouth. The DSP proceeded to administer Chlorhexidine on a toothette to the roof, tongue and inside the the individuals mouth. The DSP stated they did not have prepared thickened liquids in the medication room and if needed would have to go to the kitchen to mix	W 368	The Nurse Manager or designee will meet with DSP #1 to review the proper procedure to use if Individual #3 or any other resident of the facility does not initially swallow their medication. This review will include stressing the importance of ensuring the DSP is prepared before beginning medication administration by having all needed supplies (i.e., proper sized gloves, spoon, food, drink) available in the medication room. If Individual #3 or any resident of the facility holds medication in their mouth, additional food of fluid (per the individual's plan) will be offered to ensure the individual swallows the medication. The DSP will not move on to administering the next medication until the individual has first swallowed the current medication. If additional food or fluids are needed during the medication administration process, the staff administering medication will ask another staff person to bring the needed food or drink to the medication room. All facility staff will receive their annual Medication Management Review training. This training includes information about being prepared with all needed supplies before beginning medication administration and offering additional foods and fluids if needed to ensure the individual is able to swallow their medication.	10/30/2020 11/8/2020

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W 368	Continued From page 23 thickener in a liquid. On 9/24/20 at 1:30 p.m., the aforementioned observation was shared with the Residential Supervisor II and the QIDP (Qualified Intellectual Disabilities Professional). They stated the thickened liquid could have been prepared and brought into the medication room to give to the individual if needed.	W 368	As part of the facility's current practice, all medication trained DSP staff are observed administering medication four times per year by an LPN to ensure they are following proper procedures. This observation includes ensuring that the staff is prepared with all needed supplies before beginning medication administration and ensuring the individual swallows each medication before the next medication is administered.	Ongoing
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 observations of a medication pass, staff interviews and review of facility documentation, the facility staff failed to ensure medications were administered without error involving 1 of 4 individuals (Individual #3) in the survey sample. The findings included: Individual #3 was admitted to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) on 9/11/13 with diagnoses that included profound intellectual disability and seizure disability. Individual #3 had physician's orders dated 2/4/15 for Chlorhexidine rinse .12%, apply 5 milliliters (ml) with a toothette to brush teeth and gums twice a day (BID) by mouth for oral hygiene.	W 369	The Nurse Manager or designee will meet individually with DSP #1 to review the proper procedure to use when measuring liquid medication for Individual #3 or any other resident of the facility and will have her demonstrate to ensure her understanding. To ensure accuracy, the preferred method is to either draw the liquid medication up in a syringe and then place the medication into a medication cup or place a medication cup on a flat surface and pour and measure the liquid to the desired amount. The cup must remain on the flat surface and staff should bend down to check the measurement at eye level. Individual #3, as well as all other residents of the facility, receive liquid medication. All facility staff will be instructed on the preferred methods of measuring liquid medication, as described above, to ensure accuracy.	10/30/2020 10/20/20

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W 369	Continued From page 24 On 9/21/20 at 7:00 p.m., during observation of the medication pass, the Direct Support Professional (DSP) #1 administered 7.5 ml of Chlorhexidine. The DSP initially poured 10 mls in a 30 ml plastic medicine cup and held it in the air at eye level, after which she discarded some of the medication and once again held it up at eye level and indicated the amount was correct. DSP #1 sat the cup on the medication cart to retrieve a toothette at which time this surveyor observed Chlororhexidine in the cup at 7.5 ml line. On 9/22/20 at 2:30 p.m., an interview was conducted with another DSP (#5) who stated when administering liquid medications to sit the medication cup on a flat surface and check at eye level to determine an accurate amount. On 9/22/20 at 3:35 p.m., the Licensed Practical Nurse (LPN) #1 stated, "I would hold the cup up at my eye level to see the amount in the cup to give." On 9/22/20 at 4:00 p.m., another DSP (#6) said, "The best way is to pull the ordered amount of liquid medication up in a syringe for accuracy, then transfer it to the medication cup for administration, but you can sit the cup on a flat surface and pour the ordered amount. Never hold the medicine cup up in the air to check because it will cause you to tilt the cup and more chances of an inaccurate amount." On 9/24/20 at 1:30 p.m., the aforementioned medication error was shared with the Residential Supervisor II and the Qualified Intellectual Disabilities Professional (QIDP). The Residential Supervisor II stated the staff that administer medications complete medication education.	W 369	All facility staff will receive their Annual Medication Management Review training. Information about the preferred methods of measuring liquid medication to ensure accuracy will be included in the training. As part of the facility's current practice, all medication trained DSP staff are observed administering medication four times per year by an LPN to ensure they are following proper procedures. This observation includes ensuring that staff are using the preferred methods of measuring liquid to ensure accuracy.	11/8/2020 Ongoing

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W 387	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(5) If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs. This STANDARD is not met as evidenced by: Based on observation during a medication pass, staff interview and review of facility documentation the facility staff failed to securely lock a controlled drug. The findings included: During a medication pass observation on 9/21/20 at 7:00 p.m., Direct Support Professional (DSP) #1 unlocked the control box and removed a Vimpat (anticonvulsant) blister pack. After it was administered to the Individual, the DSP did not return the Vimpat to the control lock box, but placed the blister pack of 9 tablets with the individual's regular medications. After the medication pass observation, the DSP was asked if she had returned the Vimpat to the control lock box, at which time she said, "I am not sure, I need to check." When she did not find it in the control box, she checked the individual's regular medication and stated, "I was nervous and I would have wondered where it was during the narcotic count with the oncoming person!" On 9/24/20 at 2:00 p.m., the aforementioned observation was share with the Residential Supervisor II and the Qualified Intellectual Disabilities Professional (QIDP). The Residential Supervisor II stated DSP #1 told her of the incident, but that she caught she had not returned the Vimpat to the locked narcotic box.	W 387	The Nurse Manager or designee will meet individually with DSP #1 to review the proper procedure for securely storing controlled medications in the double locked controlled medication drawer of the med cart. She will be reminded to check, after completing medication administration, that all medications have been returned to their proper location, including returning controlled medications to the double locked controlled medication drawer of the med cart.	10/30/2020
			Individual #1, as well as two other residents of the facility, have controlled medications, which are stored in the double locked controlled medication drawer of the med cart. All facility staff will be instructed to check, after completing medication administration, that all medications have been returned to their proper location, including returning controlled medications to the double locked controlled medication drawer of the med cart.	10/20/20
			All facility staff will receive their Annual Medication Management Review training. The training includes Information about storing all controlled medication under double lock.	11/8/2020
			As part of the facility's current practice, all medication trained DSP staff are observed administering medication four times per year by an LPN to ensure they are following proper procedures. This observation includes ensuring that all medications are returned to their proper location, including that controlled medications are properly returned and stored under double lock in the controlled medication drawer of the med cart.	Ongoing

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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 observations, staff interview, and facility documentation review, the facility staff failed to implement active screening strategies for outside visitors and vendors to aid in the prevention and control of COVID-19. The findings included: The following observations were conducted during the survey by Surveyor #2: On 9/21/20 at approximately 4:00 p.m., upon entry into the residential home, Direct Support Professional (DSP) #5 obtained this surveyor's temperature. The temperature was not recorded and the DSP did not ask any further screening questions. This surveyor was asked to sign the visitor's sign in log. Upon inspection of the visitor's log from 3/31/20 to 9/21/20, 36 visitors signed the log. Among the visitors included janitorial services, delivery persons, bed repairmen, heating and air conditioning repairmen, fire inspector, wheelchair repairmen and maintenance. Upon entry the following day (9/22/20), the Residential Supervisor II asked if the surveyor needed to sign the visitor's log or have temperature taken, to which this surveyor responded that they should follow their procedures. The Supervisor II obtained this	W 455	During afternoon shift change on 9/23/20, the Supervisor II verbally reviewed the Sign-In/ Screening procedure to be used going forward for actively screening visitors entering the facility with the nine staff who were present. On 9/24/20, the Supervisor II instituted the written procedure for actively screening visitors, including vendors, contracted custodial personnel and repair persons, for symptoms of COVID. The Sign-In/ Screening procedure was emailed to all facility staff, who were asked to review the procedure and were given an opportunity to ask questions. A copy of the Sign-In/ Screening procedure was placed in the facility's Communication Binder, with a signature page for all staff to sign, indicating that they read and understood the procedure. All facility staff reviewed and signed-off on the procedure, indicating their understanding, by 9/30/20.	9/30/2020

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W 455	Continued From page 27 surveyor's temperature, but did not record the temperature or ask any further screening questions. She stated they did not record any temperatures of those on the visitor's log or ask any screening questions of any vendors entering the home because they did not come to visit an individual. She stated there would be a process for screening family visiting the individuals in the courtyard with a record of temperatures and further screening questions, but that procedure was not in place for vendors. She stated, "About two weeks ago, we re-instated visitation for the family and set up a screening procedure with a record of the screening for family visitors, but we have not had any family member call to set up any visits as of yet. We stopped visitation on 3/31/20, but did not consider others coming in the home as visitors, so no process or record of screening. We make sure they are wearing a mask though." On 9/23/20 from 10:00 a.m. through 1:30 p.m., a janitorial vendor was frequently observed walking down hallways and throughout the home with her facemask hanging off her left ear. On 9/23/20 at approximately 2:30 p.m., this aforementioned observation was brought to the attention of the Residential Supervisor II. She stated the practice of not wearing a mask in the home was unacceptable and she would address it with the janitorial vendor. On 9/23/20 at approximately 3:30 p.m., this surveyor was present during an inservice that was conducted by the Residential Supervisor II with 9 staff attending, to go over the screening process going forward for all persons that entered the home. The screening process included obtaining the vendor's temperature and asking if	W 455	The Emergency Preparedness policy was updated to include this screening process. The Sign-In/ Screening procedure includes having the visitor: 1) Wear a mask at all times while in the facility; 2) Clean their hands with alcohol-based hand sanitizer upon entry; 3) Complete a temperature check upon entry; 4) Sign the Visitor's Log; 5) Complete a Screening form for symptoms of COVID; and 6) Maintain social distancing from residents and staff while in the facility. Any visitor answering "yes" to any of the questions on the Screening form for symptoms of COVID-19 will be asked to immediately leave the facility. On 9/24/20, the Supervisor II contacted the contracted custodial vendor and informed the supervisor of the custodial staff that one of the of the custodial staff had been observed walking through the facility multiple times on 9/23/20 with her mask hanging from her ear. The supervisor of the custodial staff was asked to immediately inform all custodial staff who work at Indian River ICF/IID that they must wear their mask at all times while in the facility.	9/24/2020

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W 455	Continued From page 28 they experienced a cough, shortness of breath/difficulty breathing, sore throat, new loss of taste or smell, chills, head or muscle aches and or nausea, diarrhea or vomiting. During Emergency Preparedness review at 11:00 A.M. on 9/23/20 with the Supervisor II and ICF (Intermediate Care Facility Administrator, the ICF Administrator stated the Emergency Preparedness Plan was updated in August 2020. A review of a risk assessment dated 3/16/20 indicated: Alert Type- Infectious Disease Outbreak - Event Summary: "Due to the COVID-19 pandemic all visitation and community outings have been suspended starting 3/17/20. Day Support was suspended starting 3/2/20. Resident's vitals will be monitored daily. All staff will take their temperature prior to their shift to ensure they do not have a temperature greater than 100 degree F. Letters have been mailed to AR/LG (authorized representatives)/ (legal guardians) informing them of the pandemic, or precautions and our restrictions. Updated letters are sent on a regular basis. This restrictions will remain in place and will be reviewed on a regular basis in accordance with the recommendations from our regulatory agencies, CDC (Center for Disease Control) and VDH Virginia Department of Health." A review of a Visitor's sign in/out form indicated: Various outside vendors were entering the facility from 03/20/20 until 09/24/20. There was no active screening guidance per CDC recommendations. During an interview at 11:18 A.M. on 9/23/20 with the ICF Administrator he stated the agency attorney had sent out an email indicating that the	W 455	The Emergency Preparedness policy was updated to state that ICF staff will ensure visitors follow guidelines for wearing a mask at all times while in the facility; any facility staff who observes that a visitor/vendor has removed their mask while in the facility will immediately ask the visitor to put their mask back on and remind them that it must be worn at all times while in the facility. All facility staff will receive their annual emergency preparedness training and testing during the month of November. This training will include review of the above-stated policy revisions. Effective immediately, in order to ensure the Sign-In/ Screening process is being properly implemented, the House Manager will observe staff completing the Sign-In/ Screening procedure with vendors at least twice per week. In addition, the Supervisor II will complete spot-checks of documentation at least monthly, comparing names on the Visitor Sign-In Log with completed Screening forms.	11/8/2020 Ongoing

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W 455		W 455		

Continued From page 29
facility could not take and record temperatures of visitors or outside vendors.
A review of an email document dated March 27, 2020 indicated: Temperature Checks- "We cannot take staff/visitors temperatures."

CDC recommendation for Active Screening included: Screen everyone entering the healthcare facility for symptoms consistent with COVID-19.
Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature > 100.0 F or subjective fever.
Ask them if they have been advised to self-quarantine because of exposure to someone with COVID-19.
Properly manage anyone with symptoms of COVID-19 or who has been advised to self- quarantine.
According to the CDC, COVID-19 symptoms may include, but are not limited to the following: fever, cough, shortness of breath, headache, new loss of taste or smell, congestion or runny nose, sore throat, diarrhea, myaliga (muscle aches, body aches) tiredness or fatigue.

A review of the facility's Infection Control Procedures: Pandemic Influenza - indicated: Implement visitor restrictions, per CDC guidelines: wear a mask when visiting the ICF. Upon arrival temperatures will be taken and recorded, they will be instructed to wash their hands, complete a temperature check, and self-report if they have symptoms of the emerging infectious disease. If asymptomactic, the visitor will be offered an area distance from remainder of residents, such visitor must sign in in case contact tracing becomes necessary. Any

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 455	Continued From page 30 approved visitor that is symptomatic or has an elevated temperature of 100.0 F for higher when they arrive will be turned away. If the ICF's are under a 'No visitation and no community outing" status, this will include no home visits. Delivery persons will be instructed to unload supplies outside of the facility entrance and vendors will be instructed to complete their work outside, whenever possible. For vendors or repair persons who must enter the facility, the above process will used. The facility ICF Administrator was asked why the facility's infection control procedures were not implemented, he stated they were following the guidance of there legal advisor.	W 455		