STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 01/07/20 through 01/08/20. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No Emergency Preparedness complaints were investigated during the survey.	E 000		
E 037	EP Training Program CFR(s): 483.475(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037	1) The facility Program Manager scheduled Emergency Preparedness Training for 01/17/20 for the one employee cited in the survey. The employee is a PRN staff who typically works the Friday overnight shift at the facility. The training was based on the facility's emergency preparedness plan. The employee also completed the on-line Relias Learning Management System course "Workplace Emergencies and Natural Disasters: An Overview" on 01/17/20. Documentation of the trainings will be added to the employee's training file for emergency preparedness on site. 2) The Residential Supervisor and Program Manager will review training records of all facility staff, including PRN staff, to verify that all have received annual Emergency Preparedness Training, and to train any staff identified as needing it. 3) The Residential Supervisor reviewed facility Policy and Procedures #E-0037 Initial/Annual Emergency Preparedness	01/17/20 02/20/20 01/08/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darren Richards | TITLE: Director | (X6) DATE: 1/30/2020

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
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 037	Continued From page 1 hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.	E 037	Training/Documentation with the Program Manager to ensure understanding of staff training requirements. Record of this review will be added to the Program Manager's training record. The Program Manager will provide the same review for all staff during the next staff meeting, which will be recorded in staff meeting minutes. The Program Manager will maintain a training roster of all facility staff, including prn staff, to track emergency preparedness training. Program Manager will provide a status report biannually to the Residential Supervisor. The Program Manager modified the method of notifying PRN staff of required training to ensure they have sufficient time to adjust their schedules to attend. Notification of upcoming training will continue to be posted at the time clock. Additionally, the Program Manager will ensure PRN staff are notified in person by phone or face to face contact to confirm planned attendance. The Program Manager will follow up with the PRN staff immediately if staff fails to attend, to reschedule the training. 4) The Residential Supervisor will review Emergency Preparedness Training attendance reports biannually as provided by the Program Manager, to ensure all staff, including PRN staff, are trained on emergency preparedness within required time lines. A review of facility Policies and Procedures #E-0037 Initial/Annual Emergency Preparedness Training/Documentation determined that	02/20/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 037	Continued From page 2 *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.	E 037	it continues to meet federal and state requirements for providing an emergency training program for facility staff. The policy will be revised to reflect the updated regulatory language effective 11/29/19 as a result of a Burden Reduction Rule to read "This facility provides (ii) emergency preparedness training at least every 2 years."	02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 037	Continued From page 3 *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to provide annual emergency preparedness training that is based on the emergency preparedness plan.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 037	Continued From page 4 The findings included: During review of the facility's emergency preparedness plan on 01/08/20 at 1:20 p.m. the Program Manager and Residential Coordinator were asked for a sample list of four current employee training files for emergency preparedness. A review of the sample of staff training indicated one employee had not had emergency preparedness training since May of 2017. The Program Manager stated, "The employee did not have annual training on the emergency preparedness plan."	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least	E 039	1a) The Residential Supervisor will coordinate with the WTCSB Emergency Manager to contact the local Health Department, and EVHC to determine if appropriate opportunity exists for participation in any full-scale community-based exercises. If the facility is unable to identify a full-scale community-based exercise, the Residential Supervisor will develop and facilitate an individual facility-based exercise and demonstrate how it addresses any risk(s) identified in its risk assessment. 1b) The Residential Supervisor and the Program Manager will develop a table top exercise using a clinically relevant scenario. The TTX will be facilitated by the Residential Supervisor and Program Manager for all staff.	02/20/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 039	Continued From page 5 every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039	2a) A review of the facility's record of training exercises determined that the facility participated in a full-scale community-based exercise on 04/06 and 04/07/2018. Email documentation shows plans to participate in a city wide emergency preparedness simulated activity (mock chemical spill) in October 2018 however, according to the Local Health Emergency Coordinator a decision was made not to include the agency after all due to exercise limitations. The Facility Contact/ Participation Log With Interagency/ Tribal/Community Emergency Entities indicates contact was made 3/12/19 with the local Health Emergency Coordinator to seek opportunities for participation in community-based exercises, but none were available at that time. 2b) A review of the facility's record of training exercises determined that a Table Top Exercise was facilitated 07/18/19 on Workplace Violence Zero Tolerance. Documentation of training includes signed staff Attendance sheets, a copy of reviewed agency policy, and a Test based on that policy. A scenario was presented, however it was not recorded in written form. 3) The Residential Supervisor will develop a schedule to ensure ongoing engagement with state and local emergency management agencies and health department to identify potential opportunities to participate in full-scale community-based exercises as	01/21/20 01/17/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 039	Continued From page 6 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or	E 039	appropriate. The schedule will include time lines for the facility to develop alternate exercises should a community-based exercise not be available. The schedule will include meeting with the facility Program Manager biannually to review plans for tabletop exercises to ensure all components are prepared properly. The Residential Supervisor will provide training for the Program Manager on the pertinent regulation and facility Policy and Procedures #E-0039 Tabletop/Full Scale Exercises to ensure understanding that the facility must conduct exercises to test the emergency plan at least twice per year, and what is required to accomplish that. Additionally the training will ensure the Program Manager understands all the required components of a tabletop exercise. Training attendance will be added to the Program Manager's training record. 4) A review of facility Policies and Procedures #E-0039 Tabletop/Full Scale Exercises determined that it continues to meet federal and state requirements for conducting exercises to test the emergency plan. The policy will be revised to reflect the updated regulatory language effective 11/29/19 as a result of a Burden Reduction Rule to read "The facility will conduct exercises to test the emergency plan at lease twice per year."	02/20/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 978, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 039	Continued From page 8 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 039	Continued From page 10 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation of the facility's annual table top and full scale emergency preparedness exercises. The findings include: During an interview on 01/08/20 at 2:20 P.M. with the Residential Coordinator and the Program	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 039	Continued From page 11 Manager, they were asked for documentation of the facility's table top and full scale emergency preparedness exercises. The Residential Coordinator stated, "The facility did not conduct a table top exercise or participate in a full scale emergency preparedness exercise due to cancellation by the host event planner."	E 039		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 01/07/20 through 01/08/20. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 10 bed facility at the time of the survey was 10. The survey sample consisted of 4 current Individual records (Individual #1 through #4).	W 000	W104 1) Replacing the light bulb was in progress at time of survey, per the facility's work order process. Other lighting in individual #3's room was operating and provided sufficient light for safety. Purchase requisition #83876 to replace the light bulb over the sink in individual #3's room was submitted to Procurement on 01/03/20 by the Program Manager. Procurement contacted the facility 01/06/20 to clarify specifics, then contacted the vendor 01/07/20. The vendor arrived as scheduled on 01/08/20 and replaced the light bulb.	01/08/20
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain equipment and the environment in a safe manner. The findings included: During an Environmental Tour on 01/07/20 at	W 104	Purchase requisition #83869 for the oven door repair was completed 12/14/19 and submitted to Procurement 12/23/19 by DSP staff. Procurement contacted the vendor 12/26/19. The vendor came to the facility 12/27/19 and determined a part had to be ordered. At end of business 01/07/20 the vendor notified Procurement the part arrived. The following morning Procurement scheduled the vendor to go to the facility 01/09/20, and notified the facility via email. The oven door was repaired as scheduled and is functioning. Purchase requisition #83866 was done to replace a recliner chair that had a worn arm rest. A new recliner was delivered 12/13/19 and assembled by agency maintenance	01/09/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 104	Continued From page 12 11:30 A.M. Individual #2 informed the surveyor that her light fixture over the sink area was not operating properly. During an interview on 01/07/20 with Direct Support Staff (DSP) #2 she stated, the light bulb was out for several days and a request had been made for maintenance to come and replace the bulb. The bulb was observed to be out until 1:30 P.M. on 01/08/20. The kitchen oven was observed on 01/07/20 at 11:45 A.M. to have a hand written sign and duct tape across the door indicating "Do Not Use." During an interview with the Program Manager she was asked what happened to the oven. The manger stated, "The door handle came off." A review of a facility purchase requisition dated 12/14/19 indicated: Description of material or service needed. Handle on oven door." An email dated January 08, 2020 10:14 AM indicated: Importance: High- Vendor will be coming back to fix the oven handle door Thursday (01/09/20) from 11-3. I told them it was fine. If this is not the case, please let me know. Thanks !" During the days of the survey Individual #3 was observed sitting in a recliner chair daily. The chair was noted to have a right tattered arm rest. The arm rest was noted to also have worn duct tape around it. During an interview with the Residential Coordinator on 01/08/20 at 1:12 P.M. she stated, the chair should have been discarded. A Facility Physical Plant policy dated 11/18 included: "All furnishing will be ensured with proper cleaning and replacement as needed."	W 104	on 12/16/19. It was in place in the residence at time of survey. The old recliner was removed 01/08/20. 2) Program Manager conducted a building inspection on 01/09/20 and determined that: all other light bulbs in the residence were functioning properly and did not require replacement; the oven door was repaired and functioning properly; all furnishings were in good repair. 3) The Residential Supervisor will facilitate training for the Program Manager on Policy #934 Physical Plant to ensure the building inspection report is reviewed weekly and forwarded to procurement and to ensure follow up of all maintenance and repair, including removal of all furnishings that have been replaced. The Program Manager will be reminded to post any notification of scheduled vendor service in the communication log book to alert all staff when vendors are scheduled and what service is expected. The training will review the work order process and emphasize timeliness of submitting requisitions, and using the most efficient methods for submitting requisitions to ensure timely attention. Contingencies for illness/holidays/etc. will be reviewed. The training will be added to the Program Manager's training record. 4) The facility will maintain building inspection reports in general files which will be reviewed as part of a facility check annually. A review of Policy#934 Physical Plant determined that it still meets federal and state requirements for ensuring all furniture is maintained with proper cleaning and replacement as needed.	01/08/20 02/20/20 02/20/20
W 130	PROTECTION OF CLIENTS RIGHTS	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 130	Continued From page 13 CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interviews, the facility staff failed to protect 1 of 5 individuals (Individual #1), in the survey sample from public view during administration of medication through a gastrostomy tube. A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. https://medlineplus.gov/ency/article/002937.htm The findings included: Individual #1 was originally admitted to the facility 06/24/13. The current diagnoses included but not limited to, profound intellectual disabilities and dysphagia. On 01/08/20 at approximately 7:25 a.m., License Practical Nurse (LPN) #1 removed Individual #1 from the living area to the medication room to administer her morning medications. LPN #1 administered the ordered medications to Individual #1 through gastrostomy tube. While administering Individual #1's medications through her gastrostomy tube, the door was not closed to provide privacy. On 01/08/20, immediately following administration of medications, LPN #1 was asked, "Should the door be closed to maintain privacy during the administration of medication through gastrostomy	W 130	1) On 01/08/20 the Nursing Supervisor instructed the Residential Nurses and the Nurse providing evening coverage to close the door to the medication room when administering medications to Individual #1 and all individuals to ensure privacy during treatment and care of personal needs. The Nursing Supervisor confirmed that Individual #1's current Physician's Order Sheet includes the order "May give meds outside med room as needed for consumer convenience" and reviewed this option with the Residential Nurse. On 01/09/20 the Nursing Supervisor emailed all Residential Nurses and PRN nurses a reminder to ensure privacy for all medical treatments, per policy and regulation. The email emphasized this practice is mandatory and must be performed at all times. 2) The Nursing Supervisor and Residential Nurse identified 3 other residents who use wheelchairs which may require rearrangement of the medication cart in the medication room in order to close the door comfortably. 3) On 01/09/20 the Nursing Supervisor contacted the medical supplier to research privacy screens. On 01/13/20 the Nursing Supervisor submitted Requisition order #80923 for the purchase of 2 portable privacy screens, which were ordered that day. The screens are expected to arrive on 01/22/20. On 01/10/20 the Nursing Supervisor facilitated training on Policy #810 Privacy and Policy #916 Gastrostomy Tube Feeding and Medication Administration for (8) Residential Nurses including LPN #1. Content reviewed included ensuring the door is closed to ensure privacy during treatment and care	01/08/20 01/09/20 01/08/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 130	Continued From page 14 tube." The LPN stated, "I do sometimes but not always, this room can be claustrophobic because it's so small." During the administration of medication through the gastrostomy tube, the individual could be viewed by anyone walking pass the doorway because the door was left opened. On 01/08/20 at approximately 3:00 p.m., an interview was conducted with the Program Manager who stated, "The LPN should have taken (Individual #1) to her room, closed the door then administered the meditation through (Individual #1's) feeding tube." The Program Manager said the door should be closed when administering medications through a feeding tube to maintain the individual's privacy. The facility's policy titled Gastric Tube Medication Administration. -Procedure include but not limited to: Identify individual, explain procedure to individual and provide privacy.	W 130	of personal needs. Content also included option for properly administering medications in individuals' rooms, per Physician's order if necessary. Each nurse received copies of both policies. The Nursing Supervisor facilitated the training again on 01/13/20 for 4 additional residential nurses, and on 01/19/20 for 1 more. One more training will be scheduled for the 1 remaining residential nurse. Nurses signed their training sign in sheet which was forwarded to Human Resources to be added staff training records. 4) A review of facility Policies #810 Privacy and #916 Gastrostomy Tube Feeding and Medication Administration determined both continue to meet federal and state requirements for ensuring residents' privacy during treatment and care of personal needs. Both Policies will be updated to include reference to alternate use of a privacy screen when necessary. A review of the curriculum for the 32-hour Medication Administration course and 8-hour Medication Administration refresher course determined that it includes sufficient instruction for ensuring privacy during treatment and care of personal needs. The Nursing Supervisor will instruct Residential Nurses to add to their Nursing Notes for administration of medications through a gastrostomy tube that the individual's privacy was maintained and how it was maintained during medical/nursing treatment and care of personal needs (e.g., door closed, privacy screen). The Nursing Supervisor will conduct random quarterly site visits to observe the administration of	02/20/20 02/20/20 02/20/20
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by:	W 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 15 Based on observation, staff interviews and clinical record review the facility staff failed to revise/update one (Individual #1) of 5 individuals in the survey sample, Person-Centered Plan. The findings included: The facility staff failed to revise Individual #1's Person-Centered Plan to include the use of a chest strap (harness) and seatbelt while up in her wheel chair. Individual #1 was originally admitted to the facility 06/24/13. The current diagnoses included but not limited to, profound intellectual disabilities. On 01/07/20 at approximately 4:45 p.m., Individual #1 observed sitting up in her wheel chair with chest strap, build in abductor and seatbelt in place. The physician Order Sheet (POS) for October 2019 included the following orders: -Wheel chair with chest strap, build in abductor and seatbelt. Individual #1's Person-Centered plan did not include the use of a chest strap (harness) build in abductor and seatbelt to her wheelchair. On 01/08/20 at approximately 1:55 p.m., a revised Person-Centered Plan was provided to the surveyor for Individual #1 included the following: -Direct Support Professional (DSP) will ensure Individual #1 is secure in her wheelchair to include; harness and seat belt as required to prevent falls. An interview was conducted with the DSP	W 242	medications through a gastrostomy tube. The Nursing Supervisor will document in a Nursing Note whether the individual's privacy was maintained during the medical/nursing treatment and care of personal needs, including by what method. W242 1) Individual #1's Person-Centered Plan was revised on 01/08/20 to include support instruction "DSP will ensure Individual #1 is secure in her wheelchair to include: harness and seat belt as required to prevent falls." The revised plan was reviewed and signed by the individual's Authorized Representative. Individual #1's current Residential Nursing Service Plan, developed 12/31/19, identifies a Service/Objective that includes "Strategy: use of all adaptive equipment as ordered: W/C with footrests, seatbelt, and chest strap, shower gurney with safety straps." The plan identifies "Implementor: DSP, Nurse, PT/OT." 2) The Program Manager and Residential Counselor will perform a comparison of each resident's Person-Centered Plan with their respective Physician's Orders to determine that each plan includes training in personal skills essential for privacy and independence where appropriate, and that mechanical supports were identified as needed. 3) The Residential Supervisor will facilitate training for the Program Manager and Counselor on developing Person-Centered Plans. Training will emphasize reviewing current Physician's Orders when developing/updating/revising	01/08/20 02/20/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 16 Supervisor on 01/08/20 at approximately 2:50 p.m. The DSP supervisor stated, "I was not aware until today that Individual #1's Person-Centered Plan did not include the use of her harness or seatbelt." The DSP stated, "I just revised Individual #1's Person-Centered Plan today." On 01/07/20 at approximately 3:00 p.m., an interview was conducted with the Program Manager who stated, "Individual #1's Person-Centered Plan should have be been updated/revised to include the use of her harness and seatbelt while up in her wheel chair."	W 242	Person-Centered Plans to ensure any ordered mechanical supports are included in the plan. The training will be added to the Program Manager's and Counselor's training records. The Program Manager will continue to review and approve all Person-Centered Plans. The Residential Supervisor will instruct the Interdisciplinary Team to pay close attention during quarterly meetings that physician's orders are accurately reflected in the plans. Utilization Review Supervisor will continue to perform record reviews, identifying any deficiencies to be corrected. 4) A review of facility Policy #860 Person-Centered Plan, determined that it continues to meet state and federal requirements for ensuring that program plans include training in personal skills essential for privacy and independence, and that mechanical supports are identified if needed.	01/17/20
W 386	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(4) The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308). This STANDARD is not met as evidenced by: Based on observation, staff interviews, clinical record review, and facility documentation, the facility staff failed to maintain an accurate record of a controlled medication (Clonazepam), for 1 of 5 individuals (Individual #4) in the survey sample. The findings included: Individual #4 was originally admitted to the facility 11/15/12. The current diagnosis included but not limited to, severe intellectual disability and seizure	W 386	W386 1) On 01/07/20 the Nursing Supervisor and Residential Nurse performed a controlled drug count of Clonazepam 0.5mg for Individual #4 and compared it against the eMAR. They verified the count should be 26, and signed off that the medication was given as reflected in the eMAR. The eMAR verified the medication was administered at 11:30am by the DSP. The bubble pack reflects that the medication was given; the count was 26, which was consistent with the eMAR. The 11:00am dose was not signed out on the Controlled Drug Receipt/Record/Disposition form by the DSP. The Nursing Supervisor and Residential Nurse corrected the Controlled	01/07/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 386	Continued From page 17 disorder. During the medication pass with Direct Support Professional (DSP) #2 and the Program Manager on 01/07/20 at approximately 3:40 p.m., the DSP removed a card of Clonazepam from the lock box on the medication cart. She punched out the Clonazepam into a medication cup with pudding then administered the medication to Individual #4. The DSP went to sign off on the Controlled Drug Receipt/Record/Disposition Form and stated, "This is not right, while looking at the card of Clonazepam." The DSP said to the Program Manager, the card is now showing 26 but the Controlled Drug Receipt/Record/Disposition Form is showing only 3 tablets were given. The DSP and Program Manager were asked, "Is the narcotic count comparison correct for the Clonazepam 0.5 mg" the Program Manager stated, "No, it doesn't look like it." Review of Individual #4's current Physician Order Sheet (POS) for October 2019 included the following order: -Clonazepam 0.5 mg-give one tablet by mouth four times a day for seizures. Review of Individual #4's record revealed the following information: -Clonazepam 0.5 mg 1 tablet given by mouth given on 01/07/20 at approximately 11:30 a.m. On 01/07/20 at approximately 3:40 p.m., the Controlled Drug Receipt/Record/Disposition Form was compared to the actual Clonazepam medication card. The following discrepancy observed: -Individual #4's Controlled Drug Receipt/Record/Disposition Form (Clonazepam)	W 386	Drug Receipt/Record/Disposition form by inserting the correct count, authenticating it appropriately, to reestablish the accurate count for oncoming staff. The DSP's signature was obtained on the Controlled Drug Receipt/Record/Disposition form, per consultation with the pharmacist to ensure compliance with regulations for controlled drugs. 2) The Nursing Supervisor and Residential Nurse performed reviews of the Controlled Drug Receipt/Record/Disposition form for the previous full week for Individual #4 and all other residents and determined an accurate count of each drug for all residents. Each controlled drug had been signed out and witnessed by two staff,verified by both staff signatures, per facility Policy #899 Schedule II Drugs. 3) On 01/07/20 medication administration privileges were immediately suspended for DSP #1 and DSP #2 pending completion of an 8-hour Medication Administration refresher class and two medication administration observation check offs for each DSP. Both DSPs completed the class on 01/10/20. Their documented attendance was added to their training record. On 01/07/20 the Nursing Supervisor and Residential Nurse each facilitated a training in-service for all facility staff present, including DSP #2. On 01/08/20, 01/16/20, and 01/21/20 Residential Nurse facilitated duplicate trainings for all remaining facility staff including DSP #1. Documented attendance was added to all staff training	01/07/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 386	Continued From page 18 @ 27 but the narcotic count @ 26. An interview was conducted with DSP #1 on 01/08/20 at approximately 8:12 a.m., who stated, "I was having a conversation with Individual #4 during my med pass yesterday and got distracted." The DSP said, I gave Individual #4 her 11:00 a m., (Clonazepam) on 01/07/20 but did not sign off on the controlled sheet. The DSP was asked, "What is the process for administering a controlled medication" she replied, "I should have called for another person to watch me pull and administer Individual #4's medication (Clonazepam) and both of us should have signed off on the controlled sheet, I did not do that." On 01/08/20 at approximately 3:00 p.m., an interview was conducted with the Program Manager who stated, "There should always be two staff members when administering a controlled medication." The Program Manager said two staff members are to verify the count at the time the medication is administered, from shift to shift and when passing the keys from one staff member to another." The facility's policy titled Schedule II Drugs (Revision date: 08/13). Procedure include but not limited to: -4. A separate inventory on all controlled substances will be maintained on the Residential Services Controlled Substance Drug Verification Form. The verification of each controlled substance drug card will be checked against its correlating controlled substance drug verification form by two facility staff and documented that in fact all counts are accurate at the end of each shift or as the controlled medication key is	W 386	records. 4)The Residential Nurse routinely reviews the Controlled Drug Receipt/Record/ Disposition form 2-3 times a week for accuracy. Any discrepancies are reported and resolved by the Nursing Supervisor and Residential Nurse upon discovery. A review of facility Policy #899 Schedule II Drugs determined that it continues to meet federal and state requirements for reconciling the receipt and disposition of all controlled drugs in schedules II through IV.	01/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 386	Continued From page 19 handled to another staff members. -5. All requirements of the law and (name of facility) ICF/IID policy concerning storage, handling, administration, and reporting/documenting shall be followed. Definitions: Clonazepam is used alone or in combination with other medications to control certain types of seizures. It is also used to relieve panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks). Clonazepam is in a class of medications called benzodiazepines. It works by decreasing abnormal electrical activity in the brain. https://medlineplus.gov/druginfo/meds/a682279.html	W 386		
W 429	HEATING AND VENTILATION CFR(s): 483.470(e)(2)(i) The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain bedroom temperatures between 68 and 80 degrees Fahrenheit for 1 (Individual #5) of 5 Individuals in the survey sample. The findings included: During the Environmental Tour on 01/07/20 at 11:40 AM, the bed room for Individual #5 was noted to be extremely cold. On 01/08/20 at 2:50	W 429	1) The Residential Supervisor opened the door to Individual #5's bedroom and instructed staff to leave it open while Individual #5 is away from the facility. Typically the door is closed during the time Individual #5 attends Day Support programming, from 7:00am until after 3:00pm. With the door open, the temperature in the room remains at least 68 degrees Fahrenheit. The Program Manager submitted requisition #84043 to Procurement on 01/17/20 for evaluation of the heating ventilation in Individual #5's room. Service was provided the same day by vendor MG Mechanical. The vendor opened dampers above the bedroom to increase airflow, which produces more heat in the room. 2) Using the facility temperature gauge, the Residential Supervisor checked all residents' rooms on 01/08/20 and determined all rooms had temperatures of at least 68 degrees Fahrenheit.	01/08/20 01/17/20 01/08/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 429	Continued From page 20 PM the room was noted to be extremely cold. A facility digital temperature gage indicated that the temperature in the room was 67.3 degrees Fahrenheit. Individual #5 diagnoses included Tinea Pedis, abnormal liver enzymes, Vitamin D deficiency, seizures, and Anemia. A Person Centered Program (PCP) dated 12/31/19 indicated: " Routine Supports from staff including hair washing, laundry, hair care, evacuation drills, dressing and undressing, health and safety supports are provide during each shift." During an interview with the Residential Supervisor on 01/08/20 at 2:53 PM she stated, yes, the room was "Cold." She would have maintenance come out and see what is happening.	W 429	3) Residential Supervisor reviewed Policy #934 Physical Plant with the Program Manager and Residential Counselor, emphasizing required temperatures for residents' bedrooms. The Program Manager was instructed to ensure bedroom temperatures are checked during the weekly building inspection and that any temperatures below 68 degrees Fahrenheit are recorded and reported immediately for repair. 4) A review of facility Policy #934 Physical Plant determined that it continues to meet state and federal requirements for ensuring individuals' bedroom temperatures are maintained within a normal comfort range by heating, air conditioning or other means.	01/08/20 01/17/20
W 449	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by. Based on observation, record review and staff interview the facility staff failed to take corrective action following an accidental fire. The findings included: A review of an Adverse Incident Report dated 12/22/19 indicated: "At 2:05 PM on 12/22/19 staff placed a pot on the stove with oil to cook, turn the stove on. Come (sic) to the dining area to finish an email, within 2 mins. Got up to check on the	W 449	1) On 01/07/20 requisition #84255 was completed to have the faulty fire extinguisher inspected and replaced if necessary. On 01/09/20 BFPE came to the facility and refilled and tested the faulty fire extinguisher, and signed off as operating properly. 2) Since all facility fire extinguishers were inspected and signed off as operating properly on 12/5/19, the same day as the extinguisher that failed to operate, the facility Program Manager will ensure the remaining 4 fire extinguishers in the residence will be re-inspected. 3) The Residential Supervisor and Program	01/09/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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 449	Continued From page 21 pot and notice the pot smoking, turned stove off, remove (sic) the pot with oil in it from the double front right stove burner (when standing in front of it). Within removing the pot the oil started to burn and low flames came from the pot, while holding it. Ask another staff to give me salt and it did not work. Proceed to take pot out of the house, through the front door, and place the pot on the concrete sidewalk. When I came back into the house I went to get the fire extinguisher by the kitchen, did not work. In the process the alarm company called (2:06 PM) to see if any help was needed. I explained that the fire extinguisher did not work and to send the fire dept to put the pot out." Action and Follow-up - "DSP removed pot from stove and attempted to extinguisher the flame by using salt which all failed. Fire extinguisher failed to work per DSP. 911 was called, Fire dept arrived and extinguished fire in pot. Evacuated individuals. Remain in kitchen when using appliances/cooking. DSP repeat Fire Safety Training. Observations made of all fire extinguishers in the facility indicated that on 12/05/19 the extinguishers were inspected and signed off as operating properly. The fire extinguisher in the kitchen at the stove was noted to have an inspection date of 12/05/19 also. During an interview on 01/08/20 with the Residential Coordinator she was asked why the fire extinguisher that did not operate properly was still in the kitchen with no changes. The Residential Coordinator stated, the fire extinguisher should have been removed and replaced.	W 449	Manager will receive training on developing appropriate action and follow up for adverse incidents involving accidental fires. The training will emphasize developing corrective action to address any problems identified during drills, and ensuring that action is implemented, and following through to ensure implemented action was successful. Training will also include a review of Policy #934 Physical Plant and emphasize correct recording of all deficiencies so that they may be addressed in timely manner. 4) Policy #922 Fire Drill Evacuation will be revised to add procedures for taking corrective action to prevent recurrence of any problem identified during a drill, and to ensure that corrective action is implemented, and that there is follow-up to ensure the corrective action was successful.	02/20/20 02/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G056	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINCES PLACE/CHASES WAY	PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439

(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