STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G074	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT HERMON MANOR	4769 FRANKLIN TURNPKE DANVILLE, VA 24540

(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 recertification survey was conducted onsite on 07/29/2020. Emergency Preparedness information was reviewed offsite on 07/30/2020, 07/31/2020 and 08/03/2020. Corrections are required for compliance with 42 CFR 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The census in this 5 certified bed facility was 5 individuals at the time of survey. The survey sample consisted of 3 current individuals.	E 000		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [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 (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care	E 026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James F. Deheeny, LPC — TITLE: Executive Director — (X6) DATE: 09.15.2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 026	Continued From page 1 at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on facility document review and staff interviews the facility staff failed to develop an emergency preparedness plan that included a policy and procedure describing the facility's role under Waiver 1135. The findings were: The facility's emergency preparedness (EP) documentation, which was sent to the survey team via encrypted email in multiple files, was reviewed by one surveyor on 07/30/2020 and 07/31/2020. Both the facility's Director of Residential Services and the Intermediate Care Facility's (ICF) Director was informed the documentation provided did not include all of the requested emergency preparedness (EP) information. The facility staff provided further EP information via encrypted email which was reviewed by one surveyor on 07/31/2020 and 08/03/2020. On 08/03/2020 at 11:05 a.m., the survey team conducted a conference call with the facility's Director and one facility registered nurse (RN#1). The ICF's Director was informed the surveyor had not found a policy and procedure describing the facility's role under Waiver 1135. The Director stated they would look into that policy and procedure and provide further information to the survey team via email. On 08/03/2020 at 2:03 p.m., the ICF's Director sent an encrypted email which read, "We do not have [sic] policy and procedure for Waiver 1135." On 08/03/2020 at approximately 3:15 p.m., during	E 026	The Plan of Correction and procedure for implementing the specific deficency is to develop a Waiver 1135 procedure and integrate the procedure in the Emergency Preparedness Plan by September 17, 2020. The Group Home Director will ensure the ICF's Emergency Preparedness Plan, which includes the facility's role under Waiver 1135, is reviewed and updated at least annually. The Group Home Director will be responsible for implementing the acceptance Plan of Correction.	9/17/20

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E 026	Continued From page 2 a conference call between the survey team and the facility's Director with RN#1, the facility's Director verbally acknowledged the facility did not have a policy related to Waiver 1135. No further information was provided prior to the end of the exit conference.	E 026		
W 000	INITIAL COMMENTS An unannounced Medicaid re-certification survey was conducted onsite on 07/29/2020. Information related to the survey was also reviewed offsite on 07/30/2020, 07/31/2020 and 08/03/2020. The facility was not in compliance with the following Federal ICF/ID regulations. The Life Safety Code will follow. The census in this 5 certified bed facility was 5 Individuals at the time of survey. The survey sample consisted of 3 current Individual reviews (Individual #1 through #3).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for 1 of 3 Individuals, Individual #1. The findings included: Individual #1's clinical record included an	W 111		

(See Page 4)

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W 111	Continued From page 3 "Informed Consent for Psychotropic Medications" form that listed that incorrect medications. The facility was able to provide documentation in the form of a typed letter to the surveyor indicating the legal guardian was aware of the individual's medication regimen and was in agreement. Individual #1's clinical record included the diagnoses profound intellectual disabilities, downs syndrome, tracheotomy, osteoporosis, and Alzheimer's disease. Individual #1's clinical record included a form titled "Informed Consent for Psychotropic Medications" signed and dated by the legal guardian and ICF director on 01/16/2020 (prior to admit). This form included the medications trazodone and lexapro. When reviewing the clinical record the surveyor was unable to locate a physician order for these medications. These medications were not listed on the specially constituted committee informed consent form dated 05/20/2020 or on the behavior support plan updated 02/11/2020. On 07/31/2020 at approximately 12:25 p.m., during an interview with the ICF director and LPN (licensed practical nurse) #4 these staff were asked about the lexapro and trazodone. LPN #4 verbalized to the surveyors that Individual #1 was on trazodone and lexapro at the hospital. However, it was discontinued and the individual had been placed on other medications prior to their admit to the group home. When asked if they had obtained informed consent from the AR/RP (authorized representative/responsible party) the ICF director stated they had not and the medication had been changed at the hospital prior to being admitted to the ICF group home	W 111	The Plan of Correction and procedure for implementing the specific deficiency is that the Group Home Director will complete the Informed Consent for Psychotropic Medications and obtain the signature of the legal guardian by September 17, 2020. In order to ensure compliance with the regulation, the Group Home Director will complete the Informed Consent for Psychotropic Medications for all individuals prior to admissions. The informed consent will be signed by the individual, AR and/or legal guardian prior to admission. The Group Home Director will be responsible for implementing the acceptable Plan for Correction.	9/17/20

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W 111	Continued From page 4 and that is probably how the oversight happened. The ICF director then stated they had obtained informed consent via email. This email was not shared with the surveyor. On 07/31/2020 the facility provided the surveyor with a typed letter from Individual #1's legal guardian that stated "...We have been fully involved in and are aware of all of _____ medical treatment and medication regimen...We are aware of Psychotropic Medications changed before leaving the hospital and arriving at _____ on...If you have further questions you may contact me at..." This typed letter was signed but did not include a date. The facility provided the surveyor with a copy of a document titled, "ATTACHMENT TO HUMAN RIGHTS POLICY." Page 17-18 of this document read in part, "Participation in Decision Making and Consent."...The individual's services record shall include the signature or other indication of the individual's or his authorized representative's consent..." No further information regarding this issue was provided to the survey team prior to the exit conference.	W 111		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the QIDP (qualified intellectual disability professional) failed to identify and correct	W 159		

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W 159	Continued From page 5 discrepancies in the clinical record for 3 of 3 Individuals, Individual #1, #2, and #3. The findings included: For Individual #1 the QIDP failed to ensure the informed consent in the Individuals clinical record included the Individual's current medications, failed to ensure the Individuals ISP (individual service plan) was updated when community activities were put on hold due to the COVID19 pandemic, and failed to ensure the initial physician assessment was completed prior to the start of the ISP and within 30 days of admission. For Individual #2 the QIDP failed to ensure the facility staff reported an episode of yellowish light pinkish bloody discharge from vaginal area (05/28/2020) and a small amount of blood in vaginal area (05/10/2020) to the physician and completed an event report, and failed to ensure the Individuals ISP was updated when community activities were put on hold due to the COVID19 pandemic, For Individual #3 the QIDP failed to ensure the informed consent for psychotropic medication included all of the Individual's behavior medications and failed to ensure the Individuals ISP was updated when community activities were put on hold due to the COVID19 pandemic. 08/03/2020 11:05 a.m., during an interview with ICF director, the ICF director verbalized to the survey team that the QIDP was in the facility approximately 2 weeks ago. No further information regarding this issue was provided to the survey team prior to the exit	W 159	The Plan of Correction and procedure for implementing the specific deficiency is: (A) QIDP will ensure the individual's current medication is included on the Informed Consent for Psychotropic medications by September 17, 2020. (B) QIDP will update all ISPs in response to COVID-19 Pandemic and community activities by September 17, 2020. (C) QIDP will ensure that all future admissions include a physician's assessment within 30 days of admission. (D) QIDP will ensure that event reports are completed appropriately and the physician is notified accordingly. All staff will receive training by September 17, 2020 on when to complete an event report and when to contact the physician. (E) QIDP will ensure that the Informed Consent for Psychotropic medications includes current psychotropic medications.	9/17/20

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W 159	Continued From page 6 conference.	W 159		
W 254	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that contribute to an overall understanding of the client's ongoing level and quality of functioning. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to update the Individuals ISP (individual service plan) in regards to changes related to the COVID19 pandemic for 3 of 3 Individuals in the survey sample, Individual #1, #2, and #3. The findings included: The facility staff failed to make any changes to the Individuals ISP in regards to the COVID19 pandemic. The Individuals were not participating in any community activities. 1. Individual #1's clinical record included the diagnoses profound intellectual disabilities, downs syndrome, tracheotomy, osteoporosis, and Alzheimer's disease. Individual #1's ISP included the support activities: In order to become familiar with community resources, ____ participates in outing of ___ choice. Steps to get there shopping, choice of events, and transportation. Program will be run 4 times a month. In order to learn about available community resources, ____ explores ____ community. Steps to get there Variety of community activities.	W 254	The Plan for Correction and procedure for implementing the specific deficiency is the QIDP will update all ISPs in response to COVID-19 Pandemic and community activities by September 17, 2020. The Group Home Director will ensure that the Plan of Correction cited deficiencies are corrected and remain in compliance with regulatory requirements. The Group Home Director will be responsible for implementing the acceptable Plan of Correction.	9/17/20

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W 254	Continued From page 7 Support instructions included, staff ensures that ___ spends time in ___ community and staff helps ____ make a purchase in his community. No changes had been made to this ISP in regards to the individual not participating in the above community activities. 2. Individual #2's clinical record included the diagnoses of moderate intellectual disabilities, downs syndrome, dementia, and seizures. Individual #2's ISP included the support activities: In order to become familiar with community resources, ____ participates in outings. Support Instructions for community integration-program will run 2 times per month. In order for ____ to be familiar with money and its uses, ____ practices money skills. Steps to get there included selects item to buy, goes to cashier, gives money to cashier, and wait for change. For the skill building activities: Socialization-Instructions included, but were not limited to; data will be collected twice a week after an outing or after an activity at home. Community Integration-Instructions included, program will be run 4 times a month, goal will be met when ____ explores 8 different places in ___ community. Money-Makes a small purchase on an outing or during a simulation at home 12 consecutive times. No changes had been made to this ISP in regards to the individual not participating in the above community activities. 3. Individual #3's clinical record included, but was	W 254		

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W 254	Continued From page 8	W 254		

not limited to, the diagnoses profound intellectual disabilities and gross brain disease.

Individual #3's ISP included the support activities: In order to become familiar with the community and community resources, ____ participates in activities in the community. Steps to get there included shopping, choice, of events, and transportation. Support instructions included program will be run 4 times a month.
Skill building activities included:
Community integration, explores community. Program will be run 4 times per month; staff will select one community outing for ____ to attend. This may include community events, the mall, the park, etc., Staff will talk to ____ about the event and ___ community, staff will take ____ on the outing, staff will document where they went and _____ response to the outing.

No changes had been made to this ISP in regards to the Individual not participating in the above community activities.

On 07/31/2020 at approximately 4:00 p.m., during an interview with the ICF director, LPN (licensed practical nurse) #4, and RN (registered nurse) #2, the ICF director verbalized to the surveyor that the Individuals ISP had not been updated in regards to the COVID19 pandemic.

During a follow-up interview with the ICF director and RN #2 on 08/03/2020 at 11:05 a.m., the surveyor asked if there had been any changes to the Individuals ISP due to COVID19. The ICF director verbalized to the survey team that the Individuals did not go out on any community outings and that this was documented on the skill building logs. These Individuals did not attend day

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W 254	Continued From page 9 support services. No further information regarding this issue was provided to the survey team prior to the exit conference.	W 254		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure they had written informed consent from the Individuals AR (authorized representative) in regards to the psychotropic medication Buspar. This medication was part of the Individuals behavior management program. For 1 of 3 Individuals in the survey sample, Individual #3. The findings included: The facility staff failed to obtain written consent from Individual #3's AR for the psychotropic medication Buspar. Individual #3's clinical record included, but was not limited to, the diagnoses profound intellectual disabilities and gross brain disease. Individual #3's clinical record included the following items: Document titled "Informed Consent for	W 263	The Plan of Correction and procedure for implementing the specific deficiency is the Group Home Director will complete the Informed Consent for Psychotropic Medication and obtain the signature of the legal guardian by September 17, 2020. In order to ensure compliance with the regulation, the Group Home Director will complete the Informed Consent for Psyhotropic Medication to include all Psychotropic Medications.	9/17/20

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W 263	Continued From page 10 Psychotropic Medications" signed by the ICF director on 05/01/2020 and the AR on 06/19/2020 (delay due to COVID19). This document did not include the medication Buspar. A behavior support plan dated 04/10/2020 that included the medication Buspirone (Buspar). Minutes from the SCC (specially constituted committee) dated 05/20/2020 that included consent for the medication Buspar. Current physician orders for Buspar 15 mg 1 tablet by mouth three times a day. On 07/31/2020 at approximately 12:25 p.m., the ICF director and LPN (licensed practical nurse) #4 were notified that Individual #3's Buspar was not listed as a medication on the "Informed Consent for Psychotropic Medications" form signed by the ICF director on 05/01/2020 and the AR on 06/19/2020. On 07/31/2020 at 3:36 p.m., the ICF director provided the surveyor with documentation to indicate that the facility staff had "Contacted AR and informed her of error and changes. AR is in agreement." The facility provided the surveyor with a copy of a document titled, "ATTACHMENT TO HUMAN RIGHTS POLICY." Page 17-18 of this document read in part, "Participation in Decision Making and Consent."...The individual's services record shall include the signature or other indication of the individual's or his authorized representative's consent...Informed consent is always required for...use of psychotropic medications..." No further information regarding the Buspar was provided to the survey team prior to the exit conference.	W 263	The Group Home Director will be responsible for implementing the acceptable Plan of Correction.	9/17/20

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W 329	PHYSICIAN PARTICIPATION IN THE IPP CFR(s): 483.460(b)(1) A physician must participate in the establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the Individual's initial physician assessment was completed prior to the completion of the ISP (individual support plan) and within 30 days of admission for 1 of 3 Individuals in the survey sample, Individual #1. The findings included: The initial physician assessment was not completed until 03/19/2020. Which was almost 6 weeks after this Individuals admission to the facility (02/07/2020). Individual #1's clinical record included the diagnoses profound intellectual disabilities, downs syndrome, tracheotomy, osteoporosis, and Alzheimer's disease. Individual #1's clinical record included a form titled, PHYSICAL EXAMINATION FORM dated 03/19/2020. The physician signed this form on 03/30/2020. The surveyor was unable to locate an initial assessment in the clinical record prior to this exam.	W 329	The Plan of Correction and procedure for implementing the specific deficiency, the Group Home Director will ensure all individuals initial physician assessment is completed prior to the completion of the ISP and within 30 days of admission. The Group Home Director will ensure all future admissions are in compliance with regulatory guidelines. The Group Home Director will be responsible for implementing the acceptable Plan of Correction.	9/17/20

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W 329	Continued From page 12 The ICF director was asked about a prior assessment during a phone interview on 07/30/2020 at 2:40 p.m. During a follow-up interview with the ICF director on 08/03/2020 at 11:05 a.m., the director verbalized to the surveyor that they did not have a physician assessment prior to this date. That the Individual had been seen by other doctors to meet his needs but his initial assessment was not completed until that date. On 08/03/2020 at 2:05 p.m., the ICF director provided the survey team with a policy titled, "Healthcare Services." This policy read in part, "...During the initial 30 day assessment period, all individuals will have a medical evaluation completed..." No further information regarding this issue was provided to the survey team prior to the exit conference on 08/03/2020.	W 329		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide nursing interventions to meet the needs of the Individual for 1 of 3 Individuals in the survey sample, Individual #2. The findings included:	W 331		

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	49G074	A. BUILDING B. WING	08/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT HERMON MANOR	4769 FRANKLIN TURNPKE DANVILLE, VA 24540

(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 331	Continued From page 13 LPN (licensed practical nurse) #4 documented in the Individuals clinical record on 05/10/2020 that the Individual had a bruise to right side and a "small amount of blood noted while giving am care in vagina area." On 05/28/2020, LPN #8 documented that the Individual had "small amount of yellowish light pinkish bloody discharge coming from vaginal area, no distress noted for individual." No event report was completed for either incident and the physician was not notified. Individual #2's clinical record included the diagnoses of moderate intellectual disabilities, downs syndrome, dementia, and seizures. This Individual was not interviewable. Individual #2's clinical record included the following documentation. "On last round called in room by support, _____ had small amount of yellowish light pinkish bloody discharge coming from vaginal area, no distress noted for individual." This had been documented by LPN #8 and was dated 05/28/2020. "Follow-up note from bruise noted to right side (upper back). Dark purple bruise continues with no bleeding or swelling noted at this time. Small amount of blood noted while giving am care in vagina area. No discharge or odor noted. She has an extra large BM (bowel movement) this am. Will continue to monitor." This had been documented by LPN #4 on 05/10/2020. The surveyor was unable to find any documentation to indicate the physician was notified. On 07/31/2020 at approximately 12:25 p.m., during an interview with the ICF group home director and LPN #4, these staff were asked about the documentation in Individual #2's clinical record dated 05/28/2020 and 05/10/2020. LPN #4	W 331	The Plan of Correction and procedure for implementing the specific deficiency is the Group Home Director will ensure that event reports are completed and the physician is notified as needed. All staff will receive training by September 17, 2020 on when to compile an event report and when to notify the physician. The Group Home Director and/or RN Nurse Manager will ensure that event reports are completed appropriately and the physician is notified accordingly. The Group Home Director and/or RN Nurse Manager will be responsible for implementing the acceptable Plan of Correction.	9/17/20

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W 331	Continued From page 14	W 331		

verbalized to the survey team that Individual #2 did not menstruate. The ICF director verbalized to the surveyor that the Individual did not have any self-injurious behavior. When asked the procedure for completing an event report LPN #4 stated that event reports are completed for any new rash, new skin tears, and redness and are completed the day when they are discovered and that the house manager and the nurse manager are informed.

On 07/31/2020 at approximately 4:00 p.m., during an interview with the ICF director, LPN #4, and RN (registered nurse) #2, these staff stated that the nurse is notifying the physician today and they did not know why the nurse had not notified the physician. The ICF director stated Individual #2 had not had any bloody discharge prior to this. RN #2 stated that is why they wanted to let the physician know to see what if anything they wanted to do. LPN #4 verbalized to the survey team that for the note they had documented on 05/10/2020 it was a scratch or a small area around her vaginal area. LPN #4 stated she had put it in the communication book; there was no swelling or bruising, nothing that would have alarmed them to fill out an event report. Nothing significant to call the physician for.

08/03/2020 at approximately 11:05 a.m., during an interview with the ICF director and RN #2, RN #2 stated they had sent an email to the physician on Friday and called this morning, but had not heard back. RN #2 stated the Individual had not had any further discharge. When asked if this was unusual for this Individual RN #2 stated yes, based on the information they had. These staff stated they had emailed the group home staff to remind them to follow proper protocol and fill out

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W 331	Continued From page 15 and event report. These staff added if an event report had of been completed the physician would have been aware. The point of the event report is so that everyone will be aware. On 08/03/2020 at 2:05 p.m., the ICF director provided the survey team with a copy of policy titled, "Healthcare Services." Subject "Nursing Services." This policy read in part, "...To ensure that individuals will be provided appropriate medical and nursing care by designated Registered Nurses or Licensed Practical Nurses...Provides services to individuals as indicated by the assessment, the IPP (individual program plan), and in accordance with any changes in health status..." The ICF director also provided the survey team with a copy of a document titled, "Instructions for Completion of Event Report." This document read in part, "...If you see a...condition on an individual that has not previously been recorded (Event Report) and is of unknown origin to you, you need to do the following...Complete EVENT REPORT...Document in the COMMUNICATION LOG that you completed an Event Report...Follow the below chain of contacts...Call supervisor or a nurse on the property..." 08/03/2020 at approximately 3:10 p.m., during a follow-up interview with the ICF director and RN #2, these staff stated they had heard back from the physician and they had instructed them to monitor for now. The surveyor reviewed the individuals nursing care plan provided by the facility. The only medical concern listed was constipation.	W 331		

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W 331	Continued From page 16 No further information regarding this issue was provided to the survey team prior to the exit conference.	W 331		
W 341	NURSING SERVICES CFR(s): 483.460(c)(5)(ii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to implement appropriate protective and preventive health measures in regards to social distancing during a pandemic to help prevent the development and transmission of communicable diseases and infection for 2 of 3 Individuals in the survey sample. Individual #1 and #2. The findings included: The facility staff failed to ensure social distancing in the common area in regards to Individual #1 and #2. These two individuals were observed to be sitting side by side and within inches of each other. These individuals were totally dependent on staff for mobility. Neither of these individuals were wearing a face mask. Individual #1's clinical record included the diagnoses profound intellectual disabilities, downs syndrome, tracheotomy, osteoporosis, and	W 341	The Plan for Correction and procedure for implementing the specific deficiency is to encourage social distancing to the extent possible within their home. The procedure for implementing social distancing is educating staff by making information on COVID-19 available to them. An Infection Prevention and Control Plan (COVOD-19) for Developmental Services Residential Programs will be implemented by September 17, 2020.	9/17/20

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W 341	Continued From page 17 Alzheimer's disease. This individual was not interviewable. Individual #1's nursing care plan and ISP (individual service plan) did not include any information related to the COVID19 pandemic. Individual #2's clinical record included the diagnoses of moderate intellectual disabilities, downs syndrome, dementia, and seizures. This individual was not interviewable. Individual #2's nursing care plan and/or ISP did not include any information related to the COVID19 pandemic. On 07/29/2020 at approximately 10:30 a.m., the surveyor observed Individual #1 and #2 sitting side by side and within inches of each other. On 07/29/2020 at approximately 10:50 a.m., the facility staff were observed by the surveyor to separate Individual #1 and Individual #2. These Individuals were now greater than six feet apart. On 07/29/2020 at approximately 10:53 a.m., the facility staff transferred Individual #1 to his room to perform a tube feeding. During this observation, LPN (licensed practical nurse) #6 verbalized to the surveyor that Individual #1 coughed at times but not a lot. At approximately 11:06 a.m., Individual #1 was transferred back to the common area and was placed directly beside of Individual #2. At approximately 11:35 a.m., the facility staff moved Individual #1 away from Individual #2. On 07/29/2020 at approximately 5:12 p.m., during an interview with the ICF director, this director	W 341	The Group Home Director and/or RN Nurse Manager will ensure procedures are followed. The Group Home Director and/or RN Nurse Manager will be responsible for implementing the acceptable Plan of Correction.	9/17/20

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W 341	Continued From page 18 verbalized to the surveyor that the Individuals did not stay up against each other all the time, Individual #1 was usually up against the window, and they did try to spread the Individuals out. The ICF director verbalized to the surveyor that it was unusual to see the Individuals that close together. On 08/03/2020 at approximately 11:05 a.m., during an interview with the ICF director and RN (registered nurse) #2, the ICF director verbalized to the survey team that they did not have a specific infection control nurse. RN #2 then stated that this was seen as a home atmosphere and that is why the Individuals were observed close together, that the Individuals did not go out into the public unless they were seeing the doctor, and the Individuals are not usually close together, as the room is large. The surveyor asked for any education on social distancing RN #2 stated they were referred to the CDC guidelines for taking care of Individuals in the home and gave a date of March 6 as a reference on the CDC website. This information was requested but was not received. The surveyor did receive an email from the facility. However, this email did not reference anything in regards to social distancing. The facility did provide the survey team with a copy of Executive Order Number 63 (2020) signed by the current governor of Virginia in regards to face coverings while inside buildings. Page 3 of this document read in part, "...The requirement to wear a face covering does not apply to following...Any person...unable to remove the face covering without assistance..." When asked about COVID19 testing, the ICF	W 341		

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W 341	Continued From page 19 director stated Individual #1 had been tested before a procedure and was negative, and they had one staff person who was tested and was negative. The ICF director stated they employed 21 staff and 3 of these worked at the day support program that was not attended by these individuals. No further information regarding this issue was provided to the survey team prior to the exit conference on 08/03/2020.	W 341		