STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G068	A. BUILDING _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN ICF	527 RIVERVIEW ROAD MADISON HEIGHTS, VA 24572

(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 03/29/2022. The facility was in substantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	E 000		
W 000	INITIAL COMMENTS An unannounced Focused Fundamental Medicaid re-certification survey was conducted 03/29/2022. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. The census in this four (4) certified bed facility was four (4) at the time of the survey. The survey sample consisted of two (2) individual reviews, Individuals #1 and Individual #2.	W 000		
W 251	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on facility document review and staff interview, the facility staff failed to implement a program plan for one of two individuals, Individual #1. Other staff #2, a residential tech, did not follow the program plan regarding the use of two persons for transfer.	W 251	1. Address the corrective action taken for the problem. An Individual counseling was completed with the staff member who did not implement the program plan using a 2-person transfer during bathing. 2. Address how the facility will identify similar occurrences of the problem. It was discussed during the monthly staff meetings on 2/24/2022 and 3/31/2022 that all program plans are to be followed and those transfers requiring 2 staff members are to be completed by 2 staff members.	4/29/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa M. Hailak	Program Manager	4/26/22

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

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W 251	Continued From page 1 Findings were: On 03/29/2022, at approximately 11:00 a.m., incident and accident reports for the previous three months were reviewed. The following incident reports for Individual #1 were reviewed: "2/16/2022 8:00 p.m. to 9:00 p.m. ...noticed swelling on (Individual #1 name) right lower half of leg was swollen....nurse notified..." "2/17/2022 11:00 a.m....General Indicant Questions: Date of Incident: 02/17/2022 Time of Incident: 10:00 a.m.... What specific medical attention was given? Off-site, On-site. The individual's doctor and nurse were both contacted. It was stated to get pictures of affected area and send them to the providers. After doing so it was noted to make an appointment to receive x-rays of the affected area...Known facts regarding the incident: Staff went to get individual up to start her day. Staff noticed that the individual was very flush and agitated. She was vocalizing more the (sic) her usual. Upon pulling the covers back, it was noticed her right leg appeared very tight (skin), there was bruising on the right inner foot, on the shin and on her toes. The bruises varied in color. Her right foot was swollen, had pitting (edema) when touched. Individual did vocalize more when the right foot/leg was touched. Staff also noticed on individual's left foot she had 2 bruises on her heel..." "2/25/2022 1:30 p.m. to 2:30 p.m. Known facts regarding the incident: (Individual name) was seen for a follow up appointment with ortho in	W 251	Continued from Page 1 3. Identify measures/systemic changes to ensure deficient practices will not recur. Quick reference sheets related to transfer procedures of each individual will be posted on the back of their bedroom doors to be readily accessible to staff. Any changes to an individual's program plan will be shared with staff immediately through email and/or EHR messaging system and reviewed at next staff meeting. 4. Indicate how facility will monitor its performance. The Residential Instructor Counselor or the Residential Manager will review the quick reference sheets at least monthly to ensure information is up to date and make any necessary changes. If changes are made to an individual's program plan mid-month, the quick reference sheet will be updated at that time. The Residential Instructor Counselor, the Night Supervisor, or the Residential Manager will monitor each staff transfer with each individual at least quarterly to ensure proper transfer techniques are followed and will keep record of this documentation of these observations. All staff will be required to take transfer and lifting training upon hire and annually thereafter. 5. Completion Date: 4/29/2022	4/29/2022

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W 251	Continued From page 2 reference of two fractures to right ankle..." On 03/29/2022 at approximately 11:45 a.m., the Residential Manager was interviewed regarding the above incident reports. She was asked if the incident described on 02/17/2022 was the ankle fracture referenced on the incident dated 02/25/2022. She stated, "Yes." She was asked what had happened to Individual #1 to cause the ankle fractures. She stated that an internal investigation had been done. The "Internal Investigation of Incident" dated 02/25/2022 referenced the incident report listed above from 02/17/2022 and summarized it as follows: "The report (02/17/2022) stated that staff noticed that the individual was very flush and agitated. She was vocalizing more than usual. Upon pulling the covers back, it was noticed her right leg appeared very tight (skin), there was bruising on the right inner foot, on the shin, and on her toes. The bruises varied in color. Her right foot was swollen, had pitting when touched. Individual did vocalize more when the right foot/leg was touched...Nurse was notified to come and evaluate the affected areas. (Name) LPN (Licensed Practical Nurse) #2...reported that (individual name) has two fractures of her right ankle. If she were weight bearing, the doctor would recommend surgery...(Name of Individual #1) was prescribed a boot/brace." Also included in the internal investigation were staff interviews and statements. An interview with Other Staff (OS) #2 included the following: "(Name of OS #2) reported that he gave (Name of Individual #1) a bath on 2/16/2022...he stated	W 251		

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W 251	Continued From page 3 there were no issues that day and nothing he can think of that would have caused an injury. He said that he gave her a thorough shower and washed her feet and he didn't notice anything. He reported the he showered (Individual #1) himself as well as transferred he himself to the shower trolley. He stated that he and (LPN #2) were the only ones working that day. Please see physical care plan dated 3/2021 that stated two staff should be with (name of Individual #1) during bath times and transfers. This is part of her fall risk plan. He reported that typically she would have two staff with her... "Findings" from the investigation were: "The injury is attributed Osteoporosis and that makes the resident prone to multiple fractures...treatment plan it is noted, '(Name of Individual #1) is very fragile, due to Osteoporosis and is prone to multiple fractures.' The plan also stated that all transfers should be performed by two staff, and not a single staff member...Based on the report of two staff, transfer procedures appear to have not been followed....the personal care plan states that two staff should be with (Name of Individual #1) during bath times and transfers." On 03/29/2020 at approximately 1:30p.m., RN (registered nurse) #1 was interviewed and asked if X-rays were available from the injury. She looked and stated, "We never got anything back from that initial visit with orthopedics as far as X-rays." A follow up ortho visit note from 02/25/2022 was presented and contained the following: "Closed bimalleolar fracture of right ankle with routine healing...IMAGING/STUDIES: X-ray ankle right...Impression: Show evidence of	W 251		

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W 251	Continued From page 4 bimalleolar ankle fracture. Significant arthritic changes within the ankle and midfoot, osteopenia." Other staff #2 was interviewed on 03/29/2022 at approximately 5:40 p.m. He was asked about the care he provided to Individual #1 on 02/16/2022. He stated, "I was by myself in the house with one of the nurses...he was giving meds and wasn't available. I transferred her from her chair to the shower...I am sure there weren't any problems with my transfer or the shower." He was asked if per Individual #1's treatment plan was she supposed to be transferred with just one person. He stated, "No, that was my bad." He was asked if at the time he transferred her, he was aware that there were supposed to be two people. He stated, "Yes, I knew that, but I didn't have time to wait." On 03/29/2022 at approximately 5:55 p.m., the Residential Manager was asked about the interview with OS #2. She was asked how many staff were normally in the house. She stated, "There were two staff here that day, but we have a floater that goes between this one and (name of house across the yard, also an ICF). He just needed to call that person to come over and help." No further information was received prior to the exit conference on 03/29/2022.	W 251		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455	1) Address the corrective action taken for the problem: The Residential Manager and the Residential Instructor Counselor held individual counseling meetings with all staff that were present on 3/29/22 during the survey. All staff present on 3/29/22 have been assigned to retake the Workplace Safety Standards training in the agency's learning management system, which includes protocols for PPE in ICF Housing. Staff members that did not follow Horizon mask protocols of ICF Homes and were not wearing a mask received disciplinary action.	04/29/2022

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W 455	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to follow infection control procedures for the prevention and control of COVID-19 for 4 of 4 individuals. Upon entry into the facility, staff were observed interacting with individuals and not wearing masks. Findings were: On 03/29/2022 at a 10:00 a.m. upon entry to the facility, staff were observed working with individuals in the common area. None of the staff were observed wearing masks on except for a "nurse" who was working in a different office. Immediately after entering the facility, Residential Tech (Other staff #1) pointed out the book with screening questions to be answered. She was not wearing a mask. She was asked if the staff were or were not required to wear masks in the facility. She shrugged her shoulders and stated, "I'm not wearing one." She was asked if masking was based on vaccine status. She did not answer the question. The Residential Manager arrived at the facility at approximately 10:30 a.m. She was asked what the proper PPE (personal protective equipment) was for facility staff. She stated, "All staff are to be wearing surgical masks." She was informed of the above observations. The facility policy regarding masks/PPE documened the following: "With the recently updated guidelines by the CDC, which advise and promote the use of masks while in the community and likely locations	W 455	Continued from Page 5 2) Address how the facility will identify similar occurrences of the problem: During a staff meeting on 3/31/22, staff were reminded that surgical masks are to be worn at all times and that staff members who fail to comply with these protocols will be disciplined. 3) Identify measures/systemic changes to ensure deficient practices will not recur: All ICF staff will repeat the Workplace Safety and Infectious Disease Plan training at least annually. Measures have been implemented to ensure that all new hires complete this assigned training. 4) Indicate how facility will monitor its performance: ICF supervisors and Residential Managers were instructed on 4/15/22 to be more vigilant in monitoring compliance. Their responsibilities were outlined relevant to monitoring and enforcing protocols. The ICF Program Manager will monitor the supervisors and the Residential Managers to ensure that they are monitoring compliance and resident care with frequent ongoing observation. 5) Completion date: 4/29/22	4/29/2022

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W 455	Continued From page 6 where social distancing is difficult to maintain (Name of Organization) will be implementing the following guidelines effective Monday, April 13, 2020." "(Organization) will be providing masks for employees to use when social distancing is difficult to maintain during face to face encounters with consumers." "Types and Uses of Masks Surgical masks: Employees who interact with clients when social distance guidelines cannot be maintained due to the nature of client interaction." "Length of continuous use Surgical masks: When staff arrive to work at their respective location and need a mask, please visit your sites admin area to pick up a mask...Staff should wear the mask upon arriving to work and discard when you leave." The above information was discussed during an end of day meeting on 03/29/2022. No further information was obtained prior to the exit conference on 03/29/2022.	W 455		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for	W 508	1) Address the corrective action taken for the problem: Provisions will be outlined in the existing policy, CMS COVID-19 Vaccine Mandate, TM 200.08.09 to communicate procedures for additional precautions to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated.	05/13/2022

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

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W 508	Continued From page 7 COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have	W 508	Continued from page 7 2) Address how the facility will identify similar occurrences of the problem: All new, hired staff will be assigned CMS COVID-19 Vaccine Mandate, TM 200.08.09 policy in the agency's electronic training system (SABA) to review. The provisions will be outlined in the policy to communicate procedures for additional precautions to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated. 3) Identify measures/systemic changes to ensure deficient practices will not recur: The Residential Manager and/or the Residential Instructor Counselor will monitor the training system(SABA) to ensure all staff are in compliance with their orientation training including the CMS COVID-19 Vaccine Mandate, TM 200.08.09 policy. 4) Indicate how facility will monitor its performance: The Residential Manager and/or the Residential Instructor Counselor will communicate with the agency's training coordinator to ensure the CMS COVID-19 Vaccine Mandate, TM 200.08.09 policy is assigned annually for all staff or if there are revisions to the policy. 5) Completion Date: 05/13/22	05/13/2022

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W 508	Continued From page 8 received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the	W 508		

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W 508	Continued From page 9 authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility failed to develop policies and procedures for additional precautions to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated.	W 508		

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W 508	Continued From page 10 Findings were: On 03/29/2022 at approximately 10:30 a.m., information was requested from the Residential Manger regarding staff vaccination status, policies and procedures regarding vaccinations, percentage of staff vaccinated, type of vaccine received, etc. Per the administrator, all staff were either vaccinated or had approved exemptions. A list of staff members and their vaccination status was presented at approximately 1:30 p.m. Five (5) staff members were listed as unvaccinated with approved exemptions, four (4) religious, and one medical. At approximately 4:00 p.m., the policy "CMS COVID-19 VACCINE MANDATE TM 200.08.09" was presented by the agency compliance officer, the Residential Manager, and the Program manager. The policy documented, "The Centers for Medicare and Medicaid Services (CMS) requires that all employees, contractors and volunteers affliated with (Agency) must be fully vaccinated with an approved COVID-19 primary series for the vaccine or have an approved medical deferment, medical exemption, or religious exemption. In addition, CMS requires that (Agency) must ensure the implementation of safety measures to mitigate the spread of COVID-19. The intent of the policy is to clarify the COVID-19 vaccine mandate provisions and define procedures for verification of vaccination and for requesting an exemption from vaccination." Section "J. Mitigation of transmission and spread of COVID-19 for all staff and visitors. (Agency)	W 508		

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W 508	Continued From page 11 workplace safety standards and protocols to mitigate risk of infection for staff and visitors are addressed in detail in the following policies and procedural documents: * (Agency) COVID -19 (COOP Addendum) * (Agency) Infectious Disease Response Plan-COVID-19 * (Agency) Infection Control Policy and Procedures * (Agency) Exposure Control Plan * (Agency) Succession Plan * (Agency) ICF Disaster Preparedness Plan All employees are informed and trained regarding these documents and each of these cited plans is posted on (Agency) intranet to ensure they are available to all employees." There was nothing in the policy detailing additional precautions to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated. The compliance fficer was asked what additional precautions were in place to mitigate the transmission and spread of COVID-19 by unvaccinated staff. He stated that all staff followed the same precautions. A discussion was held regarding the regulation and the requirements set forth by that regulation regarding what was to be included in the policies and procedures. He stated, "That is your interpretation...We don't interpret it that way...we go above and beyond and have since the beginning of the pandemic...all of our staff wear surgical masks and we social distance." The compliance officer was told that upon arrival	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G068	A. BUILDING _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN ICF	527 RIVERVIEW ROAD MADISON HEIGHTS, VA 24572

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W 508	Continued From page 12 at the facility earlier that day (03/29/2022), staff were observed working with clients and were not wearing masks, including a staff member listed as "unvaccinated" on the staff vaccination list provided. He stated, "We do not single out and call attention to any staff that are not vaccinated. The program managers and workers do not know who is and who isn't vaccinated...we don't set them apart, we treat everyone the same...we wear surgical masks and we social distance." The Program Manager was asked if all staff had been fit tested for N95 masks, if N95 masks were available, and if there was any shortage of PPE. She stated, "We are all fit tested and we have N95's, PPE is not a problem." She was asked how staff working in the facility were able to "social distance" with individuals who required feeding, bathing, dressing, etc. She stated, "We can't." No further information was received prior to the exit conference on 03/29/2022.	W 508		