STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G023	A. BUILDING _____ B. WING _____	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSTONE RESIDENCE	32 ANGUS DRIVE WAYNESBORO, VA 22980

(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 09/20/22. The facility was in substantial compliance with 42 CFR Part 483.73, 483.475, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 09/20/22. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 14 certified bed facility was 7 at the time of the survey. The survey sample consisted of 3 Individual reviews (Individuals #1 through #3).	W 000		
W 261	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to designate and use a specially constituted committee member	W 261	W261 – 1. Facility will identify and secure at least one individual with no ownership or controlling interest in the facility for specially constituted committee membership. 2. Facility will identify and secure at least one individual with no ownership or controlling interest in the facility for specially constituted committee membership as the specially constituted committee serves all clients within facility. 3. Facility will review and update committee membership list to ensure requirement is met for committee membership including that of an individual with no ownership or controlling interest in facility. Facility will revise the specially constituted committee meeting attendance sheet to include names and roles of all committee members, documentation to reflect that each member was invited, and whether they did or did not attend meetings as scheduled, and signature & date from all members who attended meetings. 4. During each specially constituted committee meeting (biannually), committee will review specially constituted committee member ship list to ensure membership meets requirements and to monitor for any changes to membership.	11/4/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Marie Harris | ICF Assist. Manager | 9/30/22

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 261	Continued From page 1 consisting of a person and/or persons with no ownership or controlling interest in the facility. Findings include: During clinical record review for Individual's #1 through #3 on 09/20/22, the SCC (Specially Constituted Committee) meeting minutes and member attendances were reviewed. The SCC meeting minutes and SCC committee attendee signature pages from November 2021 to present September 2022 were reviewed and revealed that the committee did not have any "persons with no ownership or controlling interest" or any 'impartial outsider that would not have an "interest" represented by any other of the required members or the facility itself.' On 09/20/22 at approximately 1:45 PM, the administrator and QIDP (qualified intellectual disabilities professional) were made aware of the above finding and asked if they had such a person as a member of the SCC. The administrator stated that they did not. No further information and/or documentation was presented prior to the exit conference on 09/20/22 at 5:30 PM.	W 261	W361 – 1. 9/23/22 – notified pharmacy of facility's citation of failure to assure availability of prescribed medications due to not being delivered on time by pharmacy. 9/28/22 – email & phone call w/Pharmacy Manager to discuss details related to the prescribed medication not being delivered on time and resulting in missed doses of antibiotic for said client. Scheduled inservice with pharmacy for 10/18/22 to review procedures for ensuring medications are delivered in reasonable timeframe and to determine revisions for Standard Operating Procedure "Medication Management & Pharmacy Services". 2. 9/28/22 – phone call with Pharmacy Manager to discuss details related to prescribed medications not being delivered on time and process for preventing future errors from impacting other clients at Greenstone as the consulting pharmacy provides medication services for all clients at Greenstone. Scheduled inservice with pharmacy for 10/18/22 to review procedures for ensuring medications are delivered in reasonable timeframe and to determine revisions for Standard Operating Procedure "Medication Management & Pharmacy Services". 3. 10/18/22 – ICF Leadership and Medical Support Specialists to attend in-service with Pharmacy Manager and Account Manager to review facility's Standard Operating Procedure	11/4/2022
W 361	PHARMACY SERVICES CFR(s): 483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain	W 361	"Medication Management & Pharmacy Services to establish a more detailed workflow and communication process between facility, pharmacy, and prescriber. Revise Standard Operating Procedure "Medication Management & Pharmacy Services". Review standard operating procedures and recommendations relevant to assure timely receipt of medications from pharmacy (include communications with,	

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W 361	Continued From page 2 a licensed pharmacy. This STANDARD is not met as evidenced by: Based on the facility's incident/accident abuse review, clinical record review and staff interviews, the facility staff failed to ensure medications were available from the pharmacy for administration to one of three individuals (Individual #1). Findings include: On 09/20/22 during a review of the facility's incident/accident abuse review it was found that Individual #1's antibiotic medication was not available for administration. Individual #1's clinical records were reviewed and revealed an order dated 06/22/22 for Doxycycline 75 mg (milligrams) (start date: 06/23/22) to be administered BID (twice daily) for 7 days. Upon further review the individual did not get the ordered doses (a.m. or p.m.) on 06/23/22 and did not get the morning dose on 06/24/22. On 09/20/22 at approximately 3:00 PM, the administrator was interviewed regarding the above information. The administrator stated that the medication had been ordered, but had not been delivered from the pharmacy and stated that isn't an uncommon occurrence that the facility doesn't always get medications on time as ordered by the physician. No further information and/or documentation was presented prior to the exit conference on 09/20/22 at 5:30 PM.	W 361	pharmacy, notifications to supervisors, notification to prescriber, prescriber recommendations, and documentation of all communications). Revise Standard Operating Procedure "Medication Management & Pharmacy Services". Review revised procedures with ICF Leadership Team, ICF Med Techs, and ICF Medical Support specialists. 4. Facility to monitor performance during routine communications with pharmacy and through review of facility documentation during quarterly safety meetings.	

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W 440	Continued From page 3	W 440	W440 –	11/4/2022
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure evacuation drills were performed on each shift quarterly (every three months). Findings included: On 09/20/22 at 9:00 AM, the facility's evacuation drills were reviewed. The evacuation drills reviewed for 2022 documented that an evacuation drill was completed in the second quarter (April, May, June 2022) on May 15, 2022 at 12:45 PM and on May 31, 200 at 3:30 PM. No other evacuation drills were found for the second quarter of 2022. On 09/20/22 at 10:10 AM, the administrator stated that she was unable to find anything else for that quarter and stated that the facility had only completed two drills/evacuations for the second quarter of 2022. The facility's policy titled, "Evacuation Drill Procedures" documented, "...Unannounced, completed evacuation drills are held once every quarter for each shift (monthly)...held under varied conditions, at different times of day and night...using escape routes in various weather conditions...an evacuation record is completed for each drill and signed by the staff person implementing the drill...Copies of the drills are kept at the home and reviewed by the safety committee..."	W 440	1. Existing Standard Operating Procedure "Evacuation Drill Procedures" will be updated to reflect W440, "There must be an evacuation drill each shift at least quarterly" – to eliminate the existing indication of a requirement to "conduct an evacuation drill monthly". Current operating procedure will also be updated to identify specific ICF team members who will be responsible for conducting evacuation drills. Evacuation drill schedule will be revised to reflect that drills are conducted quarterly on each shift. The updated drill schedule will include a section for the drill facilitator to document which shift had an evacuation drill and signature/date of who conducted the drill. Team members identified as being responsible for conducting drills will add evacuation drill reminders to Outlook calendars. 2. The revised evacuation drill schedule will include a checklist for ensuring that an evacuation drill was conducted on each shift quarterly. 3. Existing Standard Operating Procedure "Evacuation Drill Procedures" will be updated to reflect W440, "There must be an evacuation drill each shift at least quarterly" - – to eliminate the existing indication of a requirement to "conduct an evacuation drill monthly". Current operating procedure will also be updated to identify specific ICF team members who will be responsible for conducting evacuation drills. Evacuation drill schedule will be revised to reflect that drills are conducted quarterly on each shift. The updated drill schedule will include a section for the drill facilitator to document which shift had an evacuation drill and signature/date of who conducted the drill. Team members identified as being responsible for conducting drills will add evacuation drill reminders to Outlook calendars. The revised	

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W 440	Continued From page 4 On 09/20/22 at 12:10 PM, the administrator QIDP (qualified intellectual disabilities professional) were again made aware of the above information. No further information and/or documentation was provided prior to exit conference on 09/20/22.	W 440	W440 – Continued evacuation drill schedule will include a checklist for ensuring that an evacuation drill was conducted on each shift quarterly. 4. Facility will monitor performance during quarterly safety meetings by reviewing the drill schedule and evacuation drill records to ensure all drills were conducted as required and reviewing schedule for upcoming evacuation drills.	
W 446	EVACUATION DRILLS CFR(s): 483.470(i)(2)(ii) The facility must make special provisions for the evacuation of clients with physical disabilities. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to include special provisions for the evacuation of clients with physical and/or intellectual disabilities in the facility's evacuation plan. Findings include: During a review of the facility's fire drills and emergency evacuations on 09/20/22 at approximately 9:00 AM, the evacuation plan (policy) was reviewed and did not include special provisions for individual's in this facility with physical and/or intellectual disabilities. On 09/20/22 at approximately 9:30 AM, The administrator was asked for any information regarding the evacuation plan. The administrator stated "We have an actual response plan that tells us what to do in an actual event, such as a fire, but not specific plan that outlines special provisions for the individuals." The actual response plan was presented. The response plan documented, "...all staff and	W 446	W446 – 1. Client's treatment plan updated to have a wheelchair available for physical support, as needed during fire drills to ensure safe and timely evacuation. The supportive equipment will be kept in an easily accessible area. Clients' treatment plan was updated on 9/20/2022 to reflect the change. 2. Leadership team will review each client's current treatment plan, and past fire drill documentation. If there are any physical or medical issues that have been documented, the leadership team will discuss any supports that could be put in place for the client. The QIDP will make amendments to their plan. 3. Evacuation drill form will be edited to clearly indicate physical, medical, or behavioral disabilities that interfere with evacuating the building safely. A section will be added beside each client's name to indicate the disability that was present during the drill, along with a comment box to further explain the event. 4. Safety meetings are held quarterly. During safety meetings, team members will discuss each fire drill. If there are any disabilities "checked" the comment section will be reviewed. Safety team members will discuss the concerns and make changes if warranted.	11/4/2022

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W 446	Continued From page 5 individuals exit the facility immediately...doors, windows and fire barriers should be closed (If possible)...assist individuals with returning to the the building, if clearance is given..." The information did not include and/or identify individuals with medical and/or physical/cognitive/intellectual disabilities and did not clearly specify any special evacuation procedures and/or equipment for these clients. The fire/evacuation drills (not the evacuation plan) were then reviewed and included a sheet for each drill completed since the last survey. The sheets included the name of individuals, and the response (physical assist, verbal prompts/assist, independent), but did not specify or list any special provisions (equipment/techniques) or identify individuals that required the provisions. The individual's (all individual's) demographic information was reviewed and documented that five of the individual's were 'mobile' and that identified that one individual was non-mobile and one was ambulatory. The information did not specify any type of special provisions/considerations and/or equipment regarding drills and/or evacuations. On 09/20/22 at approximately 11:55 AM, the administrator and QIDP (qualified intellectual disabilities professional) were made aware of the above information. The administrator stated that some of that information is listed separately in an IPP (individual's program plan). The IPP was reviewed for Individual's #1, #2 and #3. The information was listed for Individual #1's IPP, but was not included in the facility's evacuation plan. The administrator and QIDP agreed that all of the	W 446		

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W 446	Continued From page 6 individual's in the facility have some type of physical and/or cognitive/intellectual limitations or impairments and agreed that information should be included in there plan. No further information and/or documentation was presented prior to the exit conference on 09/20/22.	W 446		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure infection control practices to prevent the spread of COVID 19 were implemented. Findings include: Upon arriving at the facility on 09/20/22 at 6:55 AM, two staff members were observed without mask/facial coverings. On 09/20/22 at 7:00 AM, DCS (direct care staff) #1 answered the door and had her shirt/jacket pulled up towards her face and stated, "I forgot my mask." Another staff member, identified as DCS #2 was also without a mask/face covering. DCS #2 went and retrieved two masks by a side door (screening entrance) and donned a mask and then handed the other mask to DCS #1.	W 454	W454 – 1. 9/20/2022 ICF Leadership spoke to DSC #1 and DSC #2 who were not wearing masks and reminded them of the requirement to do so. ICF Leadership has scheduled a meeting with the same two employees to again review the expectations for wearing a mask – this conversation to be documented within a supervision note that with signatures from both employees and ICF Leadership. 2. Review masking requirements with all existing employees via email communication and provide printed documentation that all employees will read, sign, date. A copy of the signed & dated documentation to be filed in each employee's file. 3. Review masking requirements with all existing employees via email communication. Review masking requirements with all new employees. Update program orientation to include review of infection control practices specific to wearing a mask. Provide printed documentation that all employees will read, sign, date. A copy of the signed & dated documentation to be filed in each employee's file. 4. ICF Leadership will monitor performance through training, communications with employees, and direct observation of employees to ensure that masks are being worn.	11/4/2022

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W 454	Continued From page 7 On 09/20/22 at approximately 8:00 AM, the administrator and QIDP (qualified intellectual disability professional) were made aware of the above observations. At approximately 11:00 AM, the facility's policy and procedures for COVID 19 were reviewed. The policy documented, "...face covering...completely covers the nose and mouth...is secured...fits snugly over the nose, mouth and chin...Staff will be provided with PPE (personal protective equipment) needed to protect themselves and the individuals including surgical masks...goggles/face shields, gowns, fit tested N-95 masks, hand sanitizer..." On 09/20/22 at approximately 5:15 PM, the administrator and QIDP were asked what were the expectations for infection control practices regarding COVID-19. The administrator stated that the staff should be wearing a facial covering upon entrance to the facility and stated that the masks are readily available and located inside of the door, at the screening area and are to be donned prior to reporting to work. No further information and/or documentation was presented prior to the exit conference on 09/20/22 at 5:30 PM.	W 454		
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	W 508	W508 – 1. Communicate to employee in question the requirement to be tested weekly due to employee having an approved exemption from COVID-19 vaccination. Facility to begin implementing weekly COVID 19 testing with employee in question. Testing to be conducted at the beginning of the employee's work week at the start of employee's shift. Test results to be reported to ICF Leadership Team and ICF Medical Team. Test results to be documented in testing log.	11/4/2022

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W 508	Continued From page 8 this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for 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	W 508	2. Implement weekly COVID 19 testing for any employee with an approved exemption from COVID 19 vaccination. Testing will be conducted at the beginning of the employee's work week employee's shift begins. Test results to be reported to ICF Leadership Team and ICF Medical Team. Test results to be documented in testing log. 3. Review and revise existing policy "COVID 19 Testing and Vaccination". Review revised policy with all existing employees and new employees. Require new and existing employees to sign and date the revised policy. Maintain a signed copy of the policy in employee file. Update program orientation checklist to include a section that indicates "COVID 19 Testing and Vaccination" policy has been reviewed with employees. 4. ICF Leadership Team and ICF Medical Team will monitor the testing log at least weekly to ensure that COVID 19 testing is conducted on a weekly basis for employees with an approved exemption. ICF Leadership Team will review the testing log with the ICF Safety Committee on a quarterly basis to confirm that required testing is being implemented and documented as required each week for employees with an approved exemption.	

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W 508	Continued From page 9 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have 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	W 508		

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W 508	Continued From page 10 applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the 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 the COVID-19 vaccination review, staff interview and facility document review, the facility staff failed to implement policies and procedures	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G023	A. BUILDING _____ B. WING _____	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSTONE RESIDENCE	32 ANGUS DRIVE WAYNESBORO, VA 22980

(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 508	Continued From page 11 regarding weekly testing for an unvaccinated staff member with a medical exemption. Findings include: On 09/20/22 at approximately 12:00 noon a review of the facility's COVID-19 staff vaccination status was reviewed. The facility staff had an unvaccinated staff member, identified as DCS (direct care staff) #3. DCS #3 was a contract employee and had been granted a medical exemption. The facility's staff vaccination rate was calculated at 100 percent. The facility's policy and procedures related to employee COVID-19 vaccinations and testing documented the following: "...IV. A. Requirements: Vaccination...the following individuals must be fully vaccinated against COVID-19...employees and direct care contractors with the ICF program...(5) direct service contractors may provide proof of an approved exemption...C. Testing...(i) Employees are contractors who are granted vaccination exemptions must submit to COVID-19 testing as defined in Section III above at least once a week...IV. Contingencies & Penalties...Employees who are not vaccinated for any reason must submit to weekly COVID-19 testing and strictly adhere to universal source control...ii) Employees or contractors who are required to submit to weekly testing and fail to submit a clear COVID-19 test may not report for work until a clear test is provided..." Section III of the above policy was reviewed for clarification. There was no further information	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 508	Continued From page 12 regarding weekly testing as described above. On 09/20/22 at approximately 3:45 PM, the administrator was asked about the above policy referring to Section III about weekly testing and that no information was found regarding that. The administrator reviewed the policy and stated that there is no additional information regarding testing in Section III. The administrator was asked if this employee was new. The administrator stated that DCS #3 had been with them for approximately one year and they (the facility) were not conducting weekly testing, as outlined in the facility's policy. No further information and/or documentation was presented prior to the exit conference on 09/20/22 at 5:30 PM.	W 508		