August 2, 2023

Jo Jordan, LTC Supervisor
Divisiόn of Long -Term Care Services
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, suite 401
Henrico, Virginia 23233-1485

RE: VersAbility Resources Saunders House
Hampton, Virginia
ICFIID: 49G007

Dear Ms. Jordan:

Enclosed is the Plan of correction for Saunders House including the completed form CMS-2567 which was received on July 24, 2023.

Please contact me at (757) 876-7928 if you have any questions.

Sincerely,

Linda R. Kerns, LCSW
Chief Community Living Officer

cc: Ebonee Atkinson, Director, Community Living
Joyce Cofield, Assistant Director Community Living
Rosilyn Dodson, Assistant Director, Community Living
Erica jones, Community Living Manager

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

PRINTED: 07/24/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G007	A. BUILDING ______ B. WING ______	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERSABILITY RESOURCES SAUNDERS HOUSE	**149 SAUNDERS AVE HAMPTON, VA 23666**

(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 07/12/23 through 07/13/23. 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 (ICF/IID). No emergency preparedness complaints were investigated during the survey.	E 000	W249 Facility failed to ensure Individual #3 in the survey was given the opportunity to assist to her Individual Program Plan (IPP).	
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 07/12/2023 through 07/12/2023. 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 6 certified bed facility was 6 at the time of the survey. The survey sample consisted of 3 Individual reviews (Individuals 1 through 3).	W 000	1. DSP #1 did not provide Individual #3 the opportunity to attempt to perform her IPP/ISP goal related to applying her deodorant. DSP #1 in stead applied the deodorant for Individual #1. Manager met with DSP #1 to discuss and review proper procedure to implement Individual #3's "Apply Deodorant" outcome on 7/13/23. Staff admitted she should have followed the procedures outlined in the IPP/ISP for Individual #3. Manager will conduct an observation of DSP #1 implementing this outcome by August 4, 2023 and document DSP #1's ability to follow proper interventions on the Staff Observation form.	7/13/23 8/4/23
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249	2. This was an isolated incident and did not affect other residents within Saunders House and/or any other ICF-IID residents residing within the Community Living program. 3. All ICF-IID facilities operated by VersAbility Resources will discuss with their staff the importance of	7/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda K. Kerns LCSW	Chief Community Living Officer	8/2/23

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 249	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, the facility staff failed to ensure 1 of 3 individuals (Individual #3) in the survey was given the opportunity to assist with applying her deodorant according to her Individual Program Plan (IPP). The findings included: Individual #3 was admitted to the facility on 12/30/08. The primary diagnoses included severe intellectual disability, Cerebral Palsy, and seizure disorder. On 07/12/23 at approximately 5:20 p.m., Individual #3 was observed given a shower by Direct Support Personnel (DSP) #1. After the shower was given, DSP dried Individual #3 off with a towel, applied lotion the skin and put on her deodorant. Individual #3 was not given the opportunity to assist with applying her deodorant. The Support Data sheet dated July 2023 indicated Individual #3, required partial support, applying her deodorant after each time she bathes for the next nine months. Staff instructions included the Individual #3 will bring her personal hygiene kit, give one verbal cue before each task when to pick up her deodorant, open her deodorant, apply her deodorant under both her arms. If Individual #3 does not respond to verbal cues, then staff will provide physical support to Individual #3 with putting on her deodorant. DSP #1 was interviewed on 07/13/23 at 10:30 a.m. She stated Individual #3 refuses to apply	W 249	following the written IPP/ISP for all residents during their monthly staff meetings conducted in August 2023. 4. The Managers of all ICF-IID residential facilities operated by VersAbility Resources (along with the Assistant Manager) will continue to monitor and observe proper implementation of their resident's IPP/ISP goals/outcomes performed by DSPs. This will occur at random, at least quarterly, to ensure proper implementation of their current ISP goals/outcomes. This will assist in monitoring whether or not interventions are occuring as written. If discreprencies or changes are required to implement the goals/outcomes, DSPs/Managers will communicate this recommendation to the Support Coordinator. The Support Coordinator and/or IDT Team will determine whether or not there is a need for additional changes/revisions to the IPP/ISP based on prior data collected, Guardian/Individual preferences, change in level of care, etc. The Support Coordinator will also conduct at random observations within the plan year to ensure proper implementation of outcomes.	8/18/23 Ongoing each Quarter

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W 249	Continued From page 2 her own deodorant. DSP reviewed Individual reviewed Individual #3's written plan and stated she did not give DSP the opportunity to put on her own deodorant. An interview was conducted with the Assistant Director of Operations on 07/13/23 at 5:59 p.m. She stated the DSP should have offered Individual #3 the opportunity to assist with applying her deodorant. She stated the task should be followed as written in the plan. She stated if the resident refused or continue to refuse the task, the Support Coordinator (SC) is to be notified and the individual's plan to be reviewed. On 07/13/23 at approximately 6:05 p.m., the above information was shared with the Chief Community Living Officer, Assistant Director of Operations, and Director of Community Compliance. The facility did not present any further information about the findings.	W 249	W 440 Facility failed to ensure a fire drill was conducted on each shift at least once in each 3 month period between July 2022 and July 2023.	
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 interviews, facility record review, and the facility's policy, the facility staff failed to ensure a fire drill was conducted on each shift at least once in each 3-month period. The findings included: On 07/13/23, the Community Living Manager provided copies of the monthly fire and evacuation drills for the last 12 months. The documents reviewed was missing the day shift fire drill for July 2022. She stated she was sure it	W 440	1. Saunders House fire drill for July 2022 was missing from the monthly fire drills submitted between July 2022 and July 2023 to the Surveyor on 7/13/23. All other drills were present within the past year and alternated among various shifts. A new procedure will be developed by 8/15/23 to assist Managers with maintaining copies of all fire drills conducted monthly. Copies of the original drill paperwork will be placed inside a folder (electronically) for Saunders and used for back-up documentation. Additional folders will house fire drills conducted per shift for each ICF-IID facility operated by VersAbility Resources . 2. This deficiency affected all residents at Saunders House. All other facilities operated by VersAbility Resources, Inc. will also be audited to ensure other residents of the agency are not affected by this deficiency.	8/15/23 8/15/23

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W 440	Continued From page 3 was done but cannot provide documentation. She stated fire drills are done to ensure the individuals can exit the building safely and in a timely manner. The Assistant Director of Operations was interviewed on 07/13/23 at approximately 5:59 p.m. She stated fire drills are to be done monthly and, on each shift, (7-3, 3-11 and 11-7) every quarter. On 07/13/23 at approximately 6:05 p.m., the above information was shared with the Chief Community Living Officer, Assistant Director of Operations, and Director of Community Compliance. The facility did not present any further information about the findings. The facility's policy titled Conducting Fire/Safety Drills revised on 09/20. It is the facility's policy of Community Living to conduct fire drills at the facility once per month and safety drills quarterly. The Community Living Manager and staff will be responsible for conducting, monitoring, and documenting each drill-including putting the fire alarm system in and out of the test. Procedure: A fire and safety drill will be conducted monthly, on varying shifts, during varying times, and during various weather conditions (e.g., rain snow, cold, not, etc.).	W 440	3. All ICF-IID facilities operated by VersAbility Resources will conduct an internal audit of their facility by 8/15/23 to identify whether or not all fire drills have occurred per shift within the past year. 4. Managers will maintain folders identified for housing their fire drills and will monitor completion of the drills monthly. All missing drills will be noted and reported to the Asst. Director of Community Living-Programs. Disciplinary action may result due to non-compliance of this requirement. In addition, the Social Worker will conduct additional audits of the fire drills at least quarterly to ensure compliance with these procedures.	8/15/23 Ongoing monthly Every quarter