STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G045	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST NECK RESIDENCE	**2752 WEST NECK RD VIRGINIA BEACH, VA 23456**

(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 9/12/23 through 9/14/23. 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. No emergency preparedness complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 9/12/23 through 9/14/23. 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. Two complaints were investigated during the survey: VA00050364 was substantiated without a deficiency and VA00053371 was unsubstantiated due to lack of evidence. The census in this 24 certified bed facility was 19 at the time of the survey. The survey sample consisted of 5 Individual reviews (Clients 1 through 5).	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility staff failed to ensure the living environment was safe and sanitary. The findings included: During the course of the survey, observations	W 104		

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

Natacha Dolson | Dr. Natacha Dolson | Developmental Services Division Director | 10/18/2023

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 104	Continued From page 1 revealed Jenny's Place front porch was with a broken wooden pallet and two broken rocking chairs. The front door was with a large amount of a dark substance, some which smeared when wiped with your hand. In the kitchen multiple cabinet doors were absent from the cabinets making stored items visible, and the floor drain beneath the three-compartment sink was with a large amount of a dry, dark and hard substance. Terry's Place front porch contained two bags of low-temperature rock salt on the front porch. On 9/14/23 at approximately 2:15 PM an interview was conducted with the two House Supervisors. House Supervisor #2 stated they had started the kitchen remodel prior to the pandemic but there had been changes in staff at the cabinet company which required them to restart the process again. House Supervisor #2 further stated they recently picked the cabinets out again and they are waiting for installation. House supervisor #2 also stated she had power washed the porches and when it was brought to her attention about the dark substances, she worked on removing the substance. During the last survey conducted 1/24/2020, the facility staff stated the kitchen was in the process of a remodel which was to include new cabinets, countertops, a stove top and an oven. On 9/14/23 at approximately 3:00 PM the above information was shared with the two House Supervisors, the Quality Representative, the Nurse Supervisor and two other Corporate Personnel. An opportunity was afforded for the staff to provide additional information, a Corporate Representative stated they would	W 104	Immediately upon being notified of the broken items and rock salt on the porch, the items were removed. The floor drain beneath the three-compartment sink was also cleaned on the same day as the inspection. Moving forward, the Program Supervisor will ensure that monthly inspections of the facility occur and that all noted areas of attention are immediately addressed. The Program Supervisor has also held a meeting with the cleaning contractor to discuss expectations moving forward and a maintenance spreadsheet was implemented to document and track all repair and cleaning needs. A meeting with the landlord was held on September 18, 2023, to conduct a full walkthrough of the facility and discuss the importance of the repair of the current cabinets and the completion of the kitchen remodel. The landlord has been	09/22/23 12/01/23

			made aware of the urgency to complete this project as quickly as possible. During the monthly inspections, the Program Supervisor will ensure that the agreed-upon maintenance has taken place and follow-up as needed to ensure completion. A maintenance and cleaning spreadsheet was created to track all repairs and cleaning needs.	

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W 104	Continued From page 2 forward the identified environmental concerns to Maintenance.	W 104		
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. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, the facility staff failed to ensure 1 of 5 individuals (Individual #5) left hand Palmar roll was applied to prevent further decrease in range of motion and contracture according to his written plan. The findings included: Individual #5 was admitted to the facility on 06/17/2008. The primary diagnoses included Moderate Intellectual Disability, Traumatic Brain Injury (TBI), left spastic hemiplegia and organic mental disorder. A review of Individual #5's Physical Management Plan revised on 05/20/23 indicated the use for Palmar Roll on his left hand during the daytime hours. On 09/13/23 at 12:30 p.m., Individual #5 was	W 249		

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W 249	Continued From page 3 observed at the day program without the Palmar Roll in his left hand. On the same day at 3:30 p.m., Individual #5 returned to the facility, the left hand remained without the Palmar Roll. On the wall below the television (TV) in a plastic bag were two (2) Palmar hand rolls. Direct Staff Support (DSP) #2 was interviewed on 09/14/23 at 9:40 a.m. She stated Individual #5 refused the Palmar roll. She stated she forgot to document the refusal in Care Tracker and did not notify the Supervisor/QA of the refusal. An interview was conducted with the Clinician II/Human Services on 09/14/23 at 12:00 p.m. She stated the facility does not have a policy specific to splint/devices but follow the physician orders and plan of care. On 09/14/23 at approximately 6:05 p.m., the above information was shared with the House Supervisor I & II and Corporate. Supervisor #1 stated if Individual #5 refused to allow staff to apply his Palmar roll, the refusal should have been documented in Care Tracker and the day program notified.	W 249	The Qualified Developmental Disabilities Professional will re-train all direct support professionals assigned to the West Neck facility on the appropriate implementation and documentation of individual support plans, specifically discussing the process of documenting refusals. In addition, the facility will purchase an additional palmar roll to keep in the individual's backpack in case he changes his mind about wearing them while at his day support program.	10/20/23
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:	W 440	The Program Supervisor has revised the fire drill document to clearly identify which month each shift will complete their drills. The Program Supervisor will review documentation of drills on a monthly basis to ensure compliance.	11/01/23

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W 440	Continued From page 4 On 09/12/23, the facility provided copies of the monthly fire and evacuation drills for the last 12 months. The documents reviewed were missing the evening shift fire drills for February and July 2023. An interview was conducted with Supervisor #1 on 09/13/23 at 2:22 p.m. He stated according to the documents provided; fire drills were done monthly but were not being alternated on different shift. He stated the fire drill completed in 07/23 should had been done on the evening shift and not the night shift. Supervisor II was interviewed on 09/14/23 at 9:40 a.m. She stated the fire drill completed in 02/23 should had been completed on the evening shift and not the morning shift. On 09/14/23 at approximately 2:55 p.m., the above information was shared with the Supervisor I, Supervisor II and Corporate. The facility did not present any further information about the findings. The facility's policy titled Fire Safety revised on 01/24/23. The purpose of fire drills is to promote the health and safety, independence and learning of the clients of the Intermediate Care Facilities (ICF) during fire emergencies. 3. Procedures: Evacuation Drills -Evacuation drills will be conducted by the Safety and Health Officer or a designee on a monthly basis during different shifts (morning, evening, and overnight) to ensure that each staff person has participated in a drill at least quarterly.	W 440		

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W 440	Continued From page 5 ,	W 440		