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

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 _____	10/17/2023

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
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted on 10/16/21 through 10/17/21. 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 4 certified bed facility was 2 at the time of the survey. The survey sample consisted of 2 Individual reviews (Individuals 1 through 2).	W 000	1.)Address the corrective action taken for the problem. •Residential Night Supervisors will complete a wheelchair inspection form weekly for each individual using a wheelchair. •The Residential Night Supervisor will enter a Maintenance Ticket for any repair needed and communicate through email with the Residential Manager and Instructor Counselor (Assistant Manager) the issue needing fixed and that a maintenance ticket was entered. •The Residential Night Supervisor will turn the wheelchair inspection form into the Residential Manager upon completion. •ICF/IID staff will complete an online training, including video regarding how to properly load and unload individuals using wheelchairs in a wheelchair-accessible van.	11/30/23
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, staff interview, and facility document review, the facility failed to maintain specialized equipment for one of 2 residents in the survey sample. Resident #1's (R1) wheelchair brake failed causing R1 to roll and tip over. The Findings Include: Resident #1 was admitted to the facility on 1/2/2019 with a profound intellectual disability and medical diagnoses that included Epilepsy and osteoporosis.	W 436		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa M. Harbach | TITLE: Program Manager | (X6) DATE: 11/8/23

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 436	Continued From page 1 On 10/16/23, review of incident reports indicated, on 3/24/23, R1's wheelchair was disconnected from the tie downs (wheelchair securement devices) in the facility's van, wheelchair brakes were applied, and the staff member (identified as Direct Care Staff, DCS #1) then turned to release another resident, when R1's wheelchair rolled from the van and tipped over. According to this documentation, R1 was then transported to the emergency department via medical transport. Review of the emergency department report indicated R1 had small abrasions to the head, hands, and knees. According to this documentation, a CT scan (diagnostic radiological imaging) was completed, which showed no signs of acute intercranial hemorrhage or other concerns, and R1 returned back to the facility without additional treatments. On 10/16/23 at 1:30, the assistant manager (Administrative Staff, AS #3) was interviewed. AS #3 verbalized that DCS #1 had released R1 from the tie downs on the van and set the brake and while releasing another resident from the wheelchair tie downs DCS #1 turned and hit against R1's wheelchair causing the chair to roll from the van. AS #3 went onto to say that all staff have been reeducated on loading and unloading residents from the van. An internal investigation report was reviewed and indicated that DCS #1 had released R1's wheelchair from the tie downs of the van and while releasing another resident's wheelchair from the tie downs DCS #1 bumped R1's wheelchair causing R1 to roll from the van and spill over.	W 436	2.)Address how the facility will identify similar occurrences of the problem. •Residential Night Supervisors will complete a wheelchair inspection form weekly for each individual using a wheelchair. •The Residential Night Supervisor will enter a Maintenance Ticket for any repair needed and communicate through email with the Residential Manager and Instructor Counselor (Assistant Manager) the issue needing fixed and that a maintenance ticket was entered. •The Residential Manager will ensure that a wheelchair inspection form is submitted by the Residential Night Supervisor weekly for each individual using a wheelchair.	11/30/23

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W 436	Continued From page 2 On 10/17/23 at 8:40 AM, AS #3 and the resident manager (AS #1) was interviewed. When asked what happened regarding R1 falling from the van, AS #1 verbalized that she had interviewed DCS #1 and found that DCS #1 had locked R1's brakes in place, but, while working with another resident, had bumped R1's wheelchair, which rolled out of the van. When questioned further, AS #1 verbalized that night shift does wheelchair checks to ensure proper working condition, as well as cleanliness. AS #3 verbalized that the wheelchair was checked at that time to see if there was a problem with the brakes. AS #3 stated that it was found that the right side wheel brake was not engaging and while pushing the wheelchair, the right wheel would roll and the left wheel would slide (due to brake working correctly on the left side). AS #3 also verbalized that a work order was placed and maintenance had made the needed adjustments to repair the brake. AS #1 and AS #3 both verbalized that up until the incident, there was no indication or report that the brakes were not working properly on R1's wheelchair. Wheelchair inspection logs for March 2023 (the month of incident) and maintenance repair order was requested. AS #1 was unable to provide wheelchair inspection logs for the month of March saying that the facility doesn't usually keep the logs that long. AS #1 was able to provide the maintenance repair record that indicated that the repair to R1's wheelchair brake was completed on 3/25/23. AS #1 also provided educational check off for	W 436	3.) Identify measures/systemic changes to ensure deficient practices will not recur. •Residential Night Supervisors will complete a wheelchair inspection form weekly for each individual using a wheelchair. •The Residential Night Supervisor will enter a Maintenance Ticket for any repair needed and communicate through email with the Residential Manager and Instructor Counselor (Assistant Manager) the issue needing fixed and that a maintenance ticket was entered. •The Residential Manager will ensure that a wheelchair inspection form is submitted by the Residential Night Supervisor weekly for each individual using a wheelchair. •The Residential Manager will ensure that the maintenance department responds to the maintenance request within 48-72 hours (depending on severity of issue—failing braker as compared to a ripped arm rest) before escalating the issue to The Health and Safety Officer. •If the issue is something that Horizon's Maintenance Department cannot fix, the Residential Manager or Instructor Counselor (Assistance Manager) will contact National Seating and Mobility or DBHDS Mobile Engineering Unit for assistance. •Wheelchair maintenance will be discussed during the Specially Constituted Committee meetings for individuals who use wheelchairs.	11/30/23

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W 436	Continued From page 3 loading and unloading residents from the facility van which included DCS #1 and all other staff. DCS #1 was unavailable for interview. On 10/17/23 at 11:15 AM, the above information was presented to AS #1, AS #3 and program manager (AS #4). No other information was presented prior to exit conference on 10/17/23.	W 436	4.) Indicate how facility will monitor its performance. • Residential Night Supervisors will complete a wheelchair inspection form weekly for each individual using a wheelchair. • The Residential Night Supervisor will enter a Maintenance Ticket for any repair needed and communicate through email with the Residential Manager and Instructor Counselor (Assistant Manager) the issue needing fixed and that a maintenance ticket was entered. • The Residential Night Supervisor will turn the wheelchair inspection form into the Residential Manager upon completion. • ICF/IID staff will complete an online training including video regarding how to properly load and unload individuals using wheelchairs from a wheelchair-accessible van. • The Residential Manager will ensure that a wheelchair inspection form is submitted by the Residential Night Supervisor weekly for each individual using a wheelchair. • The Residential Manager will ensure that the maintenance department responds to the maintenance request within 48-72 hours (depending on severity of issue—failing brake as compared to a ripped arm rest) before escalating the issue to The Health and Safety Officer. • If the issue is something that Horizon's Maintenance Department cannot fix, the Residential Manager or Instructor Counselor (Assistance Manager) will contact National Seating and Mobility or DBHDS Mobile Engineering Unit for assistance. • Wheelchair maintenance will be discussed during the Specially Constituted Committee meetings for individuals who use wheelchairs.	11/30/23