STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted 01/03/18 through 01/04/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Mentally Retarded. The Life Safety Code survey report will follow. The census in this seven bed facility was six at the time of the survey. The survey sample consisted of three current Individual reviews (Individuals # 1, # 2, and # 3).	W 000		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on residential program record reviews, day program record review and staff interview, it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate and monitor the individuals' active treatment programs for three of three individuals in the survey sample, Individuals # 1, # 2 and # 3. 1a. The QIDP failed to ensure the following PCP (Person Centered Plan) outcomes were developed in measurable terms for Individual # 1: "Outcome # 1: Socialization skills; Outcome # 2: Community integration; Outcome # 3: Sensory stimulation / Stress management; Outcome # 4: Communication; Outcome # 6: Independent living skills; Outcome # 7: Money management; and Outcome # 8: Medication management."	W 159	W 159 QIDP. CFR(s):483.430(a) individual #1 1a. ISP outcome #s 1-socialization skills, #2-Community integration, #3-sensory stimulation/ stress management, #4-communication, #6 independent living skills, #7-money management and #8-medication management for individual #1 will be updated to be quantifiable and measurable. -QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. - ISP outcomes for all other individuals in the facility will be evaluated by the QIDP/Program manager and Clinical Director to ensure that they are written in measurable terms/or updated to become measureable if they are not. - The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.	2/15/18

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

[signature] Clinical Director 1/25/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 1	W 159		

1b. The QIDP failed to ensure the data collection of Individual # 1's PCP (Person Centered Plan) outcomes were in measurable terms.

1c. The QIDP failed to ensure the active treatment programs of Socialization, Sensory stimulation/Stress management, Communication, Independent living skills, Medication management for Individual # 1 from the PCP (Person Centered Plan) were implemented.

1d. The QIDP failed to ensure Individual # 1's constipation protocol was included on the PCP (Person Centered Plan) dated 12/01/2017 through 11/30/2018.

2a. The QIDP failed to ensure the following PCP (Person Centered Plan) outcomes were developed in measurable terms for Individual # 2: "Outcome # 1: Exercise and Recreation; Outcome # 2: Communication; Outcome # 3: Community inclusion; Outcome # 4: Socialization skills; Outcome # 5A & B: Medication education skills."

2b. The QIDP failed to ensure the data collection of Individual # 2's PCP (Person Centered Plan) outcomes were in measurable terms.

2c. The QIDP failed to ensure the active treatment programs of Communication and Medication management for Individual # 2 from the PCP (Person Centered Plan) were implemented.

2d. The QIDP failed to ensure Individual # 2's PICA protocol was included on the PCP (Person Centered Plan) dated 08/01/2017 through

1b. The data collection for individual #1's PCP outcomes will be updated to be in measurable terms by the QIDP under the guidance of the program manager/clinical director.
--QIDP will receive in-service training from the clinical director on how to write data collection for individual #1 and all other individuals in measurable terms.
--Clinical director will periodically audit subsequent PCPs for all individuals to ensure that the data collection indicators are written in measurable terms.
-- The department of Mission Effectiveness will add measurability of data collection indicators in their periodic audits of clinical documents in the program.

2/15/18

1c. The QIDP will coordinate,collect and report data on the implementation of the socialization, sensory stimulation/stress management, communication, independent living skills, and medication management for individual #1.
--Program manager will ensure that the program implementation and reporting for all other individuals is done correctly and completely by the QIDP by reviewing monthly/ quarterly reports generated from program implementation.
--The Department of Mission Effectiveness will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 2 07/31/2018. 3a. The QIDP failed to ensure the following PCP (Person Centered Plan) outcomes were developed in measurable terms for Individual # 3: "Outcome # 1: Communication; Outcome # 2: Socialization; Outcome # 3: Exercise; Outcome # 4: Money management; Outcome # 5: Health & Safety and Outcome # 7: Independent living skills." 3b. The QIDP failed to ensure data collection of Individual # 3's PCP (Person Centered Plan) outcomes were in measurable terms. 3c. The QIDP failed to ensure the active treatment programs of Health and Safety for Individual # 3 from the PCP (Person Centered Plan) were implemented. 3d. The QIDP failed to ensure Individual # 3's protocol for SIB (self-injurious behavior) was included on the PCP (Person Centered Plan) dated 11/01/2017 through 10/31/2018. The findings include: 1a. The QIDP failed to ensure the following PCP (Person Centered Plan) outcomes were developed in measurable terms for Individual # 1: "Outcome # 1: Socialization skills; Outcome # 2: Community integration; Outcome # 3: Sensory stimulation / Stress management; Outcome # 4: Communication; Outcome # 6: Independent living skills; Outcome # 7: Money management; and Outcome # 8: Medication management." Individual # 1was a 24-year-old male, who was admitted to (Name of Group Home) on 10/12/11.	W 159	periodically during routine audits or upon request of the Clinical Director, review monthly/quarterly reports on program implementation for all individuals in the program. 1d. QIDP will update individual #1's ISP will with the individual's constipation protocol. --QIDP and the program manager will review the ISPs of all other individuals to ensure that their related protocols are included in the plan. -- Clinical Director will work with the department of Mission Effectiveness to ensure that internal clinical audits include a review of related protocols in every ISP audited. 2a. ISP outcome #s 1-exercise/recreation, #2-Communication, #3-community inclusion, #4-socialization skills, #5A/B-medication education skills for individual #2 will be updated to be quantifiable and measurable. -QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. - ISP outcomes for all other individuals in the facility will be evaluated by the QIDP/Program manager and Clinical Director to ensure that they are written in measurable terms/or updated to become measureable if they are not. - The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 3	W 159		

Diagnoses in the clinical record included but were not limited to: (1) moderate intellectual disability, (2) pervasive developmental disorder, (3) mood disorder and allergies.

Individual # 1's current PCP dated 12/01/2017 through 11/30/2018 documented the following:
- "Desired Outcome: Outcome # 1: Socialization Skills. (Individual # 1) likes to be social with staff and others in the house. (Individual # 1) needs to practice appropriate personal boundaries and proper initial greetings to others. (Individual # 1) likes to converse with his father on the phone and needs help to place the call. Support Activities & Instructions: (Individual # 1) socializes with others: 1. (Individual # 1) is prompted to shake hands. 2. (Individual # 1) is reminded of personal boundaries. 3. (Individual # 1) is assisted in dialogue. 4. (Individual # 1) is complimented on proper social behavior skills. Frequency: Daily. Amount: 15 minutes. Support Activities & Instructions: (Individual # 1) socializes with his father. 1. (Individual # 1) wants to call his father. 2. (Individual # 1) is assisted in retrieving the phone number. 3. (Individual # 1) is assisted in dialing the number (He is read the number as he dials). 4. When (Individual # 1) is done conversing with his father, prompt him to hang up the phone. 5. Compliment him on completing the task and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 2: Community Integration. (Individual # 1) goes out into the community to participate in events such as concerts, shopping, the library and parks. Support Activities & Instructions: (Individual # 1) integrates into the community. 1. (Individual # 1) chooses the integrated community activity from a

2b. The data collection for individual #2's PCP outcomes will be updated to be in measurable terms by the QIDP under the guidance of the program manager/clinical director.
--QIDP will receive in-service training from the clinical director on how to write data collection for individual #2 and all other individuals in measurable terms.
--Clinical director will periodically audit subsequent PCPs for all individuals to ensure that the data collection indicators are written in measurable terms.
-- The department of Mission Effectiveness will add measurability of data collection indicators in their periodic audits of clinical documents in the program.
2c. The QIDP will coordinate,collect and report data on the implementation of the communication and medication management for individual #2.
--Program manager will ensure that the program implementation and reporting for all other individuals is done correctly and completely by the QIDP by reviewing monthly/quarterly reports generated from program implementation.
--The Department of Mission Effectiveness will periodically during routine audits or upon request of the Clinical Director, review monthly/quarterly reports on program implementation for all individuals in the program.

2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 4 list of activities that are available within his community. 2. Offer choices and use the picture communication binder if needed. 3. Inform (Individual # 1) about appropriate socialization skills in the community and how important it is to focus on good behavior. 4. Praise and compliment (Individual # 1) on his efforts and document as needed. Frequency: Weekly. Amount: 30 minutes." - "Desired Outcome: Outcome # 3: Sensory Stimulation / Stress Management. (Individual # 1) enjoys puzzles, books, painting, listening to music, baking, organizing and storing items. / Stress management enjoys the stimulation of objects and needs to learn that when he is done to place items back to be able to enjoy next time. Support Activities & Instructions: (Individual # 1) participates in sensory stimulation. 1. (Individual # 1) spends time in the sensory room. 2. (Individual # 1) is offered choices focusing on only one or two items to choose from at a time. 3. When (Individual # 1) is done working with the items he is prompted to clean up. 4. Compliment (Individual # 1) on completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes." - "Desired Outcome: Outcome # 4: Communication Skills. (Individual # 1) uses words and some sign language to communicate to others. (Individual # 1) learns more vocabulary and signs to communicate more effectively. Support Activities & Instructions: 1. (Individual # 1) communicates his wants and needs verbally and through some sign language. 2. (Individual # 1) signs/says he needs to brush his teeth. 3. (Individual # 1) signs/says he wants to go to bed. Frequency: Daily. Amount: Continually."	W 159	2d. QIDP will update individual #2's ISP will with the individual's PICA protocol. --QIDP and the program manager will review the ISPs of all other individuals to ensure that their related protocols are included in the plan. -- Clinical Director will work with the department of Mission Effectiveness to ensure that internal clinical audits include a review of related protocols in every ISP audited. 3a. ISP outcome #s 1-communication, #2-socialization, #3-exercise, #4-money management, #5-health and safety, #7-independent living skills for individual #3 will be updated to be quantifiable and measurable. -- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. -- ISP outcomes for all other individuals in the facility will be evaluated by the QIDP/Program manager and Clinical Director to ensure that they are written in measurable terms/or updated to become measureable if they are not. -- The department of Mission Effectiveness will review the measurability of ISP outcomes in their periodic audits of clinical documents in the program.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 5 - "Desired Outcome: Outcome # 6: Independent Living Skills. (Individual # 1) likes to help around the house. He can help by cleaning the table after meals/activities. (Individual # 1) can help around the house by taking trash out, doing dishes, cleaning his room, doing his laundry and other chores. Support Activities & Instructions: Independent Living Skills. 1. (Individual # 1) helps around the house with the following: A. Cleaning the table after his meals or activities. B. Taking out the trash. C. D. Doing his dishes. E. Doing his laundry. F. Assisting with other chores. 1. (Individual # 1) is prompted its [sic] time to clean up. 2. Provide assistance with hand over hand, verbal prompting or demonstration when needed. 3. Should (Individual # 1) offer to help on his own initiative, continue to encourage his and document as needed. Frequency: Daily. Amount: 15 minutes." - "Desired Outcome: Outcome # 7: Money Management. (Individual # 1) selects items he wants to buy with his personal money. Support Activities & Instructions: (Individual # 1) is supported by staff to go with him to the store and make purchases at the register for items of his choosing or for services he needs. 1. (Individual # 1) is supported in the store of his choice. 2. (Individual # 1) chooses items he would like to purchase. 3. (Individual # 1) is provided with verbal prompting at the checkout to complete the transaction. 4. (Individual # 1) is complemented and document as needed. Frequency: Weekly. Amount: 15 minutes." - "Desired Outcome: Outcome # 8: Medication Management. (Individual # 1) is prompted it is time to take his medication. He tells staff one	W 159	3b. The data collection for individual #3's PCP outcomes will be updated to be in measurable terms by the QIDP under the guidance of the program manager/clinical director. --QIDP will receive in-service training from the clinical director on how to writer data collection for individual #3 and all other individuals in measurable terms. --Clinical director will periodically audit subsequent PCPs for all individuals to ensure that the data collection indicators are written in measurable terms. -- The department of Mission Effectiveness will add measurability of data collection indicators in their periodic audits of clinical documents in the program. 3c. The QIDP will coordinate,collect and report data on the implementation of the communication and medication management for individual #3. --Program manager will ensure that the program implementation and reporting for all other individuals is done correctly and completely by the QIDP by reviewing monthly/quarterly reports generated from program implementation. --The Department of Mission Effectiveness will periodically during routine audits or upon request of the Clinical Director, review monthly/quarterly reports on program implementation for all individuals in the program.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 6	W 159		

reason he takes his medication either by signing or verbally communicating. Support Activities & Instructions: (Individual # 1) informs staff the reason for his medication either signing or verbally communicating. 1. (Individual # 1) is prompted it is time to take his medication. 2. (Individual # 1) fills up his own glass of water (verbal prompts maybe needed). 3. (Individual # 1) informs staff the reason for one medication (staff assistance maybe needed for clarity). 4. (Individual # 1) swallows the medication with water. 5. (Individual # 1) is complimented for completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

On 01/03/18 at approximately 2:45 p.m.an interview was conducted with OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional). When asked what the purpose of the PCP was, OSM # 1 stated, "To help maintain their (Individual's) daily goals and independence for their daily living." When asked if the PCP serves as a guide to teach individuals new skills, OSM # 1 stated, "Yes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked what the purpose of the PCP was, ASM # 2 stated, "They are guidelines on how to work with individuals and what goals to work on and how to follow up of achieving a goal." During the interview ASM # 2 and OSM # 1 were asked to review the PCP (Person Centered Plan) outcomes for Individuals # 1. When asked if the PCP outcomes for Individual # 1 for socialization skills, community

3d. QIDP will update individual #2's ISP will with the individual's Self Injurious Behavior (SIB) protocol. --QIDP and the program manager will review the ISPs of all other individuals to ensure that their related protocols are included in the plan. -- Clinical Director will work with the department of Mission Effectiveness to ensure that internal clinical audits include a review of related protocols in every ISP audited.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 7	W 159		

integration, sensory stimulation/stress management, communication, independent living skills, money management; and medication management were written in measurable terms ASM # 2 and OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

The facility's policy "4.1 Individual Service Plan (ISP)" documented, "4.1.3 Procedures: C. (Name of Corporation) ensures that an ISP will contain at a minimum: 4. Goals / outcomes and measurable objectives / desired outcomes for addressing each identified need. 4.1.4 Individual Service Plan (ISP) Development. E. Goals / Outcomes and Objectives/Desired Outcomes: The objectives / desired outcomes will be expressed in terms that are behavioral and provide measurable indexes of progress."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 8	W 159		

schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) Autism spectrum disorder (ASD) is a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. It includes what used to be known as Asperger syndrome and pervasive developmental disorders. This information was obtained from the website: https://medlineplus.gov/autismspectrumdisorder.html.

(3) A mood disorder affects a person's everyday emotional state. These include depression and bipolar disorder (also called manic depression). Mood disorders can increase a person's risk for heart disease, diabetes, and other diseases. Treatments include medication, psychotherapy, or a combination of both. With treatment, most people with mood disorders can lead productive lives. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=mood+disorder&_ga=2.250975558.1992980465.1515165534-57118619.1515023902.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 9 1b. The QIDP failed to ensure the data collection of Individual # 1's PCP (Person Centered Plan) outcomes were in measurable terms. Individual # 1's current PCP dated 12/01/2017 through 11/30/2018 documented the following: - "Desired Outcome: Outcome # 1: Socialization Skills. (Individual # 1) likes to be social with staff and others in the house. (Individual # 1) needs to practice appropriate personal boundaries and proper initial greetings to others. (Individual # 1) likes to converse with his father on the phone and needs help to place the call. Support Activities & Instructions: (Individual # 1) socializes with others: 1. (Individual # 1) is prompted to shake hands. 2. (Individual # 1) is reminded of personal boundaries. 3. (Individual # 1) is assisted in dialogue. 4. (Individual # 1) is complimented on proper social behavior skills. Frequency: Daily. Amount: 15 minutes. Support Activities & Instructions: (Individual # 1) socializes with his father. 1. (Individual # 1) wants to call his father. 2. (Individual # 1) is assisted in retrieving the phone number. 3. (Individual # 1) is assisted in dialing the number (He is read the number as he dials). 4. When (Individual # 1) is done conversing with his father, prompt him to hang up the phone. 5. Compliment him on completing the task and document as needed. Frequency: Daily. Amount: 15 minutes." - "Desired Outcome: Outcome # 2: Community Integration. (Individual # 1) goes out into the community to participate in events such as concerts, shopping, the library and parks. Support Activities & Instructions: (Individual # 1) integrates into the community. 1. (Individual # 1) chooses the integrated community activity from a list of activities that are available within his	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 10	W 159		

community. 2. Offer choices and use the picture communication binder if needed. 3. Inform (Individual # 1) about appropriate socialization skills in the community and how important it is to focus on good behavior. 4. Praise and compliment (Individual # 1) on his efforts and document as needed. Frequency: Weekly. Amount: 30 minutes."

- "Desired Outcome: Outcome # 3: Sensory Stimulation / Stress Management. (Individual # 1) enjoys puzzles, books, painting, listening to music, baking, organizing and storing items. / Stress management enjoys the stimulation of objects and needs to learn that when he is done to place items back to be able to enjoy next time. Support Activities & Instructions: (Individual # 1) participates in sensory stimulation. 1. (Individual # 1) spends time in the sensory room. 2. (Individual # 1) is offered choices focusing on only one or two items to choose from at a time. 3. When (Individual # 1) is done working with the items he is prompted to clean up. 4. Compliment (Individual # 1) on completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 4: Communication Skills. (Individual # 1) uses words and some sign language to communicate to others. (Individual # 1) learns more vocabulary and signs to communicate more effectively. Support Activities & Instructions: 1. (Individual # 1) communicates his wants and needs verbally and through some sign language. 2. (Individual # 1) signs/says he needs to brush his teeth. 3. (Individual # 1) signs/says he wants to go to bed. Frequency: Daily. Amount: Continually."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 11	W 159		

- "Desired Outcome: Outcome # 6: Independent Living Skills. (Individual # 1) likes to help around the house. He can help by cleaning the table after meals/activities. (Individual # 1) can help around the house by taking trash out, doing dishes, cleaning his room, doing his laundry and other chores. Support Activities & Instructions: Independent Living Skills. 1. (Individual # 1) helps around the house with the following: A. Cleaning the table after his meals or activities. B. Taking out the trash. C. D. Doing his dishes. E. Doing his laundry. F. Assisting with other chores. 1. (Individual # 1) is prompted its [sic] time to clean up. 2. Provide assistance with hand over hand, verbal prompting or demonstration when needed. 3. Should (Individual # 1) offer to help on his own initiative, continue to encourage his and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 7: Money Management. (Individual # 1) selects items he wants to buy with his personal money. Support Activities & Instructions: (Individual # 1) is supported by staff to go with him to the store and make purchases at the register for items of his choosing or for services he needs. 1. (Individual # 1) is supported in the store of his choice. 2. (Individual # 1) chooses items he would like to purchase. 3. (Individual # 1) is provided with verbal prompting at the checkout to complete the transaction. 4. (Individual # 1) is complemented and document as needed. Frequency: Weekly. Amount: 15 minutes."

- "Desired Outcome: Outcome # 8: Medication Management. (Individual # 1) is prompted it is time to take his medication. He tells staff one reason he takes his medication either by signing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 12	W 159		

or verbally communicating. Support Activities & Instructions: (Individual # 1) informs staff the reason for his medication either signing or verbally communicating. 1. (Individual # 1) is prompted it is time to take his medication. 2. (Individual # 1) fills up his own glass of water (verbal prompts maybe needed). 3. (Individual # 1) informs staff the reason for one medication (staff assistance maybe needed for clarity). 4. (Individual # 1) swallows the medication with water. 5. (Individual # 1) is complimented for completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. ASM # 2 and OSM # 1 were asked to review the progress notes for Individual # 1 dated 12/01/17 through 12/31/17. When asked if the data was collected in measurable terms for Individual # 1's outcome of socialization skills, community integration, sensory stimulation/stress management, communication, independent living skills, money management; and medication management, OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 13	W 159		

Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

1c. The QIDP failed to ensure the active treatment programs of Socialization, Sensory stimulation/Stress management, Communication, Independent living skills, Medication management for Individual # 1 from the PCP (Person Centered Plan) were implemented.

Individual # 1's current PCP dated 12/01/2017 through 11/30/2018 documented the following:
- "Desired Outcome: Outcome # 1: Socialization Skills. (Individual # 1) likes to be social with staff and others in the house. (Individual # 1) needs to practice appropriate personal boundaries and proper initial greetings to others. (Individual # 1) likes to converse with his father on the phone and needs help to place the call. Support Activities & Instructions: (Individual # 1) socializes with others: 1. (Individual # 1) is prompted to shake hands. 2. (Individual # 1) is reminded of personal boundaries. 3. (Individual # 1) is assisted in dialogue. 4. (Individual # 1) is complimented on proper social behavior skills. Frequency: Daily. Amount: 15 minutes. Support Activities & Instructions: (Individual # 1) socializes with his father. 1. (Individual # 1) wants to call his father. 2. (Individual # 1) is assisted in retrieving the phone number. 3. (Individual # 1) is assisted in dialing the number (He is read the number as he dials). 4. When (Individual # 1) is done conversing with his father, prompt him to hang up the phone. 5. Compliment him on completing the task and document as needed. Frequency: Daily. Amount: 15 minutes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 14	W 159		

- "Desired Outcome: Outcome # 2: Community Integration. (Individual # 1) goes out into the community to participate in events such as concerts, shopping, the library and parks. Support Activities & Instructions: (Individual # 1) integrates into the community. 1. (Individual # 1) chooses the integrated community activity from a list of activities that are available within his community. 2. Offer choices and use the picture communication binder if needed. 3. Inform (Individual # 1) about appropriate socialization skills in the community and how important it is to focus on good behavior. 4. Praise and compliment (Individual # 1) on his efforts and document as needed. Frequency: Weekly. Amount: 30 minutes."

- "Desired Outcome: Outcome # 3: Sensory Stimulation / Stress Management. (Individual # 1) enjoys puzzles, books, painting, listening to music, baking, organizing and storing items. / Stress management enjoys the stimulation of objects and needs to learn that when he is done to place items back to be able to enjoy next time. Support Activities & Instructions: (Individual # 1) participates in sensory stimulation. 1. (Individual # 1) spends time in the sensory room. 2. (Individual # 1) is offered choices focusing on only one or two items to choose from at a time. 3. When (Individual # 1) is done working with the items he is prompted to clean up. 4. Compliment (Individual # 1) on completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 4: Communication Skills. (Individual # 1) uses words and some sign language to communicate to others. (Individual # 1) learns more vocabulary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 15	W 159		

and signs to communicate more effectively. Support Activities & Instructions: 1. (Individual # 1) communicates his wants and needs verbally and through some sign language. 2. (Individual # 1) signs/says he needs to brush his teeth. 3. (Individual # 1) signs/says he wants to go to bed. Frequency: Daily. Amount: Continually."

- "Desired Outcome: Outcome # 6: Independent Living Skills. (Individual # 1) likes to help around the house. He can help by cleaning the table after meals/activities. (Individual # 1) can help around the house by taking trash out, doing dishes, cleaning his room, doing his laundry and other chores. Support Activities & Instructions: Independent Living Skills. 1. (Individual # 1) helps around the house with the following: A. Cleaning the table after his meals or activities. B. Taking out the trash. C. D. Doing his dishes. E. Doing his laundry. F. Assisting with other chores. 1. (Individual # 1) is prompted its [sic] time to clean up. 2. Provide assistance with hand over hand, verbal prompting or demonstration when needed. 3. Should (Individual # 1) offer to help on his own initiative, continue to encourage his and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 7: Money Management. (Individual # 1) selects items he wants to buy with his personal money. Support Activities & Instructions: (Individual # 1) is supported by staff to go with him to the store and make purchases at the register for items of his choosing or for services he needs. 1. (Individual # 1) is supported in the store of his choice. 2. (Individual # 1) chooses items he would like to purchase. 3. (Individual # 1) is provided with verbal prompting at the checkout to complete the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 16	W 159		

transaction. 4. (Individual # 1) is complemented and document as needed. Frequency: Weekly. Amount: 15 minutes."

- "Desired Outcome: Outcome # 8: Medication Management. (Individual # 1) is prompted it is time to take his medication. He tells staff one reason he takes his medication either by signing or verbally communicating. Support Activities & Instructions: (Individual # 1) informs staff the reason for his medication either signing or verbally communicating. 1. (Individual # 1) is prompted it is time to take his medication. 2. (Individual # 1) fills up his own glass of water (verbal prompts maybe needed). 3. (Individual # 1) informs staff the reason for one medication (staff assistance maybe needed for clarity). 4. (Individual # 1) swallows the medication with water. 5. (Individual # 1) is complimented for completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

Review of the progress notes and data collection dated 12/01/17 through 12/31/17 for Individual # 1's socialization skills program revealed it was implemented 23 of 31 opportunities; socialization with his father program was implemented 20 of 31 opportunities; sensory stimulation program was implemented 23 of 31 opportunities; communication program was implemented 23 of 31 opportunities; independent living skill was implemented 24 of 31 opportunities and the medication management program was implemented 16 of 31 opportunities.

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 17	W 159		

member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked about the missing documentation for the implementation Individual # 1's PCP, OSM # 1 stated, "If the progress note does not reflect the outcome it wasn't implemented." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

1d. The QIDP failed to ensure Individual # 1's constipation protocol was included on the PCP (Person Centered Plan) dated 12/01/2017 through 11/30/2018.

Review of the (Name of Group Home) medical record for Individual # 1 revealed a protocol entitled "Protocol-Constipation (Name of Individual # 1)" dated 11/02/17.

Review of PCP (Person Centered Plan) dated 12/01/2017 through 11/30/2018 failed to evidence the constipation protocol for Individual #1.

An interview on 01/04/18 at approximately 2:55 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and LPN (licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 18	W 159		

practical nurse) # 1. When asked if an individual's protocol should be documented on the individual's PCP, ASM # 2 and OSM # 1 stated, "Yes." OSM # 1 was asked to review Individual # 1's current PCP dated 12/01/2017 through 11/30/2018. When asked if the PCP contained the constipation protocol for Individual #1, OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

2a. The QIDP failed to ensure the following PCP (Person Centered Plan) outcomes were developed in measurable terms for Individual # 2: "Outcome # 1: Exercise and Recreation; Outcome # 2: Communication; Outcome # 3: Community inclusion; Outcome # 4: Socialization skills; Outcome # 5A & B: Medication education skills."

Individual # 2 was a 63-year-old female, who was admitted to (Name of Group Home) on 11/23/10. Diagnoses in the clinical record included but were not limited to: (1) profound intellectual disability, (2) epilepsy, (3) mild dysphagia, (4) myopia, (5) vitamin D deficiency and (6) PICA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 19	W 159		

Individual # 2's current PCP dated 08/01/2017 through 07/31/2018 documented the following:

- "Desired Outcome: Outcome # 1: Exercise and Recreation. (Individual # 2) engages in different forms of exercise/recreation 75% (percent) of the time using different parts of her body especially her legs and hands. Support Activities & Instructions: 1. (Individual # 2) is selects going to the patio by walking directly to the back door. 2. (Individual # 2) walks for 10 to 15 minutes in the neighborhood or at the park. 3. (Individual # 2) selects to dance to 10 to 15 minutes twice a week. Frequency: Weekly. Amount: 15 minutes."

- "Desired Outcome: Outcome # 2: Communication. (Individual # 2) is nonverbal and she enjoys communicating with people who understand her 75% of the time. Support Activities & Instructions: (Individual # 2) communicates her wants and needs to others using nonverbal cues like a communication device (Book) 75% of the time daily. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: continually."

- "Desired Outcome: Outcome # 3: Community inclusion. (Individual # 2) engages in some community activities of her choice 80% of the time. Support Activities & Instructions: (Individual # 2) makes preference from a variety of places with the help of her communication log book.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 20	W 159		

She decides what activity she likes to engage in and staff supports her where needed. 1. (Individual # 2) is supported to research and select a place she would like to go in her communication book. 2. (Individual # 2) is prompted to get ready for the outing by putting together her needs for the outing. 3. (Individual # 2) is encouraged to have meet [sic] new friends and have as much fun as possible. 4. (Individual # 2's) strengths and weaknesses are documented so as to see needs help. Frequency: Weekly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 4: Socialization skills. (Individual # 2) develops some social skills by signing 'hi' 50% of the time while out in the community. Support Activities & Instructions: (Individual # 2) increases her level of socialization with her peers and makes new friends while out in the community. 1. (Individual # 2) smiles or makes eye contact with people she meets. 2. (Individual # 2) is encouraged to wave her hand to say hello or good-bye. 3. (Individual # 2) is encouraged to raise her hand and sign "hi" to the people she meets as a sign of being cordial. 4. (Individual # 2's) is congratulated if she does a good job at greeting. Frequency: Weekly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 5: Medication education skills. (Individual # 2) participates in her medication education goal by knowing the importance of her medications and why she should take them with water 75% of the time. Support Activities & Instructions: 5A (Individual # 2) listens to the importance of taking her medication with water. 1. (Individual # 2) is encouraged to learn about her medication by reviewing with staff the importance of taking her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 21	W 159		

medication. 2. (Individual # 2) reviews the importance of taking her medications with water. 3. (Individual # 2) takes her medication with water when requested. Frequency: Daily. Amount: 15 minutes." 5B. (Individual # 2) turns her cup (nosey cup of water into her mouth with prompts from staff who monitors her throughout the process. Support Activities & Instructions: 1. (Individual # 2) is prompted to open her mouth to get her medication as per her MAR (medication administration record). 2. (Individual # 2) is encouraged to pick up her cup of water. 3. (Individual # 2) is prompted to turn her nosey cup of water into her mouth. 4. (Individual # 2) is praised for doing a good job and her progress is documented for review. Frequency: Daily. Amount: 15 minutes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. During the interview ASM # 2 and OSM # 1 were asked to review the PCP (Person Centered Plan) outcomes for Individuals # 2. When asked if the PCP outcomes for Individual # 2 of exercise and recreation, communication, community inclusion, socialization skills, medication education skills were written in measurable terms, ASM # 2 and OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 22	W 159		

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 23	W 159		

(4) Nearsightedness is when light entering the eye is focused incorrectly, making distant objects appear blurred. Nearsightedness is a type of refractive error of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001023.htm.

(5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html.

(6) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm.

2b. The QIDP failed to ensure the data collection of Individual # 2's PCP (Person Centered Plan) outcomes were in measurable terms.

Individual # 2's current PCP dated 08/01/2017 through 07/31/2018 documented the following:

- "Desired Outcome: Outcome # 1: Exercise and Recreation. (Individual # 2) engages in different forms of exercise/recreation 75% (percent) of the time using different parts of her body especially her legs and hands. Support Activities & Instructions: 1. (Individual # 2) is selects going to the patio by walking directly to the back door. 2. (Individual # 2) walks for 10 to 15 minutes in the neighborhood or at the park. 3. (Individual # 2) selects to dance to 10 to 15 minutes twice a week. Frequency: Weekly. Amount: 15 minutes."

- "Desired Outcome: Outcome # 2: Communication. (Individual # 2) is nonverbal and she enjoys communicating with people who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 24	W 159		

understand her 75% of the time. Support Activities & Instructions: (Individual # 2) communicates her wants and needs to others using nonverbal cues like a communication device (Book) 75% of the time daily. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: continually."

- "Desired Outcome: Outcome # 3: Community inclusion. (Individual # 2) engages in some community activities of her choice 80% of the time. Support Activities & Instructions: (Individual # 2) makes preference from a variety of places with the help of her communication log book. She decides what activity she likes to engage in and staff supports her where needed. 1. (Individual # 2) is supported to research and select a place she would like to go in her communication book. 2. (Individual # 2) is prompted to get ready for the outing by putting together her needs for the outing. 3. (Individual # 2) is encouraged to have meet [sic] new friends and have as much fun as possible. 4. (Individual # 2's) strengths and weaknesses are documented so as to see needs help. Frequency: Weekly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 4: Socialization skills. (Individual # 2) develops some social skills by signing 'hi' 50% of the time while out in the community. Support Activities & Instructions: (Individual # 2) increases her level of socialization with her peers and makes new friends while out in the community. 1. (Individual # 2) smiles or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 25	W 159		

makes eye contact with people she meets. 2. (Individual # 2) is encouraged to wave her hand to say hello or good-bye. 3. (Individual # 2) is encouraged to raise her hand and sign "hi" to the people she meets as a sign of being cordial. 4. (Individual # 2's) is congratulated if she does a good job at greeting. Frequency: Weekly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 5: Medication education skills. (Individual # 2) participates in her medication education goal by knowing the importance of her medications and why she should take them with water 75% of the time. Support Activities & Instructions: 5A (Individual # 2) listens to the importance of taking her medication with water. 1. (Individual # 2) is encouraged to learn about her medication by reviewing with staff the importance of taking her medication. 2. (Individual # 2) reviews the importance of taking her medications with water. 3. (Individual # 2) takes her medication with water when requested. Frequency: Daily. Amount: 15 minutes." 5B. (Individual # 2) turns her cup (nosey cup of water into her mouth with prompts from staff who monitors her throughout the process. Support Activities & Instructions: 1. (Individual # 2) is prompted to open her mouth to get her medication as per her MAR (medication administration record). 2. (Individual # 2) is encouraged to pick up her cup of water. 3. (Individual # 2) is prompted to turn her nosey cup of water into her mouth. 4. (Individual # 2) is praised for doing a good job and her progress is documented for review. Frequency: Daily. Amount: 15 minutes."

An interview was conducted on 01/04/18 at approximately 3:45 p.m. with ASM (administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 26	W 159		

staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. During the interview ASM # 2 and OSM # 1 were asked to review the PCP (Person Centered Plan) outcomes for Individuals # 2. When asked if the PCP outcomes for Individual # 2 of exercise and recreation, communication, community inclusion, socialization skills, medication education skills were written in measurable terms, ASM # 2 and OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

2c. The QIDP failed to ensure the active treatment programs of Communication and Medication management for Individual # 2 from the PCP (Person Centered Plan) were implemented.

Individual # 2's current PCP dated 08/01/2017 through 07/31/2018 documented the following:

- "Desired Outcome: Outcome # 2: Communication. (Individual # 2) is nonverbal and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 27	W 159		

she enjoys communicating with people who understand her 75% of the time. Support Activities & Instructions: (Individual # 2) communicates her wants and needs to others using nonverbal cues like a communication device (Book) 75% of the time daily. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: continually."

- "Desired Outcome: Outcome # 5: Medication education skills. (Individual # 2) participates in her medication education goal by knowing the importance of her medications and why she should take them with water 75% of the time. Support Activities & Instructions: 5A (Individual # 2) listens to the importance of taking her medication with water. 1. (Individual # 2) is encouraged to learn about her medication by reviewing with staff the importance of taking her medication. 2. (Individual # 2) reviews the importance of taking her medications with water. 3. (Individual # 2) takes her medication with water when requested. Frequency: Daily. Amount: 15 minutes." 5B. (Individual # 2) turns her cup (nosey cup of water into her mouth with prompts from staff who monitors her throughout the process. Support Activities & Instructions: 1. (Individual # 2) is prompted to open her mouth to get her medication as per her MAR (medication administration record). 2. (Individual # 2) is encouraged to pick up her cup of water. 3. (Individual # 2) is prompted to turn her nosey cup of water into her mouth. 4. (Individual # 2) is praised for doing a good job and her progress is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 28	W 159		

documented for review. Frequency: Daily. Amount: 15 minutes."

Review of the progress notes and data collection dated 12/01/17 through 12/31/17 of Individual # 2's communication program revealed it was implemented 27 of 31 opportunities and the medication management program was implemented 24 of 31 opportunities.

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked about the missing documentation for the implementation Individual # 2's PCP, OSM # 1 stated, "If the progress note does not reflect the outcome it wasn't implemented." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

2d. The QIDP failed to ensure Individual # 2's PICA protocol was included on the PCP (Person Centered Plan) dated 08/01/2017 through 07/31/2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 29	W 159		

Review of the (Name of Group Home) medical record for Individual # 2 revealed a protocol entitled "PICA Protocol for (Name of Individual # 2)" dated 07/02/17.

Review of PCP (Person Centered Plan) dated 08/01/2017 through 07/31/2018 failed to evidence the PICA protocol for Individual #2.

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked if an individual's protocol should be documented on the individual's PCP, ASM # 2 and OSM # 1 stated, "Yes." OSM # 1 was asked to review Individual # 2's current PCP dated 08/01/2017 through 07/31/2018. When asked if the PCP contained the PICA protocol for Individual #2, OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 30 3a. The QIDP failed to ensure the following PCP (Person Centered Plan) outcomes were developed in measurable terms for Individual # 3: "Outcome # 1: Communication; Outcome # 2: Socialization; Outcome # 3: Exercise; Outcome # 4: Money management; Outcome # 5: Health & Safety and Outcome # 7: Independent living skills." Individual # 3 was a 57-year-old female, who was admitted to (Name of Group Home) on 1/24/96. Diagnoses in the clinical record included but were not limited to: (1) severe intellectual disability, (2) PICA, (3) grand maul seizure disorder, non-verbal and status/post (condition after) right ankle fracture. Individual # 3's current PCP dated 08/01/2017 through 07/31/2018 documented the following: - "Desired Outcome: Outcome # 1: Communication. (Individual # 3) communicates her wants and needs by using facial expressions, gestures, and making vocalizations 80% of the time until 10/20/18. (Individual # 3) uses her preferred language to express her wants and needs three times a day to staff and or her peers. Support Activities & Instructions: 1. (Individual # 3) points at what she would like. 2. (Individual # 3) shakes her head for yes or no when asked a question. 3. (Individual # 3) uses vocalizations and or facial to express her thoughts. Frequency: Daily. Amount: 15 Continually." - "Desired Outcome: Outcome # 2: Socialization. (Individual # 3) socializes with others by greeting with handshakes and making eye contact to increase good social skills 90% of the time until 10/20/18. Support Activities & Instructions:	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 31	W 159		

(Individual # 3) greets others. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 3: Exercise. (Individual # 3) likes to maintain her healthy (4) BMI (body mass index) by exercising 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) exercises four times a week for 15 or more minutes weekly by going for walks, using the recumbent bike, dancing, participating in chair yoga or and/or another form of exercise of her choice. 1. (Individual # 3) selects the type of exercise that she would like to do by gesturing, pointing, or making vocalizations when presented to her. 2. (Individual # 3) puts on the correct footwear to perform the exercise. 3. (Individual # 3) reviews instructions on how to perform exercise. 4. (Individual # 3) checks her weight once monthly to track progress. Frequency: Weekly. Amount: 30 minutes."

- "Desired Outcome: Outcome # 4: Money management. (Individual # 3) purchases items of her choice with her money when on a community outing 50% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) engages in spending her own money to purchase items of her choice once monthly. 1. (Individual # 3) selects where she would like to go to purchase items by reviewing and discussing with the staff what items she wants to shop for. 2. In the store (Individual # 3) selects items she needs and wants to purchase. 3. (Individual # 3) brings the items to the checkout register. 4. (Individual # 3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 32	W 159		

completes the purchase by providing the cashier with the funds. (Individual # 3) gets the change and receipt from the cashier and provides staff with them. Frequency: Monthly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 5: Health & Safety. (Individual # 3) makes healthy choices during meal time 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) selects to drink a healthy beverage with her meal i.e. water as opposed to coffee and selects a healthy snack and makes a healthy meal choice twice daily while following apperation [sic] protocol. 1. (Individual # 3) selects to drink a healthy beverage.as opposed to coffee or hot coco with her dinner. 2. (Individual # 3) selects a healthy fruit snack as opposed to chips or cookies. 3. (Individual # 3) choose to eat healthy meal by participating in menu selection during house meeting. 4. (Individual # 3) maintains that all meats are chopped to help with swallowing her food with drinking a beverage slowly and properly each meal daily. Frequency: Daily. Amount: Continually."

- "Desired Outcome: Outcome # 7: Independent living skills. (Individual # 3) folds her laundry during the week 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) neatly folds tops, pants, socks and underwear and places them in the laundry basket. 1. (Individual # 3) retrieves clean laundry from the laundry area and/or dryer. 2. (Individual # 3) takes laundry to her bedroom or common area. 3. (Individual # 3) sits in chair and folds clothing item. 4. (Individual # 3) places folded items back in the laundry basket. Frequency: Weekly. Amount: 30 minutes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 33	W 159		

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. During the interview ASM # 2 and OSM # 1 were asked to review the PCP (Person Centered Plan) outcomes for Individuals # 3. When asked if the PCP outcomes for Individual # 3 of communication, socialization, exercise, money management, health & safety, and independent living skills were written in measurable terms OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 34	W 159		

18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm.

(3) Epilepsy is a brain disorder in which a person has repeated seizures over time. Seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior. Generalized tonic-clonic (grand mal) seizure (involves the entire body, including aura, rigid muscles, and loss of alertness). This information was obtained from the website: https://medlineplus.gov/ency/article/000694.htm.

(4) A good way to decide if your weight is healthy for your height is to figure out your body mass index (BMI). You and your health care provider can use your BMI to estimate how much body fat you have. This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm.

3b. The QIDP failed to ensure data collection of Individual # 3's PCP (Person Centered Plan) outcomes were in measurable terms.

Individual # 3's current PCP dated 08/01/2017 through 07/31/2018 documented,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 35	W 159		

Individual # 3's current PCP dated 08/01/2017 through 07/31/2018 documented the following:

- "Desired Outcome: Outcome # 1: Communication. (Individual # 3) communicates her wants and needs by using facial expressions, gestures, and making vocalizations 80% of the time until 10/20/18. (Individual # 3) uses her preferred language to express her wants and needs three times a day to staff and or her peers. Support Activities & Instructions: 1. (Individual # 3) points at what she would like. 2. (Individual # 3) shakes her head for yes or no when asked a question. 3. (Individual # 3) uses vocalizations and or facial to express her thoughts. Frequency: Daily. Amount: 15 Continually."

- "Desired Outcome: Outcome # 2: Socialization. (Individual # 3) socializes with others by greeting with handshakes and making eye contact to increase good social skills 90% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) greets others. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 3: Exercise. (Individual # 3) likes to maintain her healthy (4) BMI (body mass index) by exercising 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) exercises four times a week for 15 or more minutes weekly by going for walks, using the recumbent bike, dancing, participating in chair yoga or and/or another form of exercise of her choice. 1. (Individual # 3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 36	W 159		

selects the type of exercise that she would like to do by gesturing, pointing, or making vocalizations when presented to her. 2. (Individual # 3) puts on the correct footwear to perform the exercise. 3. (Individual # 3) reviews instructions on how to perform exercise. 4. (Individual # 3) checks her weight once monthly to track progress. Frequency: Weekly. Amount: 30 minutes."

- "Desired Outcome: Outcome # 4: Money management. (Individual # 3) purchases items of her choice with her money when on a community outing 50% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) engages in spending her own money to purchase items of her choice once monthly. 1. (Individual # 3) selects where she would like to go to purchase items by reviewing and discussing with the staff what items she wants to shop for. 2. In the store (Individual # 3) selects items she needs and wants to purchase. 3. (Individual # 3) brings the items to the checkout register. 4. (Individual # 3) completes the purchase by providing the cashier with the funds. (Individual # 3) gets the change and receipt from the cashier and provides staff with them. Frequency: Monthly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 5: Health & Safety. (Individual # 3) makes healthy choices during meal time 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) selects to drink a healthy beverage with her meal i.e. water as opposed to coffee and selects a healthy snack and makes a healthy meal choice twice daily while following apperation [sic] protocol. 1. (Individual # 3) selects to drink a healthy beverage.as opposed to coffee or hot coco with her dinner. 2. (Individual # 3) selects a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 37	W 159		

healthy fruit snack as opposed to chips or cookies. 3. (Individual # 3) choose to eat healthy meal by participating in menu selection during house meeting. 4. (Individual # 3) maintains that all meats are chopped to help with swallowing her food with drinking a beverage slowly and properly each meal daily. Frequency: Daily. Amount: Continually."

- "Desired Outcome: Outcome # 7: Independent living skills. (Individual # 3) folds her laundry during the week 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) neatly folds tops, pants, socks and underwear and places them in the laundry basket. 1. (Individual # 3) retrieves clean laundry from the laundry area and/or dryer. 2. (Individual # 3) takes laundry to her bedroom or common area. 3. (Individual # 3) sits in chair and folds clothing item. 4. (Individual # 3) places folded items back in the laundry basket. Frequency: Weekly. Amount: 30 minutes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. During the interview OSM # 1 was asked to review the progress notes for Individual # 3 dated 12/01/17 through 12/31/17. When asked if the data was collected in measurable terms for Individual # 3's communication, socialization, exercise, money management, health & safety, and independent living skills OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 38	W 159		

data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1were made aware of the above findings.

No further information was provided prior to exit.

3c. The QIDP failed to ensure the active treatment programs of Health and Safety for Individual # 3 from the PCP (Person Centered Plan) were implemented.

Individual # 3's current PCP dated 08/01/2017 through 07/31/2018 documented,

- "Desired Outcome: Outcome # 5: Health & Safety. (Individual # 3) makes healthy choices during meal time 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) selects to drink a healthy beverage with her meal i.e. water as opposed to coffee and selects a healthy snack and makes a healthy meal choice twice daily while following apperation [sic] protocol. 1. (Individual # 3) selects to drink a healthy beverage.as opposed to coffee or hot coco with her dinner. 2. (Individual # 3) selects a healthy fruit snack as opposed to chips or cookies. 3. (Individual # 3) choose to eat healthy meal by participating in menu selection during house meeting. 4. (Individual # 3) maintains that all meats are chopped to help with swallowing her food with drinking a beverage slowly and properly each meal daily. Frequency: Daily. Amount:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 39	W 159		

Continually."

Review of the progress notes and data collection dated 12/01/17 through 12/31/17 for Individual # 3's health and safety program reveled it was implemented 7 of 31 opportunities.

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked about the missing documentation of the implementation Individual # 3's PCP programs, OSM # 1 stated, "If the progress note does not reflect the outcome it wasn't implemented." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

3d. The QIDP failed to ensure Individual # 3's protocol for SIB (self-injurious behavior) was included on the PCP (Person Centered Plan) dated 11/01/2017 through 10/31/2018.

Review of the (Name of Group Home) medical record for Individual # 1 revealed a protocol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 159	Continued From page 40 entitled "Self-Injurious Behavior Protocol for (Name of Individual # 1)" dated 10/01/17. Review of PCP (Person Centered Plan) dated 11/01/2017 through 10/31/2018 failed to evidence a self-injurious behavior protocol for Individual #3. An interview on 01/04/18 at approximately 2:55 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and LPN (licensed practical nurse) # 1. When asked if an individual's protocol should be documented on the individual's PCP, ASM # 2 and OSM # 1 stated, "Yes." OSM # 1 was asked to review Individual # 3's current PCP dated 08/01/2017 through 07/31/2018. When asked if the PCP contained the self-injurious behavior protocol for Individual #3, OSM # 1 stated, "No." When asked about the responsibility of the QIDP in terms of the development of measureable outcomes and data collection, implementation of the active treatment and accuracy of the PCP (Person Centered Plan), OSM # 1, QIDP stated, "It's the responsibility of the QIDP." On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings. No further information was provided prior to exit.	W 159		
W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that	W 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 41 provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined the facility staff failed to develop PCP (Person Centered Plan) outcomes in measurable terms for three of three individuals in the survey sample, Individuals # 1, # 2 and # 3. 1. The facility staff failed to develop and define the following PCP (Person Centered Plan) outcomes in measurable terms for Individual # 1: "Outcome # 1: Socialization skills; Outcome # 2: Community integration; Outcome # 3: Sensory stimulation / Stress management; Outcome # 4: Communication; Outcome # 6: Independent living skills; Outcome # 7: Money management; and Outcome # 8: Medication management." 2. The facility staff failed to developed and define the following PCP (Person Centered Plan) outcomes in measurable terms for Individual # 2: "Outcome # 1: Exercise and Recreation; Outcome # 2: Communication; Outcome # 3: Community inclusion; Outcome # 4: Socialization skills; Outcome # 5A & B: Medication education skills." 3. The facility staff failed to develop and define the following PCP (Person Centered Plan) outcomes in measurable terms for Individual # 3: "Outcome # 1: Communication; Outcome # 2: Socialization; Outcome # 3: Exercise; Outcome # 4: Money management; Outcome # 5: Health & Safety and Outcome # 7: Independent living skills."	W 231	Individual #1 --ISP outcome #s 1-socialization skills, #2-Community integration, #3-sensory stimulation/ stress management, #4-communication, #6 independent living skills, #7-money management and #8-medication management for individual #1 will be updated to be quantifiable and measurable. -QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. - ISP outcomes for all other individuals in the facility will be evaluated by the QIDP/Program manager and Clinical Director to ensure that they are written in measurable terms/or updated to become measureable if they are not. - The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 42	W 231		

The findings include:

1. Individual # 1was a 24-year-old male, who was admitted to (Name of Group Home) on 10/12/11. Diagnoses in the clinical record included but were not limited to: (1) moderate intellectual disability, (2) pervasive developmental disorder, (3) mood disorder and allergies.

Individual # 1's current PCP dated 12/01/2017 through 11/30/2018 documented the following:
- "Desired Outcome: Outcome # 1: Socialization Skills. (Individual # 1) likes to be social with staff and others in the house. (Individual # 1) needs to practice appropriate personal boundaries and proper initial greetings to others. (Individual # 1) likes to converse with his father on the phone and needs help to place the call. Support Activities & Instructions: (Individual # 1) socializes with others: 1. (Individual # 1) is prompted to shake hands. 2. (Individual # 1) is reminded of personal boundaries. 3. (Individual # 1) is assisted in dialogue. 4. (Individual # 1) is complimented on proper social behavior skills. Frequency: Daily. Amount: 15 minutes. Support Activities & Instructions: (Individual # 1) socializes with his father. 1. (Individual # 1) wants to call his father. 2. (Individual # 1) is assisted in retrieving the phone number. 3. (Individual # 1) is assisted in dialing the number (He is read the number as he dials). 4. When (Individual # 1) is done conversing with his father, prompt him to hang up the phone. 5. Compliment him on completing the task and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 2: Community Integration. (Individual # 1) goes out into the community to participate in events such as

Individual #2
-- ISP outcome #s 1-exercise/recreation, #2-Communication, #3-community inclusion, #4-socialization skills, #5A/B-medication education skills for individual #2 will be updated to be quantifiable and measurable.
-QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner.
- ISP outcomes for all other individuals in the facility will be evaluated by the QIDP/Program manager and Clinical Director to ensure that they are written in measurable terms/or updated to become measureable if they are not.
- The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.

2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 43	W 231	Individual #3 --ISP outcome #s 1-communication, #2-socialization, #3-exercise, #4-money management, #5-health and safety, #7-independent living skills for individual #3 will be updated to be quantifiable and measurable. -- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. -- ISP outcomes for all other individuals in the facility will be evaluated by the QIDP/Program manager and Clinical Director to ensure that they are written in measurable terms/or updated to become measureable if they are not. -- The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.	2/15/18

concerts, shopping, the library and parks. Support Activities & Instructions: (Individual # 1) integrates into the community. 1. (Individual # 1) chooses the integrated community activity from a list of activities that are available within his community. 2. Offer choices and use the picture communication binder if needed. 3. Inform (Individual # 1) about appropriate socialization skills in the community and how important it is to focus on good behavior. 4. Praise and compliment (Individual # 1) on his efforts and document as needed. Frequency: Weekly. Amount: 30 minutes."

- "Desired Outcome: Outcome # 3: Sensory Stimulation / Stress Management. (Individual # 1) enjoys puzzles, books, painting, listening to music, baking, organizing and storing items. / Stress management enjoys the stimulation of objects and needs to learn that when he is done to place items back to be able to enjoy next time. Support Activities & Instructions: (Individual # 1) participates in sensory stimulation. 1. (Individual # 1) spends time in the sensory room. 2. (Individual # 1) is offered choices focusing on only one or two items to choose from at a time. 3. When (Individual # 1) is done working with the items he is prompted to clean up. 4. Compliment (Individual # 1) on completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 4: Communication Skills. (Individual # 1) uses words and some sign language to communicate to others. (Individual # 1) learns more vocabulary and signs to communicate more effectively. Support Activities & Instructions: 1. (Individual # 1) communicates his wants and needs verbally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 44	W 231		

and through some sign language. 2. (Individual # 1) signs/says he needs to brush his teeth. 3. (Individual # 1) signs/says he wants to go to bed. Frequency: Daily. Amount: Continually."

- "Desired Outcome: Outcome # 6: Independent Living Skills. (Individual # 1) likes to help around the house. He can help by cleaning the table after meals/activities. (Individual # 1) can help around the house by taking trash out, doing dishes, cleaning his room, doing his laundry and other chores. Support Activities & Instructions: Independent Living Skills. 1. (Individual # 1) helps around the house with the following: A. Cleaning the table after his meals or activities. B. Taking out the trash. C. D. Doing his dishes. E. Doing his laundry. F. Assisting with other chores. 1. (Individual # 1) is prompted its [sic] time to clean up. 2. Provide assistance with hand over hand, verbal prompting or demonstration when needed. 3. Should (Individual # 1) offer to help on his own initiative, continue to encourage his and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 7: Money Management. (Individual # 1) selects items he wants to buy with his personal money. Support Activities & Instructions: (Individual # 1) is supported by staff to go with him to the store and make purchases at the register for items of his choosing or for services he needs. 1. (Individual # 1) is supported in the store of his choice. 2. (Individual # 1) chooses items he would like to purchase. 3. (Individual # 1) is provided with verbal prompting at the checkout to complete the transaction. 4. (Individual # 1) is complemented and document as needed. Frequency: Weekly. Amount: 15 minutes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 45	W 231		

- "Desired Outcome: Outcome # 8: Medication Management. (Individual # 1) is prompted it is time to take his medication. He tells staff one reason he takes his medication either by signing or verbally communicating. Support Activities & Instructions: (Individual # 1) informs staff the reason for his medication either signing or verbally communicating. 1. (Individual # 1) is prompted it is time to take his medication. 2. (Individual # 1) fills up his own glass of water (verbal prompts maybe needed). 3. (Individual # 1) informs staff the reason for one medication (staff assistance maybe needed for clarity). 4. (Individual # 1) swallows the medication with water. 5. (Individual # 1) is complimented for completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

On 01/03/18 at approximately 2:45 p.m.an interview was conducted with OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional). When asked what the purpose of the PCP was, OSM # 1 stated, "To help maintain their (Individual's) daily goals and independence for their daily living." When asked if the PCP serves as a guide to teach individuals new skills, OSM # 1 stated, "Yes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked what the purpose of the PCP was, ASM # 2 stated, "They are guidelines on how to work with individuals and what goals to work on and how to follow up of achieving a goal." During the interview ASM # 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 46	W 231		

and OSM # 1 were asked to review the PCP (Person Centered Plan) outcomes for Individuals # 1. When asked if the PCP outcomes for Individual # 1 for socialization skills, community integration, sensory stimulation/stress management, communication, independent living skills, money management; and medication management were written in measurable terms ASM # 2 and OSM # 1 stated, "No."

The facility's policy "4.1 Individual Service Plan (ISP)" documented, "4.1.3 Procedures: C. (Name of Corporation) ensures that an ISP will contain at a minimum: 4. Goals / outcomes and measurable objectives / desired outcomes for addressing each identified need. 4.1.4 Individual Service Plan (ISP) Development. E. Goals / Outcomes and Objectives/Desired Outcomes: The objectives / desired outcomes will be expressed in terms that are behavioral and provide measurable indexes of progress."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 47	W 231		

causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) Autism spectrum disorder (ASD) is a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. It includes what used to be known as Asperger syndrome and pervasive developmental disorders. This information was obtained from the website: https://medlineplus.gov/autismspectrumdisorder.html.

(3) A mood disorder affects a person's everyday emotional state. These include depression and bipolar disorder (also called manic depression). Mood disorders can increase a person's risk for heart disease, diabetes, and other diseases. Treatments include medication, psychotherapy, or a combination of both. With treatment, most people with mood disorders can lead productive lives. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=mood+disorder&_ga=2.250975558.1992980465.1515165534-57118619.1515023902.

2. The facility staff failed to developed and define the following PCP (Person Centered Plan) outcomes in measurable terms for Individual # 2: "Outcome # 1: Exercise and Recreation;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 48	W 231		

Outcome # 2: Communication; Outcome # 3: Community inclusion; Outcome # 4: Socialization skills; Outcome # 5A & B: Medication education skills."

Individual # 2 was a 63-year-old female, who was admitted to (Name of Group Home) on 11/23/10. Diagnoses in the clinical record included but were not limited to: (1) profound intellectual disability, (2) epilepsy, (3) mild dysphagia, (4) myopia, (5) vitamin D deficiency and (6) PICA.

Individual # 2's current PCP dated 08/01/2017 through 07/31/2018 documented the following:

- "Desired Outcome: Outcome # 1: Exercise and Recreation. (Individual # 2) engages in different forms of exercise/recreation 75% (percent) of the time using different parts of her body especially her legs and hands. Support Activities & Instructions: 1. (Individual # 2) is selects going to the patio by walking directly to the back door. 2. (Individual # 2) walks for 10 to 15 minutes in the neighborhood or at the park. 3. (Individual # 2) selects to dance to 10 to 15 minutes twice a week. Frequency: Weekly. Amount: 15 minutes."

- "Desired Outcome: Outcome # 2: Communication. (Individual # 2) is nonverbal and she enjoys communicating with people who understand her 75% of the time. Support Activities & Instructions: (Individual # 2) communicates her wants and needs to others using nonverbal cues like a communication device (Book) 75% of the time daily. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 49	W 231		

is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: continually."

- "Desired Outcome: Outcome # 3: Community inclusion. (Individual # 2) engages in some community activities of her choice 80% of the time. Support Activities & Instructions: (Individual # 2) makes preference from a variety of places with the help of her communication log book. She decides what activity she likes to engage in and staff supports her where needed. 1. (Individual # 2) is supported to research and select a place she would like to go in her communication book. 2. (Individual # 2) is prompted to get ready for the outing by putting together her needs for the outing. 3. (Individual # 2) is encouraged to have meet [sic] new friends and have as much fun as possible. 4. (Individual # 2's) strengths and weaknesses are documented so as to see needs help. Frequency: Weekly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 4: Socialization skills. (Individual # 2) develops some social skills by signing 'hi' 50% of the time while out in the community. Support Activities & Instructions: (Individual # 2) increases her level of socialization with her peers and makes new friends while out in the community. 1. (Individual # 2) smiles or makes eye contact with people she meets. 2. (Individual # 2) is encouraged to wave her hand to say hello or good-bye. 3. (Individual # 2) is encouraged to raise her hand and sign "hi" to the people she meets as a sign of being cordial. 4. (Individual # 2's) is congratulated if she does a good job at greeting. Frequency: Weekly. Amount: 60 minutes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 50	W 231		

- "Desired Outcome: Outcome # 5: Medication education skills. (Individual # 2) participates in her medication education goal by knowing the importance of her medications and why she should take them with water 75% of the time. Support Activities & Instructions: 5A (Individual # 2) listens to the importance of taking her medication with water. 1. (Individual # 2) is encouraged to learn about her medication by reviewing with staff the importance of taking her medication. 2. (Individual # 2) reviews the importance of taking her medications with water. 3. (Individual # 2) takes her medication with water when requested. Frequency: Daily. Amount: 15 minutes." 5B. (Individual # 2) turns her cup (nosey cup of water into her mouth with prompts from staff who monitors her throughout the process. Support Activities & Instructions: 1. (Individual # 2) is prompted to open her mouth to get her medication as per her MAR (medication administration record). 2. (Individual # 2) is encouraged to pick up her cup of water. 3. (Individual # 2) is prompted to turn her nosey cup of water into her mouth. 4. (Individual # 2) is praised for doing a good job and her progress is documented for review. Frequency: Daily. Amount: 15 minutes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. During the interview ASM # 2 and OSM # 1 were asked to review the PCP (Person Centered Plan) outcomes for Individuals # 2. When asked if the PCP outcomes for Individual # 2 of exercise and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 51	W 231		

recreation, communication, community inclusion, socialization skills, medication education skills were written in measurable terms, ASM # 2 and OSM # 1 stated, "No."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

(3) A swallowing disorder. This information was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 52	W 231		

obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(4) Nearsightedness is when light entering the eye is focused incorrectly, making distant objects appear blurred. Nearsightedness is a type of refractive error of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001023.htm.

(5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html.

(6) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm.

3. The facility staff failed to develop and define the following PCP (Person Centered Plan) outcomes in measurable terms for Individual # 3: "Outcome # 1: Communication; Outcome # 2: Socialization; Outcome # 3: Exercise; Outcome # 4: Money management; Outcome # 5: Health & Safety and Outcome # 7: Independent living skills."

Individual # 3 was a 57-year-old female, who was admitted to (Name of Group Home) on 1/24/96. Diagnoses in the clinical record included but were not limited to: (1) severe intellectual disability, (2) PICA, (3) grand maul seizure disorder, non-verbal and status/post (condition after) right ankle fracture.

Individual # 3's current PCP dated 08/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 53	W 231		

through 07/31/2018 documented the following:

- "Desired Outcome: Outcome # 1: Communication. (Individual # 3) communicates her wants and needs by using facial expressions, gestures, and making vocalizations 80% of the time until 10/20/18. (Individual # 3) uses her preferred language to express her wants and needs three times a day to staff and or her peers. Support Activities & Instructions: 1. (Individual # 3) points at what she would like. 2. (Individual # 3) shakes her head for yes or no when asked a question. 3. (Individual # 3) uses vocalizations and or facial to express her thoughts. Frequency: Daily. Amount: 15 Continually."

- "Desired Outcome: Outcome # 2: Socialization. (Individual # 3) socializes with others by greeting with handshakes and making eye contact to increase good social skills 90% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) greets others. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 3: Exercise. (Individual # 3) likes to maintain her healthy (4) BMI (body mass index) by exercising 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) exercises four times a week for 15 or more minutes weekly by going for walks, using the recumbent bike, dancing, participating in chair yoga or and/or another form of exercise of her choice. 1. (Individual # 3) selects the type of exercise that she would like to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 54	W 231		

do by gesturing, pointing, or making vocalizations when presented to her. 2. (Individual # 3) puts on the correct footwear to perform the exercise. 3. (Individual # 3) reviews instructions on how to perform exercise. 4. (Individual # 3) checks her weight once monthly to track progress. Frequency: Weekly. Amount: 30 minutes."

- "Desired Outcome: Outcome # 4: Money management. (Individual # 3) purchases items of her choice with her money when on a community outing 50% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) engages in spending her own money to purchase items of her choice once monthly. 1. (Individual # 3) selects where she would like to go to purchase items by reviewing and discussing with the staff what items she wants to shop for. 2. In the store (Individual # 3) selects items she needs and wants to purchase. 3. (Individual # 3) brings the items to the checkout register. 4. (Individual # 3) completes the purchase by providing the cashier with the funds. (Individual # 3) gets the change and receipt from the cashier and provides staff with them. Frequency: Monthly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 5: Health & Safety. (Individual # 3) makes healthy choices during meal time 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) selects to drink a healthy beverage with her meal i.e. water as opposed to coffee and selects a healthy snack and makes a healthy meal choice twice daily while following apperation [sic] protocol. 1. (Individual # 3) selects to drink a healthy beverage.as opposed to coffee or hot coco with her dinner. 2. (Individual # 3) selects a healthy fruit snack as opposed to chips or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 55	W 231		

cookies. 3. (Individual # 3) choose to eat healthy meal by participating in menu selection during house meeting. 4. (Individual # 3) maintains that all meats are chopped to help with swallowing her food with drinking a beverage slowly and properly each meal daily. Frequency: Daily. Amount: Continually."

- "Desired Outcome: Outcome # 7: Independent living skills. (Individual # 3) folds her laundry during the week 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) neatly folds tops, pants, socks and underwear and places them in the laundry basket. 1. (Individual # 3) retrieves clean laundry from the laundry area and/or dryer. 2. (Individual # 3) takes laundry to her bedroom or common area. 3. (Individual # 3) sits in chair and folds clothing item. 4. (Individual # 3) places folded items back in the laundry basket. Frequency: Weekly. Amount: 30 minutes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. During the interview ASM # 2 and OSM # 1 were asked to review the PCP (Person Centered Plan) outcomes for Individuals # 3. When asked if the PCP outcomes for Individual # 3 of communication, socialization, exercise, money management, health & safety, and independent living skills were written in measurable terms, ASM # 2 and OSM # 1 stated, "No."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 56	W 231		

acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm.

(3) Epilepsy is a brain disorder in which a person has repeated seizures over time. Seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior. Generalized tonic-clonic (grand mal) seizure (involves the entire body, including aura, rigid muscles, and loss of alertness). This information was obtained from the website: https://medlineplus.gov/ency/article/000694.htm.

(4) A good way to decide if your weight is healthy for your height is to figure out your body mass index (BMI). You and your health care provider can use your BMI to estimate how much body fat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 231	Continued From page 57 you have. This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm.	W 231		
W 241	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(ii) The individual program plan must identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to include the individual's protocols on the current PCPs (Person Centered Plans) for three of three individuals in the survey sample, Individuals # 1, # 2 and # 3. 1. The facility staff failed to include Individual # 1's constipation protocol on the PCP (Person Centered Plan) dated 12/01/2017 through 11/30/2018. 2. The facility staff failed to include Individual # 2's PICA protocol on the PCP (Person Centered Plan) dated 08/01/2017 through 07/31/2018. 3. The facility staff failed to include Individual # 3's protocol for SIB (self-injurious behavior) on the PCP (Person Centered Plan) dated 11/01/2017 through 10/31/2018. The findings include: 1. The facility staff failed to include Individual # 1's constipation protocol on the PCP (Person	W 241	Individual #1. --QIDP will update individual #1's ISP will with the individual's constipation protocol. --QIDP and the program manager will review the ISPs of all other individuals to ensure that their related protocols are included in the plan. -- QIDP/Program manager will ensure that staff retrieve and report on protocols for all individuals using the electronic health record system when documenting on the individuals' progress or lack thereof. -- Clinical Director will work with the department of Mission Effectiveness to ensure that internal clinical audits include a review of related protocols in every ISP audited to ensure that they are relevant and accessible without encumbrances to all staff.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 241	Continued From page 58 Centered Plan) dated 12/01/2017 through 11/30/2018. Individual # 1was a 24-year-old male, who was admitted to (Name of Group Home) on 10/12/11. Diagnoses in the clinical record included but were not limited to: (1) moderate intellectual disability, (2) pervasive developmental disorder, (3) mood disorder and allergies. Review of the (Name of Group Home) medical record for Individual # 1 revealed a protocol entitled "Protocol-Constipation (Name of Individual # 1)" dated 11/02/17. Review of PCP (Person Centered Plan) dated 12/01/2017 through 11/30/2018 failed to evidence the constipation protocol for Individual #1. An interview on 01/04/18 at approximately 2:55 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and LPN (licensed practical nurse) # 1. When asked if an individual's protocol should be documented on the individual's PCP, ASM # 2 and LPN # 1 stated, "Yes." ASM # 2 and LPN # 1 were asked to review Individual # 1's current PCP dated 12/01/2017 through 11/30/2018. When asked if the PCP contained the constipation protocol for Individual #1, ASM # 2 and LPN # 1 stated, "No." On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings. No further information was provided prior to exit.	W 241	For individual #2. --QIDP will update individual #2's ISP will with the individual's PICA protocol. --QIDP and the program manager will review the ISPs of all other individuals to ensure that their related protocols are included in the plan. -- QIDP/Program manager will ensure that staff retrieve and report on protocols for all individuals using the electronic health record system when documenting on the individuals' progress or lack thereof. -- Clinical Director will work with the department of Mission Effectiveness to ensure that internal clinical audits include a review of related protocols in every ISP audited to ensure that they are relevant and accessible without encumbrances to all staff.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 241	Continued From page 59	W 241		

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) Autism spectrum disorder (ASD) is a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. It includes what used to be known as Asperger syndrome and pervasive developmental disorders. This information was obtained from the website: https://medlineplus.gov/autismspectrumdisorder.html.

(3) A mood disorder affects a person's everyday emotional state. These include depression and bipolar disorder (also called manic depression). Mood disorders can increase a person's risk for heart disease, diabetes, and other diseases. Treatments include medication, psychotherapy, or a combination of both. With treatment, most people with mood disorders can lead productive lives. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-

For individual #3
--QIDP will update individual #3's ISP will with the individual's Self Injurious Behavior (SIB) protocol.
--QIDP and the program manager will review the ISPs of all other individuals to ensure that their related protocols are included in the plan.
-- QIDP/Program manager will ensure that staff retrieve and report on protocols for all individuals using the electronic health record system when documenting on the individuals' progress or lack thereof.
-- Clinical Director will work with the department of Mission Effectiveness to ensure that internal clinical audits include a review of related protocols in every ISP audited to ensure that they are relevant and accessible without encumbrances to all staff.

2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 241	Continued From page 60	W 241		

meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=mood+disorder&_ga=2.250975558.1992980465.1515165534-5711861 9.1515023902.

2. The facility staff failed to include Individual # 2's PICA protocol on the PCP (Person Centered Plan) dated 08/01/2017 through 07/31/2018.

Individual # 2 was a 63-year-old female, who was admitted to (Name of Group Home) on 11/23/10. Diagnoses in the clinical record included but were not limited to: (1) profound intellectual disability, (2) epilepsy, (3) mild dysphagia, (4) myopia, (5) vitamin D deficiency and (6) PICA.

Review of the (Name of Group Home) medical record for Individual # 1 revealed a protocol entitled "PICA Protocol for (Name of Individual # 1)" dated 07/02/17.

Review of PCP (Person Centered Plan) dated 08/01/2017 through 07/31/2018 failed to evidence the PICA protocol for Individual #2.

An interview on 01/04/18 at approximately 2:55 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and LPN (licensed practical nurse) # 1. When asked if an individual's protocol should be documented on the individual's PCP, ASM # 2 and LPN # 1 stated, "Yes." ASM # 2 and LPN # 1 were asked to review Individual # 2's current PCP dated 08/01/2017 through 07/31/2018. When asked if the PCP contained the PICA protocol for Individual #2, ASM # 2 and LPN # 1 stated, "No."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 241	Continued From page 61	W 241		

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(4) Nearsightedness is when light entering the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 241	Continued From page 62	W 241		

eye is focused incorrectly, making distant objects appear blurred. Nearsightedness is a type of refractive error of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001023.htm.

(5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html.

(6) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm.

3. The facility staff failed to include Individual # 3's protocol for SIB (self-injurious behavior) on the PCP (Person Centered Plan) dated 11/01/2017 through 10/31/2018.

Individual # 3 was a 57-year-old female, who was admitted to (Name of Group Home) on 1/24/96. Diagnoses in the clinical record included but were not limited to: (1) severe intellectual disability, (2) PICA, (3) grand maul seizure disorder, non-verbal and status/post (condition after) right ankle fracture.

Review of the (Name of Group Home) medical record for Individual # 1 revealed a protocol entitled "Self-Injurious Behavior Protocol for (Name of Individual # 1)" dated 10/01/17.

Review of PCP (Person Centered Plan) dated 11/01/2017 through 10/31/2018 failed to evidence a self-injurious behavior protocol for Individual #3.

An interview on 01/04/18 at approximately 2:55

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 241	Continued From page 63	W 241		

p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and LPN (licensed practical nurse) # 1. When asked if an individual's protocol should be documented on the individual's PCP, ASM # 2 and LPN # 1 stated, "Yes." ASM # 2 and LPN # 1 were asked to review Individual # 3's current PCP dated 08/01/2017 through 07/31/2018. When asked if the PCP contained the self-injurious behavior protocol for Individual #3, ASM # 2 and LPN # 1 stated, "No."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 241	Continued From page 64 (3) Epilepsy is a brain disorder in which a person has repeated seizures over time. Seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior. Generalized tonic-clonic (grand mal) seizure (involves the entire body, including aura, rigid muscles, and loss of alertness). This information was obtained from the website: https://medlineplus.gov/ency/article/000694.htm. (4) A good way to decide if your weight is healthy for your height is to figure out your body mass index (BMI). You and your health care provider can use your BMI to estimate how much body fat you have. This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm.	W 241		
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 staff interview, clinical record review and facility document review it was determined that the facility staff failed to implement the active treatment programs from the PCPs (Person Centered Plans) for three of three individuals in	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 65 the survey sample, Individuals # 1, # 2 and # 3. 1. The facility staff failed to implement the active treatment programs of Socialization, Sensory stimulation/Stress management, Communication, Independent living skills, Medication management for Individual # 1 from the PCP (Person Centered Plan). 2. The facility staff failed to implement the active treatment programs of Communication and Medication management for Individual # 2 from the PCP (Person Centered Plan). 3. The facility staff failed to implement the active treatment programs of Health and Safety for Individual # 3 from the PCP (Person Centered Plan). The findings include: 1. The facility staff failed to implement the active treatment programs of Socialization, Sensory stimulation/Stress management, Communication, Independent living skills, Medication management for Individual # 1 from the PCP (Person Centered Plan). Individual # 1was a 24-year-old male, who was admitted to (Name of Group Home) on 10/12/11. Diagnoses in the clinical record included but were not limited to: (1) moderate intellectual disability, (2) pervasive developmental disorder, (3) mood disorder and allergies. Individual # 1's current PCP dated 12/01/2017 through 11/30/2018 documented: - "Desired Outcome: Outcome # 1: Socialization	W 249	For individual #1 --The QIDP will coordinate,collect and report data on the implementation of the socialization, sensory stimulation/stress management, communication, independent living skills, and medication management active treatment programs for individual #1. --Program manager will ensure that the program implementation and reporting for all other individuals is done correctly and completely by the QIDP by reviewing monthly/ quarterly reports generated from program implementation. --The Department of Mission Effectiveness will periodically during routine audits or upon request of the Clinical Director, review monthly/quarterly reports on program implementation for all individuals in the program. --Clinical Director will see to it that the above plan is implemented accordingly or intervene in a timely manner to make changes needed to ensure the full implementation on individuals' treatment plans.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 66 Skills. (Individual # 1) likes to be social with staff and others in the house. (Individual # 1) needs to practice appropriate personal boundaries and proper initial greetings to others. (Individual # 1) likes to converse with his father on the phone and needs help to place the call. Support Activities & Instructions: (Individual # 1) socializes with others: 1. (Individual # 1) is prompted to shake hands. 2. (Individual # 1) is reminded of personal boundaries. 3. (Individual # 1) is assisted in dialogue. 4. (Individual # 1) is complimented on proper social behavior skills. Frequency: Daily. Amount: 15 minutes. Support Activities & Instructions: (Individual # 1) socializes with his father. 1. (Individual # 1) wants to call his father. 2. (Individual # 1) is assisted in retrieving the phone number. 3. (Individual # 1) is assisted in dialing the number (He is read the number as he dials). 4. When (Individual # 1) is done conversing with his father, prompt him to hang up the phone. 5. Compliment him on completing the task and document as needed. Frequency: Daily. Amount: 15 minutes." - "Desired Outcome: Outcome # 3: Sensory Stimulation / Stress Management. (Individual # 1) enjoys puzzles, books, painting, listening to music, baking, organizing and storing items. / Stress management enjoys the stimulation of objects and needs to learn that when he is done to place items back to be able to enjoy next time. Support Activities & Instructions: (Individual # 1) participates in sensory stimulation. 1. (Individual # 1) spends time in the sensory room. 2. (Individual # 1) is offered choices focusing on only one or two items to choose from at a time. 3. When (Individual # 1) is done working with the items he is prompted to clean up. 4. Compliment (Individual # 1) on completing the goal and	W 249	For individual #2 --The QIDP will coordinate,collect and report data on the implementation of the communication and medication management active treatment programs for individual #2. --Program manager will ensure that the program implementation and reporting for all other individuals is done correctly and completely by the QIDP by reviewing monthly/quarterly reports generated from program implementation. --The Department of Mission Effectiveness will periodically during routine audits or upon request of the Clinical Director, review monthly/quarterly reports on program implementation for all individuals in the program. --Clinical Director will see to it that the above plan is implemented accordingly or intervene in a timely manner to make changes needed to ensure the full implementation on individuals' treatment plans.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 67	W 249		

document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 4: Communication Skills. (Individual # 1) uses words and some sign language to communicate to others. (Individual # 1) learns more vocabulary and signs to communicate more effectively. Support Activities & Instructions: 1. (Individual # 1) communicates his wants and needs verbally and through some sign language. 2. (Individual # 1) signs/says he needs to brush his teeth. 3. (Individual # 1) signs/says he wants to go to bed. Frequency: Daily. Amount: Continually."

- "Desired Outcome: Outcome # 6: Independent Living Skills. (Individual # 1) likes to help around the house. He can help by cleaning the table after meals/activities. (Individual # 1) can help around the house by taking trash out, doing dishes, cleaning his room, doing his laundry and other chores. Support Activities & Instructions: Independent Living Skills. 1. (Individual # 1) helps around the house with the following: A. Cleaning the table after his meals or activities. B. Taking out the trash. C. D. Doing his dishes. E. Doing his laundry. F. Assisting with other chores. 1. (Individual # 1) is prompted its [sic] time to clean up. 2. Provide assistance with hand over hand, verbal prompting or demonstration when needed. 3. Should (Individual # 1) offer to help on his own initiative, continue to encourage his and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 8: Medication Management. (Individual # 1) is prompted it is time to take his medication. He tells staff one reason he takes his medication either by signing

The QIDP will coordinate,collect and report data on the implementation of the health and safety active treatment program for individual #3.
--Program manager will ensure that the program implementation and reporting for all other individuals is done correctly and completely by the QIDP by reviewing monthly/quarterly reports generated from program implementation.
--The Department of Mission Effectiveness will periodically during routine audits or upon request of the Clinical Director, review monthly/quarterly reports on program implementation for all individuals in the program.
--Clinical Director will see to it that the above plan is implemented accordingly or intervene in a timely manner to make changes needed to ensure the full implementation on individuals' treatment plans.

2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 68	W 249		

or verbally communicating. Support Activities & Instructions: (Individual # 1) informs staff the reason for his medication either signing or verbally communicating. 1. (Individual # 1) is prompted it is time to take his medication. 2. (Individual # 1) fills up his own glass of water (verbal prompts maybe needed). 3. (Individual # 1) informs staff the reason for one medication (staff assistance maybe needed for clarity). 4. (Individual # 1) swallows the medication with water. 5. (Individual # 1) is complimented for completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

Review of the progress notes and data collection dated 12/01/17 through 12/31/17 for Individual # 1's socialization skills program revealed it was implemented 23 of 31 opportunities; socialization with his father program was implemented 20 of 31 opportunities; sensory stimulation program was implemented 23 of 31 opportunities; communication program was implemented 23 of 31 opportunities; independent living skill was implemented 24 of 31 opportunities and the medication management program was implemented 16 of 31 opportunities.

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked about the missing documentation for the implementation Individual # 1's PCP programs, ASM # 2 stated, "If it wasn't documented I can't say it was implemented." OSM # 1 stated, "If the progress note does not reflect the outcome it wasn't implemented."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 69	W 249		

The facility's policy "4.1 Individual Service Plan (ISP)" documented, "4.1.3 Procedures: C. (Name of Corporation) ensures that an ISP will contain at a minimum: 4. Goals / outcomes and measurable objectives / desired outcomes for addressing each identified need. 4.1.4 Individual Service Plan (ISP) Development. E. Goals / Outcomes and Objectives/Desired Outcomes: The objectives / desired outcomes will be expressed in terms that are behavioral and provide measurable indexes of progress."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) Autism spectrum disorder (ASD) is a neurological and developmental disorder that begins early in childhood and lasts throughout a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 70	W 249		

person's life. It affects how a person acts and interacts with others, communicates, and learns. It includes what used to be known as Asperger syndrome and pervasive developmental disorders. This information was obtained from the website: https://medlineplus.gov/autismspectrumdisorder.html.

(3) A mood disorder affects a person's everyday emotional state. These include depression and bipolar disorder (also called manic depression). Mood disorders can increase a person's risk for heart disease, diabetes, and other diseases. Treatments include medication, psychotherapy, or a combination of both. With treatment, most people with mood disorders can lead productive lives. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=mood+disorder&_ga=2.250975558.1992980465.1515165534-57118619.1515023902.

2. The facility staff failed to implement the active treatment programs of Communication and Medication management for Individual # 2 from the PCP (Person Centered Plan).

Individual # 2 was a 63-year-old female, who was admitted to (Name of Group Home) on 11/23/10. Diagnoses in the clinical record included but were not limited to: (1) profound intellectual disability, (2) epilepsy, (3) mild dysphagia, (4) myopia, (5) vitamin D deficiency and (6) PICA.

Individual # 2's current PCP dated 08/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 71	W 249		

through 07/31/2018 documented:

- "Desired Outcome: Outcome # 2: Communication. (Individual # 2) is nonverbal and she enjoys communicating with people who understand her 75% of the time. Support Activities & Instructions: (Individual # 2) communicates her wants and needs to others using nonverbal cues like a communication device (Book) 75% of the time daily. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: continually."

- "Desired Outcome: Outcome # 5: Medication education skills. (Individual # 2) participates in her medication education goal by knowing the importance of her medications and why she should take them with water 75% of the time. Support Activities & Instructions: 5A (Individual # 2) listens to the importance of taking her medication with water. 1. (Individual # 2) is encouraged to learn about her medication by reviewing with staff the importance of taking her medication. 2. (Individual # 2) reviews the importance of taking her medications with water. 3. (Individual # 2) takes her medication with water when requested. Frequency: Daily. Amount: 15 minutes." 5B. (Individual # 2) turns her cup (nosey cup of water into her mouth with prompts from staff who monitors her throughout the process. Support Activities & Instructions: 1. (Individual # 2) is prompted to open her mouth to get her medication as per her MAR (medication administration record). 2. (Individual # 2) is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 72	W 249		

encouraged to pick up her cup of water. 3. (Individual # 2) is prompted to turn her nosey cup of water into her mouth. 4. (Individual # 2) is praised for doing a good job and her progress is documented for review. Frequency: Daily. Amount: 15 minutes."

Review of the progress notes and data collection dated 12/01/17 through 12/31/17 for Individual # 2's communication program revealed it was implemented 27 of 31 opportunities and the medication management program was implemented 24 of 31 opportunities.

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked about the missing documentation of the implementation Individual # 2's PCP programs ASM # 2 stated, "If it wasn't documented I can't say it was implemented." OSM # 1 stated, "If the progress note does not reflect the outcome it wasn't implemented."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 73	W 249		

adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(4) Nearsightedness is when light entering the eye is focused incorrectly, making distant objects appear blurred. Nearsightedness is a type of refractive error of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001023.htm.

(5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html.

(6) A pattern of eating non-food materials, such as dirt or paper. This information was obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 74	W 249		

from the website:
https://medlineplus.gov/ency/article/001538.htm.

3. The facility staff failed to implement the active treatment programs of Health and Safety for Individual # 3 from the PCP (Person Centered Plan).

Individual # 3 was a 57-year-old female, who was admitted to (Name of Group Home) on 1/24/96. Diagnoses in the clinical record included but were not limited to: (1) severe intellectual disability, (2) PICA, (3) grand maul seizure disorder, non-verbal and status/post (condition after) right ankle fracture.

Individual # 3's current PCP dated 08/01/2017 through 07/31/2018 documented:

- "Desired Outcome: Outcome # 5: Health & Safety. (Individual # 3) makes healthy choices during meal time 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) selects to drink a healthy beverage with her meal i.e. water as opposed to coffee and selects a healthy snack and makes a healthy meal choice twice daily while following apperation [sic] protocol. 1. (Individual # 3) selects to drink a healthy beverage.as opposed to coffee or hot coco with her dinner. 2. (Individual # 3) selects a healthy fruit snack as opposed to chips or cookies. 3. (Individual # 3) choose to eat healthy meal by participating in menu selection during house meeting. 4. (Individual # 3) maintains that all meats are chopped to help with swallowing her food with drinking a beverage slowly and properly each meal daily. Frequency: Daily. Amount: Continually."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 75	W 249		

Review of the progress notes and data collection dated 12/01/17 through 12/31/17 for Individual # 3's health and safety program reveled it was implemented 7 of 31 opportunities.

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked about the missing documentation of the implementation Individual # 3's PCP programs ASM # 2 stated, "If it wasn't documented I can't say it was implemented." OSM # 1 stated, "If the progress note does not reflect the outcome it wasn't implemented."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website:
https://report.nih.gov/nihfactsheets/ViewFactShee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 249	Continued From page 76 t.aspx?csid=100. (2) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm. (3) Epilepsy is a brain disorder in which a person has repeated seizures over time. Seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior. Generalized tonic-clonic (grand mal) seizure (involves the entire body, including aura, rigid muscles, and loss of alertness). This information was obtained from the website: https://medlineplus.gov/ency/article/000694.htm. (4) A good way to decide if your weight is healthy for your height is to figure out your body mass index (BMI). You and your health care provider can use your BMI to estimate how much body fat you have. This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed collect data of PCP	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 77	W 252		

(Person Centered Plan) outcomes in measurable terms for three of three individuals in the survey sample, Individual # 1, # 2 and # 3.

1. The facility staff failed to document the data collection of Individual # 1's PCP (Person Centered Plan) outcomes were in measurable terms.

2. The facility staff failed to document the data collection of Individual # 2's PCP (Person Centered Plan) outcomes were in measurable terms.

3. The facility staff failed to document the data collection of Individual # 3's PCP (Person Centered Plan) outcomes were in measurable terms.

The findings include:

1. The facility staff failed to document the data collection of Individual # 1's PCP (Person Centered Plan) outcomes were in measurable terms.

Individual # 1was a 24-year-old male, who was admitted to (Name of Group Home) on 10/12/11. Diagnoses in the clinical record included but were not limited to: (1) moderate intellectual disability, (2) pervasive developmental disorder, (3) mood disorder and allergies.

Individual # 1's current PCP dated 12/01/2017 through 11/30/2018 documented:

- "Desired Outcome: Outcome # 1: Socialization Skills. (Individual # 1) likes to be social with staff and others in the house. (Individual # 1) needs to

For individual #1
--The data collection for individual #1's PCP outcomes will be updated to be in measurable terms by the QIDP under the guidance of the program manager/clinical director.
--QIDP will receive in-service training from the clinical director on how to write data collection for individual #1 and all other individuals in measurable terms.
--Clinical director will periodically audit subsequent PCPs for all individuals to ensure that the data collection indicators are written in measurable terms.
-- The department of Mission Effectiveness will review measurability of data collection indicators in their periodic audits of clinical documents in the program.

2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 78 practice appropriate personal boundaries and proper initial greetings to others. (Individual # 1) likes to converse with his father on the phone and needs help to place the call. Support Activities & Instructions: (Individual # 1) socializes with others: 1. (Individual # 1) is prompted to shake hands. 2. (Individual # 1) is reminded of personal boundaries. 3. (Individual # 1) is assisted in dialogue. 4. (Individual # 1) is complimented on proper social behavior skills. Frequency: Daily. Amount: 15 minutes. Support Activities & Instructions: (Individual # 1) socializes with his father. 1. (Individual # 1) wants to call his father. 2. (Individual # 1) is assisted in retrieving the phone number. 3. (Individual # 1) is assisted in dialing the number (He is read the number as he dials). 4. When (Individual # 1) is done conversing with his father, prompt him to hang up the phone. 5. Compliment him on completing the task and document as needed. Frequency: Daily. Amount: 15 minutes." - "Desired Outcome: Outcome # 2: Community Integration. (Individual # 1) goes out into the community to participate in events such as concerts, shopping, the library and parks. Support Activities & Instructions: (Individual # 1) integrates into the community. 1. (Individual # 1) chooses the integrated community activity from a list of activities that are available within his community. 2. Offer choices and use the picture communication binder if needed. 3. Inform (Individual # 1) about appropriate socialization skills in the community and how important it is to focus on good behavior. 4. Praise and compliment (Individual # 1) on his efforts and document as needed. Frequency: Weekly. Amount: 30 minutes."	W 252	For individual #2 --The data collection for individual #2's PCP outcomes will be updated to be in measurable terms by the QIDP under the guidance of the program manager/clinical director. --QIDP will receive in-service training from the clinical director on how to write data collection for individual #2 and all other individuals in measurable terms. --Clinical director will periodically audit subsequent PCPs for all individuals to ensure that the data collection indicators are written in measurable terms. -- The department of Mission Effectiveness will review measurability of data collection indicators in their periodic audits of clinical documents in the program.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 79 - "Desired Outcome: Outcome # 3: Sensory Stimulation / Stress Management. (Individual # 1) enjoys puzzles, books, painting, listening to music, baking, organizing and storing items. / Stress management enjoys the stimulation of objects and needs to learn that when he is done to place items back to be able to enjoy next time. Support Activities & Instructions: (Individual # 1) participates in sensory stimulation. 1. (Individual # 1) spends time in the sensory room. 2. (Individual # 1) is offered choices focusing on only one or two items to choose from at a time. 3. When (Individual # 1) is done working with the items he is prompted to clean up. 4. Compliment (Individual # 1) on completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes." - "Desired Outcome: Outcome # 4: Communication Skills. (Individual # 1) uses words and some sign language to communicate to others. (Individual # 1) learns more vocabulary and signs to communicate more effectively. Support Activities & Instructions: 1. (Individual # 1) communicates his wants and needs verbally and through some sign language. 2. (Individual # 1) signs/says he needs to brush his teeth. 3. (Individual # 1) signs/says he wants to go to bed. Frequency: Daily. Amount: Continually." - "Desired Outcome: Outcome # 6: Independent Living Skills. (Individual # 1) likes to help around the house. He can help by cleaning the table after meals/activities. (Individual # 1) can help around the house by taking trash out, doing dishes, cleaning his room, doing his laundry and other chores. Support Activities & Instructions: Independent Living Skills. 1. (Individual # 1) helps around the house with the following: A.	W 252	For individual #3 --The data collection for individual #3's PCP outcomes will be updated to be in measurable terms by the QIDP under the guidance of the program manager/clinical director. --QIDP will receive in-service training from the clinical director on how to write data collection for individual #3 and all other individuals in measurable terms. --Clinical director will periodically audit subsequent PCPs for all individuals to ensure that the data collection indicators are written in measurable terms. -- The department of Mission Effectiveness will review measurability of data collection indicators in their periodic audits of clinical documents in the program.	2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 80	W 252		

Cleaning the table after his meals or activities. B. Taking out the trash. C. D. Doing his dishes. E. Doing his laundry. F. Assisting with other chores. 1. (Individual # 1) is prompted its [sic] time to clean up. 2. Provide assistance with hand over hand, verbal prompting or demonstration when needed. 3. Should (Individual # 1) offer to help on his own initiative, continue to encourage his and document as needed. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 7: Money Management. (Individual # 1) selects items he wants to buy with his personal money. Support Activities & Instructions: (Individual # 1) is supported by staff to go with him to the store and make purchases at the register for items of his choosing or for services he needs. 1. (Individual # 1) is supported in the store of his choice. 2. (Individual # 1) chooses items he would like to purchase. 3. (Individual # 1) is provided with verbal prompting at the checkout to complete the transaction. 4. (Individual # 1) is complemented and document as needed. Frequency: Weekly. Amount: 15 minutes."

- "Desired Outcome: Outcome # 8: Medication Management. (Individual # 1) is prompted it is time to take his medication. He tells staff one reason he takes his medication either by signing or verbally communicating. Support Activities & Instructions: (Individual # 1) informs staff the reason for his medication either signing or verbally communicating. 1. (Individual # 1) is prompted it is time to take his medication. 2. (Individual # 1) fills up his own glass of water (verbal prompts maybe needed). 3. (Individual # 1) informs staff the reason for one medication (staff assistance maybe needed for clarity). 4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 81	W 252		

(Individual # 1) swallows the medication with water. 5. (Individual # 1) is complimented for completing the goal and document as needed. Frequency: Daily. Amount: 15 minutes."

On 01/03/18 at approximately 2:45 p.m.an interview was conducted with OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional). When asked what the purpose of the PCP was, OSM # 1 stated, "To help maintain their (Individual's) daily goals and independence for their daily living." When asked if the PCP serves as a guide to teach individuals new skills, OSM # 1 stated, "Yes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked how progress is determined, ASM # 2 and OSM # 1 stated, "It's based on what staff are writing and what the staff and individual are doing at that particular time." During the interview ASM # 2 and OSM # 1 were asked to review the progress notes for Individual # 1 dated 12/01/17 through 12/31/17. When asked if the data was collected in measurable terms for Individual # 1's outcome of socialization skills, community integration, sensory stimulation/stress management, communication, independent living skills, money management; and medication management, ASM # 2 and OSM # 1 stated, "No."

The facility's policy "4.1 Individual Service Plan (ISP)" documented, "4.1.4 Individual Service Plan (ISP) Development. H. Data Collection: Data collection is recorded on all objectives/desired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 82	W 252		

outcomes in a format that accurately represents the consumer's progress. Data is tracked, documented in measureable terms and analyzed to ensure that appropriate objectives/desired outcomes and interventions/support strategies are in place for the consumer. On-going documentation is kept in the progress notes regarding the progress, changes or significant events relating to the functioning of the consumer."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

2. The facility staff failed to document the data collection of Individual # 2's PCP (Person Centered Plan) outcomes were in measurable terms.

Individual # 2 was a 63-year-old female, who was admitted to (Name of Group Home) on 11/23/10. Diagnoses in the clinical record included but were not limited to: (1) profound intellectual disability, (2) epilepsy, (3) mild dysphagia, (4) myopia, (5) vitamin D deficiency and (6) PICA.

Individual # 2's current PCP dated 08/01/2017 through 07/31/2018 documented:

- "Desired Outcome: Outcome # 1: Exercise and Recreation. (Individual # 2) engages in different forms of exercise/recreation 75% (percent) of the time using different parts of her body especially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 83	W 252		

her legs and hands. Support Activities & Instructions: 1. (Individual # 2) is selects going to the patio by walking directly to the back door. 2. (Individual # 2) walks for 10 to 15 minutes in the neighborhood or at the park. 3. (Individual # 2) selects to dance to 10 to 15 minutes twice a week. Frequency: Weekly. Amount: 15 minutes."

- "Desired Outcome: Outcome # 2: Communication. (Individual # 2) is nonverbal and she enjoys communicating with people who understand her 75% of the time. Support Activities & Instructions: (Individual # 2) communicates her wants and needs to others using nonverbal cues like a communication device (Book) 75% of the time daily. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: continually."

- "Desired Outcome: Outcome # 3: Community inclusion. (Individual # 2) engages in some community activities of her choice 80% of the time. Support Activities & Instructions: (Individual # 2) makes preference from a variety of places with the help of her communication log book. She decides what activity she likes to engage in and staff supports her where needed. 1. (Individual # 2) is supported to research and select a place she would like to go in her communication book. 2. (Individual # 2) is prompted to get ready for the outing by putting together her needs for the outing. 3. (Individual # 2) is encouraged to have meet [sic] new friends

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 84	W 252		

and have as much fun as possible. 4. (Individual # 2's) strengths and weaknesses are documented so as to see needs help. Frequency: Weekly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 4: Socialization skills. (Individual # 2) develops some social skills by signing 'hi' 50% of the time while out in the community. Support Activities & Instructions: (Individual # 2) increases her level of socialization with her peers and makes new friends while out in the community. 1. (Individual # 2) smiles or makes eye contact with people she meets. 2. (Individual # 2) is encouraged to wave her hand to say hello or good-bye. 3. (Individual # 2) is encouraged to raise her hand and sign "hi" to the people she meets as a sign of being cordial. 4. (Individual # 2's) is congratulated if she does a good job at greeting. Frequency: Weekly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 5: Medication education skills. (Individual # 2) participates in her medication education goal by knowing the importance of her medications and why she should take them with water 75% of the time. Support Activities & Instructions: 5A (Individual # 2) listens to the importance of taking her medication with water. 1. (Individual # 2) is encouraged to learn about her medication by reviewing with staff the importance of taking her medication. 2. (Individual # 2) reviews the importance of taking her medications with water. 3. (Individual # 2) takes her medication with water when requested. Frequency: Daily. Amount: 15 minutes." 5B. (Individual # 2) turns her cup (nosey cup of water into her mouth with prompts from staff who monitors her throughout the process. Support Activities & Instructions: 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 85	W 252		

(Individual # 2) is prompted to open her mouth to get her medication as per her MAR (medication administration record). 2. (Individual # 2) is encouraged to pick up her cup of water. 3. (Individual # 2) is prompted to turn her nosey cup of water into her mouth. 4. (Individual # 2) is praised for doing a good job and her progress is documented for review. Frequency: Daily. Amount: 15 minutes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked how progress is determined, ASM # 2 and OSM # 1 stated, "It's based on what staff are writing and what the staff and individual are doing at that particular time." During the interview ASM # 2 and OSM # 1 were asked to review the progress notes for Individual # 2 dated 12/01/17 through 12/31/17. When asked if the data was collected in measurable terms for Individual # 2's exercise and recreation, communication, community inclusion, socialization skills, medication education skills, ASM # 2 and OSM # 1 stated, "No."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1were made aware of the above findings.

No further information was provided prior to exit.

References:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 86	W 252		

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(4) Nearsightedness is when light entering the eye is focused incorrectly, making distant objects appear blurred. Nearsightedness is a type of refractive error of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001023.htm.

(5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 87	W 252		

(6) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm.

3. The facility staff failed to document the data collection of Individual # 3's PCP (Person Centered Plan) outcomes were in measurable terms.

Individual # 3 was a 57-year-old female, who was admitted to (Name of Group Home) on 1/24/96. Diagnoses in the clinical record included but were not limited to: (1) severe intellectual disability, (2) PICA, (3) grand maul seizure disorder, non-verbal and status/post (condition after) right ankle fracture.

Individual # 3's current PCP dated 08/01/2017 through 07/31/2018 documented:

- "Desired Outcome: Outcome # 1: Communication. (Individual # 3) communicates her wants and needs by using facial expressions, gestures, and making vocalizations 80% of the time until 10/20/18. (Individual # 3) uses her preferred language to express her wants and needs three times a day to staff and or her peers. Support Activities & Instructions: 1. (Individual # 3) points at what she would like. 2. (Individual # 3) shakes her head for yes or no when asked a question. 3. (Individual # 3) uses vocalizations and or facial to express her thoughts. Frequency: Daily. Amount: 15 Continually."

- "Desired Outcome: Outcome # 2: Socialization. (Individual # 3) socializes with others by greeting with handshakes and making eye contact to increase good social skills 90% of the time until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 88	W 252		

10/20/18. Support Activities & Instructions: (Individual # 3) greets others. 1. (Individual # 2) is prompted to pick up her communication device. 2. (Individual # 2) point to what she wants on the device. 3. (Individual # 2) is completes [sic] that activity or get the items she selects. 4. (Individual # 2) is praised for following instructions. Frequency: Daily. Amount: 15 minutes."

- "Desired Outcome: Outcome # 3: Exercise. (Individual # 3) likes to maintain her healthy (4) BMI (body mass index) by exercising 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) exercises four times a week for 15 or more minutes weekly by going for walks, using the recumbent bike, dancing, participating in chair yoga or and/or another form of exercise of her choice. 1. (Individual # 3) selects the type of exercise that she would like to do by gesturing, pointing, or making vocalizations when presented to her. 2. (Individual # 3) puts on the correct footwear to perform the exercise. 3. (Individual # 3) reviews instructions on how to perform exercise. 4. (Individual # 3) checks her weight once monthly to track progress. Frequency: Weekly. Amount: 30 minutes."

- "Desired Outcome: Outcome # 4: Money management. (Individual # 3) purchases items of her choice with her money when on a community outing 50% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) engages in spending her own money to purchase items of her choice once monthly. 1. (Individual # 3) selects where she would like to go to purchase items by reviewing and discussing with the staff what items she wants to shop for. 2. In the store (Individual # 3) selects items she needs and wants to purchase. 3. (Individual # 3) brings the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 89	W 252		

items to the checkout register. 4. (Individual # 3) completes the purchase by providing the cashier with the funds. (Individual # 3) gets the change and receipt from the cashier and provides staff with them. Frequency: Monthly. Amount: 60 minutes."

- "Desired Outcome: Outcome # 5: Health & Safety. (Individual # 3) makes healthy choices during meal time 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) selects to drink a healthy beverage with her meal i.e. water as opposed to coffee and selects a healthy snack and makes a healthy meal choice twice daily while following apperation [sic] protocol. 1. (Individual # 3) selects to drink a healthy beverage.as opposed to coffee or hot coco with her dinner. 2. (Individual # 3) selects a healthy fruit snack as opposed to chips or cookies. 3. (Individual # 3) choose to eat healthy meal by participating in menu selection during house meeting. 4. (Individual # 3) maintains that all meats are chopped to help with swallowing her food with drinking a beverage slowly and properly each meal daily. Frequency: Daily. Amount: Continually."

- "Desired Outcome: Outcome # 7: Independent living skills. (Individual # 3) folds her laundry during the week 80% of the time until 10/20/18. Support Activities & Instructions: (Individual # 3) neatly folds tops, pants, socks and underwear and places them in the laundry basket. 1. (Individual # 3) retrieves clean laundry from the laundry area and/or dryer. 2. (Individual # 3) takes laundry to her bedroom or common area. 3. (Individual # 3) sits in chair and folds clothing item. 4. (Individual # 3) places folded items back in the laundry basket. Frequency: Weekly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 90	W 252		

Amount: 30 minutes."

An interview on 01/04/18 at approximately 3:45 p.m. was conducted with ASM (administrative staff member) # 2, the acting program manager for (Name of Group Home), and OSM (other staff member) # 1, QDIP (Qualified Intellectual Disabilities Professional. When asked how progress is determined, ASM # 2 and OSM # 1 stated, "It's based on what staff are writing and what the staff and individual are doing at that particular time." During the interview ASM # 2 and OSM # 1 were asked to review the progress notes for Individual # 3 dated 12/01/17 through 12/31/17. When asked if the data was collected in measurable terms for Individual # 3's communication, socialization, exercise, money management, health & safety, and independent living skills, ASM # 2 and OSM # 1 stated, "No."

On 01/04/18 at 5:00 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, acting program manager of (Name of Group Home) and LPN (licensed practical nurse) # 1 were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G044	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI OAK STREET ICF/MR	7811 OAK STREET MANASSAS, VA 20111

(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 252	Continued From page 91	W 252		

https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100.

(2) A pattern of eating non-food materials, such as dirt or paper. This information was obtained from the website: https://medlineplus.gov/ency/article/001538.htm.

(3) Epilepsy is a brain disorder in which a person has repeated seizures over time. Seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior. Generalized tonic-clonic (grand mal) seizure (involves the entire body, including aura, rigid muscles, and loss of alertness). This information was obtained from the website: https://medlineplus.gov/ency/article/000694.htm.

(4) A good way to decide if your weight is healthy for your height is to figure out your body mass index (BMI). You and your health care provider can use your BMI to estimate how much body fat you have. This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm.