PRINTED: 02/19/2016 **FORM APPROVED** OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G017	B. WING		02/17/2	2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1631 VIRGINIA AVENUE HARRISONBURG, VA 22802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE CON THE APPROPRIATE	(X5) MPLETION DATE	
	re-certification surthrough 02/17/16. compliance with 42 for Intermediate Cowith Intellectual Dis Safety Code surve complaints were in The census in this at the time of the sconsisted of 4 Indithrough four). 483.410(d)(3) SEF OUTSIDE SOURCE The facility must as meet the needs of This STANDARD Based on observarecord review and facility staff failed to implemented the according to the survey samp Findings included: Individual # 2 was program on 02/17/11:45 a.m. The incomplement of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of him in an according to the survey samp front of the survey samp front	Fundamental Medicaid vey was conducted 02/16/16 The facility was not in 2 CFR Part 483 Requirements are Facilities for Individuals sabilities (ICF/IID). The Life cy/report will follow. No exestigated during the survey. 15 certified bed facility was 15 survey. The survey sample vidual reviews (Individuals one cylical reviews (Individuals one cylical reviews (Individuals one cylical reviews). Is not met as evidenced by: It is not	W 0	In response to W120 Harrison ICF -IID (to ensure outside source specific needs for east according to program professional protoco. This will be done as The QIDP for the fawill provide docume of any specialized not treatments to the Da Coordinator, and wi	the facility) will the sees meet the such individual in plans and /or sols. follows: cility tentation teeds or the original of the population of the solution of the population of the population thoroughly thor		
		DER/SUPPLIER REPRESENTATIVE'S SIG	LATINC.	TITLE	VDH/OLC	DATE	

LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0936-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		49G017	B. WING	, yyans yyaqqa nigas on anayyah yiling sayaqa ilminying yaqqa yong sayaqa midale salalah.	02/17/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
HARRIS	ON ICF-MR			1631 VIRGINIA AVENUE HARRISONBURG, VA 22802	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
W 120	Continued From pa	ige 1	W 1	20	
		ndividual's food was			
	At 11:20 a.m., the in the food in front of	ndividual's spoon was placed of him.		The Day Program and the team	ı
	individual. The DS	# 3 started to feed the P did not sit down beside the tood by the individual's side		leaders will continually monitor for compliance with protocols, and will provid correction, retraining, and docu	
	observed standing the DSP had his lef back of the individu holding the individu	1:30 a.m., DSP # 3 was on the individual's right side, it arm wrapped around the al's neck with his left hand al's jaw and tilting the ackward, while pouring the int hand.		as necessary. The QIDP for the facility shall continue to complete observation and random spot checks of the provided to individuals in the conservices.	ons services
	interviewed regardi	:35 a.m., DSP # 3 was ng the above observation. at this was part of Individual #			
	DSP # 3 was asked of the plan. DSP # plan that read, "th chin pushing his low with the lower edge holds the cup, restin The DSP was askethis technique. The	gram plan was retrieved and to show where this was part 3 pointed to the individual's e palm of one hand rests on wer lip upward to form a seal of the cup, the other hand ng it against his lower lip" d if anyone instructed him on DSP voiced, no and went on just read it from the		RECE MAR 17	
		cal record was reviewed on mately 1:30 p.m. The current		VDH/	OLC

physician's orders were reviewed and

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039 ⁻					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G017	B. WING			02	2/17/2016	
	PROVIDER OR SUPPLIER			1631	ET ADDRESS, CITY, STATE, ZIP CODE VIRGINIA AVENUE RRISONBURG, VA 22802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 120	food, give him the sminutes feed him the A document was re TECHNIQUES" dat documented read, 'minutesallow 20 n has not finished his will feed him for the the feeder for solids feeder for liquidss rests on chin pushir a seal with the lower hand holds the cup, The hand that is reshead backward into	elp him with 1st bite or two of spoon to feed himself, after 20 he rest of his meal" viewed titled, "FEEDING ed February 7, 2001. The "maximum feeding time 40 hinutes to feed himself, if he plate, then a staff member next 20 minutesposition of ssitting downposition of the standingpalm of one hand high is lower lip upward to form or edge of the cup, the other resting it against his lower lip. Sting on the chin pushes the a mild extension to reduce suching of individual's head and	W 1	20				
	Professional) was in approximately 2:10 techniques' for individual that everyone is trail went on to say that day program to obseshe (QIDP) had not during lunch at the day project that the day project that the day professional trails are the content of the cont	d Intellectual Disability Interviewed on 02/17/16 at p.m. regarding the 'feeding ridual # 2. The QIDP voiced ned on how to do it (feed) and twe' (facility staff) go to the erve, but further added that observed the individual day program. The QIDP program staff and house staff that they (day program) know ose to be doing.						
W 155	presented prior to the 02/17/16 at 3:30 p.m	on or documentation was be exit conference on n. F TREATMENT OF CLIENTS	W 1	55				

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MAR 17 2016 VDH/OLC

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		(<u>OMB NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		49G017	B. WING		02/17/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HADDIC	ON ICE NO			1631 VIRGINIA AVENUE	
HARRIS	ON ICF-MR			HARRISONBURG, VA 22802	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
					Completion Date:
W 155	Continued From pa	ge 3	W 1	55	3/18/16
	The facility must pro	event further potential abuse		As a corrective action for	
	while the investigati			W155 483.420 (d) (3) Staff	
	J	. 0		Treatment of Clients, the facility	
				shall continue to follow the agency's	
	This STANDARD is	s not met as evidenced by:		(Pleasant View, Inc) Human Rights	
		rview, clinical record review		Policy regarding abuse and neglect,	
		nt review; the facility staff		as approved by the Department of	
		irect staff person (DSP) was		Behavioral Health and Development	
		loyment after an allegation of		Services, the local Human Rights	
		restigation was underway for		Advocate, and the local Human	
	one (1) of 4 Individu	iais, individuai #1.		Rights Committee. Full documentation	
	Individual #1 was su	uspected of being abused by a		of any abuse allegations and the	
		investigation was conducted		resulting investigations will be	
		ppleted on 10/6/15, the DSP		maintained per agency policy.	
		hour shift on 10/3/15 through		To ensure this, the following procedures	
		vestigation was being		will be followed:	
	conducted.	9		- All new staff will have a through training	-
				in Human Rights policies, with an empha	Į.
	The findings include) :		on the State Human Rights Regulations (
				This training will be updated for every en	nployee,
		eximately 3:00 p.m., the		and as the need may arise.	
		resented to the Surveyors an		- For any individual(s) found to be affect	
		spected Abuse." The form		by any breach of rights, the following ste	eps
	was reviewed to inc			shall be enacted:	
		e: 10/2/15[Individual ite: BedroomRelation:		* The identified staff member shall be in	nmediately
		sical" was marked on the		removed from contact with any individu	al served
		Staff reported that they heard		within PV,Inc. program, pending comple	tion of
		of an individual's bedroom.		the investigation.	
		a history of smacking people		* Per timelines established within the ag	
		ne person that was changing		policies, the incident will be reported to	all
		imDescription of Medical		appropriate agencies.	
		& Finding: There were no			
		n individual and he is has			
		ctions and as not able to			
		in (sic)Investigation Begin			
	Date: 10/2/15Date	Investigation Final Report:			

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10/6/15..." Further review of "Witness

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DEIANI		A MEDIONI OF OFFICE				MAD NO 0029 0204
		& MEDICAID SERVICES	T		······································	<u>)MB NO. 0938-0391</u> T
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G017	B. WING			02/17/2016
NAME OF F	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
			1631	1 VIRGINIA AVENUE		
HARRISC	ON ICF-MR			HAI	RRISONBURG, VA 22802	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
VA/ 155	Continued From pa	ine 4	W ·	155		
VV 100	•		VV	100		
		the DSP's that overheard the ed the allegation, which were			* The Social Work Department will	
		y's Social Workers revealed			begin the investigation within the pr	
		ed of "smacking" the			time frame. At this time, any other i	
		e the following statement			who may have been affected by the	
		ing, explicit language] brat,			will be identified, and included in the	
	I'll take care of him.				as needed.	
					* The investigation of the alleged in	ncident will
		oximately 4:30 p.m., the			be completed promptly, and all data	
	. •	or and the director of			will be recorded and maintained in	
		/ Qualified Intellectual			per PV, Inc's policies. The agency v	
		ional (QIDP) was interviewed employment at the facility and			clear interview form as well as a tra	
		ing, the QIDP stated, "Yes,			use during the investigation in orde	
	she is working tonig				clear documentation of the investig	
		ng statement made by the			The documentation shall include co	
		lings being "Unsubstantiated,"			and times of all reports.	
		he social worker and the			* If the incident is founded, the staf	f member
		on said as long as it didn't			will be subject to the findings of the	e investigation.
		ne resident or others it wasn't			if termination occurs, the staff mem	
	considered abuse				will be prohibited from access to ar	ny of
		oximately 8:00 a.m., the Social nterviewed regarding the			Pleasant View, Inc's properties or in	ndividuals.
		the DSP and the findings of			if the staff person is found to be ret	rainable,
		ostantiated." The SW stated,			the staff member will undergo a thr	ough
		ere involved were agency staff			Human Rights retraining with the S	Social
		n named] did not hear			Worker and work closely observed	
	anything she was ju	st going off of what [person			Program Coordinator for a specifie	d period of time.
		f [person accused of abused			-The Program Coordinator and the	
		dn't like her" When			Program Director/QIDP shall conti	nually
		ng the statement made by the			observe and monitor staff behavior	
		ouse, the SW stated, "When			interactions with the individuals re-	siding
	they can vent to each	ff it is not considered abuse,			within the facility, and correction v	vith
	mey can vent to eat	STOUIGI.			documentation will occur as necess	
	On 2/17/16 at appro	eximately 8:30 a.m., the DSP,			any further breaches of human righ	
		se allegation and will be			-	Completion Date

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accused of the abuse allegation and will be identified as DSP #1 hence forward, was

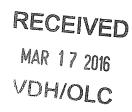
interviewed regarding the accusation of abuse.

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	B. WING		02/17/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			1631 VIRGINIA AVENUE	
HARRISON ICF-MR			HARRISONBURG, VA 22802	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
W 155 Continued From particles of the Employee's Timreceived, the Times worked on 10/3/15, (8) hours, while the conducted. On 2/17/16 at approthe facility's abuse particles of the facility's abuse particles of the facility's abused, mannerIndividual and the conducted.	age 5 vas in the room with [Individual vidual named] tried to hit me up to block it and [DSP named] the noise and thought I hit "When interviewed regarding imented on the "Witness ding the Individual being a nguage] brat," DSP #1 stated, that about anybody." I know [Program Coordinator named] me aware of what was going eave, I left and went home. It ursday night and I was off fulled to work on Saturday night and told me everything was work on Saturday night." DSP and asked if she had worked after the allegation, DSP #1 of edon't have assignments on to everything together. We nother out." Distinctly 9:00 a.m., a copy of ne sheet was requested and sheet evidenced that DSP #1 10/4/15 and 10/5/15 for eight investigation was still being eximately 9:45 a.m., a copy of policy was reviewed to include the is the policy of the agency to iduals will be treated fairly and neglected, or exploited in any abuse or mistreatment is	W 1		
which would humilia individual; or condo	d. Statements or actions ate, demean, or exploit an ning, or permitting the abuse			
ot an individualAn	y staff person having			

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knowledge of such abuse or mistreatment or

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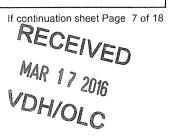
PRINTED: 02/19/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(, , , , , , , , , , , , , , , , , , ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G017	B. WING		02/17/2016
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 631 VIRGINIA AVENUE HARRISONBURG, VA 22802	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 159	taking place will: 1. allegation of abuse will immediately tak the individual until a On 2/17/16 at appro QIDP stated to this was not followed, s been allowed to retrinvestigation was converted to the surverterning to work prinvestigation regard 483.430(a) QIDP Each client's active integrated, coordinated qualified intellectual This STANDARD is Based on staff inteand facility docume Intellectual Disabilitiensure the policies implemented for abfailed to ensure the was implemented red 1. Individuals in the survey a DSP on 10/2/1 conducted on 10/2/1 the DSP worked an through 10/5/15, who conducted.	cause to believe abuse is Immediately report an to his or her supervisor who se necessary steps to protect an investigation is complete" oximately 10:30 a.m., the Surveyor, "I know the policy he [DSP #1] shouldn't have urn to work until after the ompleted (sic)." ion was provided during the ey pertaining to the DSP rior to the completion of an ding the allegation of abuse. It treatment program must be ated and monitored by a all disability professional. Is not met as evidenced by: erview, clinical record review ent review; the QIDP (Qualified by Professional failed to 1) and procedures were euse investigations and 2). Active Treatment Plan (ATP) egarding feeding for one (1) of survey sample, Individual #2. Is suspected of being abused 5; an investigation was 15 and completed on 10/6/15, a eight (8) hour shift on 10/3/15 inile the investigation was being active Treatment Plan (ATP).	W 159	Pursuant to W159 438.430 (a), the facility QIDP shall ensure that all agency policies involving protection of the individuals are followed. Individual #1 will be protected as follow the facility shall continue to follow the agency's (Pleasant View, Inc) Human Rights Policy regarding abuse and neglect, as approved by the Department of Behavioral Health and Development Services, the local Human Rights Advocate, and the local Human Rights Committee. Full documentation of any abuse allegations and the resulting investigations will be maintained per agency policy.	Completion Date: 3/15/16

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Facility ID: VA49G017



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		I AND HOMAN SERVICES			FURNI APPROVEL
CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	DESTION DENTIES ATION NUMBER		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		49G017	B. WING		02/17/2016
NAME OF I	NAME OF PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CO	
			1	1631 VIRGINIA AVENUE	
HARRIS	ON ICF-MR			HARRISONBURG, VA 22802	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	A SOO DESERVATED TO THE A	HOULD BE COMPLETION
W 159	Continued From pa	nge 7	W 1	59	
	The findings includ	e:			
	executive director properties of the state o	oproximately 3:00 p.m., the oresented to the Surveyors an uspected Abuse." The form clude the following: te: 10/2/15[Individual site: BedroomRelation: ysical" was marked on the Staff reported that they heard of an individual's bedroom. a history of smacking people he person that was changing himDescription of Medical d & Finding: There were no n individual and he is has actions and as not able to ain (sic)Investigation Begin to Investigation Final Report:		For Individual # 2, feeding protocy will be done as follows: The QIDP for the facility will provide documentation of any specialized needs or treatments to the Day Program Coordinator, and will review the documentation with her. Before the procedures are implemented, all support staff will be trained and observed on the correct procedures by the QIDP or his/her designee.	ol
	10/6/15" Further r Statements," from t "smack" and report written by the facilit that the DSP accus Individual also mad	review of "Witness he DSP's that overheard the ed the allegation, which were y's Social Workers revealed ed of "smacking" the e the following statementing, explicit language] brat,		All training will be thoroughly documented and this documentati will be maintained both at the Da Program site and within the personnel files. Each new hire shall receive specific training as part of the orientation process.	
	program coordinate residential services Disability Profession the DSP employme still working, the QII	oximately 4:30 p.m., the or and the director of / QIDP (Qualified Intellectual nal) was interviewed regarding nt at the facility and if she was DP stated, "Yes, she is ne QIDP was interviewed		The Day Program and the team leaders will continually monitor for compliance with protocols, and will provide correction, retraining, and documentation as necessary.	

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regarding statement made by the DSP and of the findings being "Unsubstantiated," the QIDP stated, "The social worker and the Human Rights

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-03				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G017	B. WING			02/17/2016		
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS	ON ICF-MR				VIRGINIA AVENUE RRISONBURG, VA 22802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
W 159	person said as long the resident or other abuse" On 2/17/16 at approver Worker (SW) was instatement made by abuse being "Unsus "The people that we persons and [person anything she was junamed] told her and named] said they dinterviewed regarding DSP, accused of abit it is done around state they can vent to ear on 2/17/16 at approaccused of the abusing the statement of the statement docustatements" regard "spoiled [explicit land" I would never say the statement of the stateme	g as it didn't happen in front of ers it wasn't considered oximately 8:00 a.m., the Social interviewed regarding the the DSP and the findings of obstantiated." The SW stated, ere involved were agency staff in named] did not hear just going off of what [person accused of abused idn't like her" When ing the statement made by the ouse, the SW stated, "When iff it is not considered abuse,	W ·	159	The QIDP of the facility she continue to complete obser and random spot checks of provided to individuals in tax services.	vations the services		
	came in and made on and told me to le happened on a Thu Friday. I was sched and they called me	me aware of what was going eave, I left and went home. It rsday night and I was off uled to work on Saturday night and told me everything was work on Saturday night." DSP						

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#1 was interviewed and asked if she had worked with the Individual after the allegation, DSP #1

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STATEMENT OF DEFICIENCES AND PLANCE CORRECTION INTERPRETADINATION NAME OF PROVIDER OR SUPPLIER HARRISON ICF-MIR INTERPRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDER OR SUPPLIER HARRISON ICF-MIR INTERPRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDER OR SUPPLIER INTERPRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDER OR SUPPLIER INTERPRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDER OR SUPPLIER INTERPRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDERS TRAN OF CORRECTION W 159 STATEMENT AND STATE AND CORRECTION INTERPRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDERS TRAN OF CORRECTION INTERPRETADINE ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDERS TRAN OF CORRECTION ISSUED AND STATE ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDERS TRAN OF CORRECTION ISSUED AND STATE ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDERS TRAN OF CORRECTION ISSUE CORRECTION ISSUE CITY TO THE APPROPRIATE W 159 STATE TABLEST AND STATE. INTERPRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PRETADINESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDER CITY. W 159 STATE TABLEST ADDRESS. CITY. STATE. ZIP CODE 1331 VIRGINIA MENUE HARRISON REAL PROVIDER CITY. TAG STATE TABLEST STA	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> MB NC</u>	<u>MB NO. 0938-0391</u>	
NAME OF PROVIDER OR SUPPLIER HARRISON ICF-MR SUMMARY STATEMENT OF DETICITABLES PROVIDER STAN OF CORRECTION PREFIX PROVIDER STAN OF CORRECTION PROVIDER STAN OF CORRECTIO	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '				
NAME OF PROVIDER OR SUPPLIER HARRISON ICF-MR X3 ID PREFIX STATE ZIP CODE 1631 VIRGINIA AVENUE HARRISONBURG, VA 22802		!	49G017	B. WING			02	2/17/2016
HARRISON ICF-MR 153	NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		And the second s
MARKSUMARY STATEMENT OF DEFICIENCIES 10 PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROSPRETER SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE					1	1631 VIRGINIA AVENUE		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) W 159 Continued From page 9 stated, "Oh yeah, we don't have assignments on the night shift, we do everything together. We work and help each other out." On 2/17/16 at approximately 9:00 a.m., a copy of the Employee's Time sheet evidenced that DSP #1 worked on 10/3/15, 10/4/15 and 10/5/15 for eight (8) hours, while the investigation was still being conducted. On 2/17/16 at approximately 9:45 a.m., a copy of the facility's abuse policy was reviewed to include the following: "Subject: DignityIt is the policy of the agency to ensure that all individuals will be treated fairly and will not be abused, neglected, or exploited in any mannerIndividual abuse or mistreatment is defined as followsd. Statements or actions which would humiliate, demean, or exploit an individual. Any staff person having knowledge of such abuse or mistreatment or having reasonable cause to believe abuse is taking place will: 1. Immediately report an allegation of abuse to his or her supervisor who will immediately take necessary steps to protect the individual and proving place wills. I mediately to 0:30 a.m., the QIP stated to this Surveyor, "I know the policy was not followed, she [DSP #1] shouldn't have been allowed to return to work until after the investigation was completed (sic.)" No further information was provided during the course of the survey pertaining to the DSP returning to work pror to the completion of an	HAKKISU)N ICF-WK			ŀ	HARRISONBURG, VA 22802		
stated, "Oh yeah, we don't have assignments on the night shift, we do everything together. We work and help each other out." On 2/17/16 at approximately 9:00 a.m., a copy of the Employee's Time sheet was requested and received; the Timesheet evidenced that DSP #1 worked on 10/3/15, 10/4/15 and 10/5/15 for eight (8) hours, while the investigation was still being conducted. On 2/17/16 at approximately 9:45 a.m., a copy of the facility's abuse policy was reviewed to include the following: "Subject: DignityIt is the policy of the agency to ensure that all individuals will be treated fairly and will not be abused, neglected, or exploited in any mannerIndividual abuse or mistreatment is defined as follows:d. Statements or actions which would humiliate, demean, or exploit an individual; or condoning, or permitting the abuse of an individualAny staff person having knowledge of such abuse or mistreatment or having reasonable cause to believe abuse is taking place will: 1. Immediately report an allegation of abuse to his or her supervisor who will immediately take necessary steps to protect the individual until an investigation is complete" On 2/17/16 at approximately 10:30 a.m., the QIDP stated to this Surveyor, "I know the policy was not followed, she [DSP #1] shouldn't have been allowed to return to work until after the investigation was completed (sic)." No further information was provided during the course of the survey pertaining to the DSP returning to work prior to the completion of an	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
	W 159	stated, "Oh yeah, we the night shift, we do work and help each On 2/17/16 at approte the Employee's Time received; the Times worked on 10/3/15, (8) hours, while the conducted. On 2/17/16 at approte the facility's abuse puthe following: "Subject: DignityIt ensure that all indivivial not be abused, amannerIndividual defined as follows: which would humilia individual; or condot of an individualAn knowledge of such a having reasonable of taking place will: 1. allegation of abuse will immediately take the individual until a On 2/17/16 at approduced to the individual until and 2/17/1	ve don't have assignments on do everything together. We nother out." oximately 9:00 a.m., a copy of the sheet was requested and sheet evidenced that DSP #1, 10/4/15 and 10/5/15 for eight investigation was still being oximately 9:45 a.m., a copy of policy was reviewed to include the ist the policy of the agency to viduals will be treated fairly and neglected, or exploited in any labuse or mistreatment is and. Statements or actions ate, demean, or exploit an oning, or permitting the abuse my staff person having abuse or mistreatment or cause to believe abuse is Immediately report and to his or her supervisor who are necessary steps to protect an investigation is complete" oximately 10:30 a.m., the Surveyor, "I know the policy he [DSP #1] shouldn't have urn to work until after the ompleted (sic)." ion was provided during the ty pertaining to the DSP for to the completion of an		159			

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2. The facility staff failed to ensure the active

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				C	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G017	B. WING	;		02/17/2016
	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1 VIRGINIA AVENUE	
HARRISC	ON ICF-MR			HAI	RRISONBURG, VA 22802	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
W 159	Continued From pa		W	159		
	monitored by the Q	s integrated, coordinated and NDP (qualified intellectual nal) for individual # 2 related to				
	Findings included:					
	Professional) failed techniques' for Indicoordinated and moindividual's home a Individual's home on 02/17/16, a.m. The individua for approximately 2 and three separate approximately 7:55 person) # 2 approa assisted with feeding the individual and foon the food tray and the table. The DSF with a special spoodrinks of the bevera positioned her hand put the nosey cup undividual would dripositioning was per individual.	observed eating breakfast at between 7:30 a.m. and 8:10 al was observed to be left alone 20 minutes with his food tray beverages in front of him. At 5 a.m., DSP (direct staff ached the individual and ng. DSP # 2 sat down beside fed the individual all of contents d two of three beverages on 2 spooned the pureed food in and gave the individual ages via 'nosey cup', DSP # 2 d under the individual's chin, up to the individual's lip and the ink. No other special rformed or required to feed the				
	interviewed regarding DSP # 2 voiced that	:00 a.m., DSP # 2 was ing the above observation. at the individual is set up for one for 20 minutes per the				

individual's plan to allow the individual opportunity to feed himself. The DSP voiced that the resident

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CENTERS FOR MEDICARE & MEDICAID SERVICES					0	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		49G017	B. WING			02/17/2016
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
HARRISC	ON ICF-MR				VIRGINIA AVENUE	
HARRIOS	MAICH-MAIC			HAR	RISONBURG, VA 22802	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
W 159	Continued From pa	age 11	W 1	159		
	·	self and that he most always				
	program on 02/17/1 11:45 a.m. The ind front of him in an al	observed at lunch at the day 16 between 10:55 a.m. and lividual's food was placed in luminum pan with a cardboard lks, each in it's own nosey cup front of him.				
	At 11:15 a.m., the ir uncovered.	ndividual's food was				
	At 11:20 a.m., the in the food in front of	ndividual's spoon was placed of him.				
	At 11:25 a.m., DSP # 3 started to feed the individual. The DSP did not sit down beside the resident, the DSP stood by the individual's side the entire time.					
	observed standing of the DSP had his lef- back of the individu- holding the individual	1:30 a.m., DSP # 3 was on the individual's right side, if arm wrapped around the sal's neck with his left hand al's jaw and tilting the ackward, while pouring the ht hand.				
	interviewed regarding	1:35 a.m., DSP # 3 was ng the above observation. at this was part of Individual #				,
	The individual's pro DSP # 3 was asked	gram plan was retrieved and I to show where this was part				

of the plan. DSP # 3 pointed to the individual's plan that read, "...the palm of one hand rests on chin pushing his lower lip upward to form a seal

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		AND HOMAN SERVICES				MB NO. 0938-0391
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(V2) MI II	TIDI E C	CONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	` ′			COMPLETED
		49G017	B. WING			02/17/2016
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	
HARRIS	ON ICF-MR				I VIRGINIA AVENUE RRISONBURG, VA 22802	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
W 159	holds the cup, resti The DSP was aske this technique. The to say that he (DSP program. Individual # 2's clini 02/17/16 at approx physician's orders of documented: "Ho food, give him the s minutes feed him the A document was re TECHNIQUES" day documented read, minutesallow 20 r has not finished his will feed him for the the feeder for solid- feeder for liquidss rests on chin pushi a seal with the lowe hand holds the cup The hand that is re head backward into	e of the cup, the other hand ng it against his lower lip" I'd if anyone instructed him on a DSP voiced, no and went on property in the property is a part of the property in the property in the property is a part of the property in the property in the property is a part of the property in the proper		159		
	Professional) was i approximately 2:10 techniques' for indi	d Intellectual Disability nterviewed on 02/17/16 at 0 p.m. regarding the 'feeding vidual # 2. The QIDP voiced ined on how to do it (feed) and				

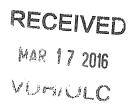
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went on to say that 'we' (facility staff) go to the day program to observe, but further added that

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		49G017	B. WING		02/17/2016
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLETION
	during lunch at the voiced that the day meet regularly and what they are supported that the appointment to be a (2016) by the doctor only due to the individual to the individ	observed the individual day program. The QIDP program staff and house staff that they (day program) know ose to be doing. The QIDP he individual had an evaluated again in March of for swallowing, but this was vidual's mother's preferences, ividual was having any type of the related to the individual's DP voiced that nothing had dividual swallowing and no ons had been identified.	W		Completion Date:
W 249	As soon as the interformulated a client's each client must red treatment program interventions and seand frequency to sure objectives identified plan. This STANDARD is Based on observation record review and facility staff failed to treatment plan/ISP (disciplinary team has individual program plan, seive a continuous active consisting of needed ervices in sufficient number pport the achievement of the in the individual program I not met as evidenced by: on, staff interview, clinical acility document review, the implement the active Individual Support Plan) for in the survey sample,	W 2	To ensure that the regulation W249 483.400 (d) (1), Program Implementation is met, the appointed QIDP for the facility shall ensure that all program plans providing active treatment for the indiv are followed as written. Individual #2 feeding procedures will be ensured as follows; The QIDP for the facility will provide documentation of any specialized need or treatments to Day Program Coordin and will review the documentation wi	3/15/16 viduals ls ators,

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Facility ID: VA49G017

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·		OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G017	B. WING _		02/17/2016		
NAME OF F	PROVIDER OR SUPPLIER	1	<u></u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
''Annie	OSCION SED			1631 VIRGINIA AVENUE			
HAKKIO	ON ICF-MR			HARRISONBURG, VA 22802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
W 249	Continued From pa	nge 14	W 24	9			
: I	The facility staff fail	led to ensure the active	D,	0 4 1			
ı	treatment plan was	integrated, coordinated and		efore the procedures are			
ı		NDP (qualified intellectual		plemented, all support staff			
ı	disability profession feeding.	nal) for individual # 2 related to	will be trained and observed on				
	reeding.			e correct procedure			
	Findings included:		-	the QIDP or his/her designee.			
	The fealth, staff fail	led to ensure a plan for		I training will be thoroughly cumented and this documentation			
		ied to ensure a plan for s' for Individual # 2 was					
	integrated, coordina	ated and monitored by the	Wı	ll be maintained both at the Day			
	QDIP (Qualified Inte	ellectual Disability	Program site and within the personnel files.				
	Professional).			ch new hire shall receive specific traini	ng as		
	Individual # 2 was c	observed eating breakfast at	-	rt of the orientation process.			
	home on 02/17/16,	between 7:30 a.m. and 8:10		te Day Program Coordinator and the tea			
		I was observed to be left alone		ders will continually monitor for comp			
		0 minutes with his food tray beverages in front of him. At		th protocols and will provide correction			
	approximately 7:55	a.m., DSP (direct staff		raining, and documentation as necessar			
	person) # 2 approac	ched the individual and	The QIDP for the facility shall continue to complete				
	assisted with feeding. DSP # 2 sat down beside the individual and fed the individual all of contents		observations and random spot checks of the services				
		d two of three beverages on	pro	ovided to individuals in the outside serv	/ices.		
	the table. The DSP	spooned the pureed food in					
		n and gave the individual					
		ages via 'nosey cup', DSP # 2 I under the individual's chin,					
	nut the nosev cup U	ip to the individual's lip and the					
	individual would drin	nk. No other special					
		formed or required to feed the					
	individual.						
		00 a.m., DSP # 2 was					

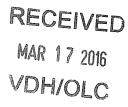
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DSP # 2 voiced that the individual is set up for meals and is left alone for 20 minutes per the individual's plan to allow the individual opportunity

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			<u>O</u> 1	<u> ИВ NO. 0938-03</u>	<u>,91</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		49G017	B. WING			02/17/2016	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY	STATE, ZIP CODE		
HADDICO	NICE MD			1631 VIRGINIA AVENUI	E		
HARRISO	N ICF-IVIK			HARRISONBURG, V	A 22802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	ИС
	rarely will feed hims waits for staff to assumatts for staff to assumatts for staff to assumatts for staff to assumatts a.m. The individual. Three drink were also placed in the food in front of the the food in front of	e DSP voiced that the resident self and that he most always sist him. bbserved at lunch at the day 6 between 10:55 a.m. and ividual's food was placed in uminum pan with a cardboard ks, each in it's own nosey cup front of him. Individual's food was	W 2				
	At approximately 11 observed standing of the DSP had his left back of the individual nolding the individual's head badrink in with the right At approximately 11 nterviewed regarding The DSP voiced that 2's program.	:30 a.m., DSP # 3 was on the individual's right side, arm wrapped around the al's neck with his left hand al's jaw and tilting the ckward, while pouring the at hand. :35 a.m., DSP # 3 was ag the above observation. It this was part of Individual #					

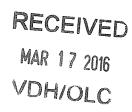
FORM CMS-2567(02-99) Previous Versions Obsolete

of the plan. DSP # 3 pointed to the individual's plan that read, "...the palm of one hand rests on

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STATEMENT OF DEFICIENCIES AND PROVIDER SUPPLIER LIA DENTIFICATION NUMBER 49G017 8. WING STREET ADDRESS. CITY. STATE. ZIP CODE 1631 VIRGINIA AVENUE HARRISON ICF-MR (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 249 Continued From page 16 chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip" The DSP was asked if anyone instructed him on this technique. The DSP voiced, no and went on to say that he (DSP) just read it from the program. Individual # 2's clinical record was reviewed on 02/17/16 at approximately 1:30 p.m. The current physician's orders were reviewed and documented: "Help him with 1st bite or two of food, give him the spoon to feed himself, after 20 minutes feed him for the next 20 minutes to feed himself, if he has not finished his plate, then a staff member will feed him for the next 20 minutes to feed himself, if he has not finished his plate, then a staff member will feed him for the next 20 minutes to feed himself, if he has not finished his plate, plane for one hand rests on chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip. A document was reviewed attiff member will feed him for the next 20 minutes to feed himself, if he has not finished his plate, then a staff member will feed him for the next 20 minutes, position of the feeder for liquidsstandingpam of one hand rests on chin pushing his lower lip, upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip.	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>)MB NO. </u>	<u>0938-0391</u>
NAME OF PROVIDER OR SUPPLIER HARRISON ICF-MR SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CHORLED TO THE APPROPRIATE DEFICIENCY				1				
HARRISON ICF-MR Summary STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE PROVI			49G017	B. WING			02/1	7/2016
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 249 Continued From page 16 chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip" The DSP was asked if anyone instructed him on this technique. The DSP voiced, no and went on to say that he (DSP) just read it from the program. Individual # 2's clinical record was reviewed on 02/17/16 at approximately 1:30 p.m. The current physician's orders were reviewed and documented: "Help him with 1st bite or two of food, give him the spoon to feed himself, after 20 minutes feed him the rest of his meal" A document was reviewed titled, "FEEDING TECHNIQUES" dated February 7, 2001. The documented read, "maximum feeding time 40 minutes—allow 20 minutes to feed himself, if he has not finished his plate, then a staff member will feed him for the next 20 minutesposition of the feeder for solidssitting downposition of the feeder for liquidsstandingpalm of one hand rests on chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other					1631	VIRGINIA AVENUE		
chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other hand holds the cup, resting it against his lower lip" The DSP was asked if anyone instructed him on this technique. The DSP voiced, no and went on to say that he (DSP) just read it from the program. Individual # 2's clinical record was reviewed on 02/17/16 at approximately 1:30 p.m. The current physician's orders were reviewed and documented: "Help him with 1st bite or two of food, give him the spoon to feed himself, after 20 minutes feed him the rest of his meal" A document was reviewed titled, "FEEDING TECHNIQUES" dated February 7, 2001. The documented read, "maximum feeding time 40 minutesallow 20 minutes to feed himself, if he has not finished his plate, then a staff member will feed him for the next 20 minutesposition of the feeder for solidssitting downposition of the feeder for liquidsstandingpalm of one hand rests on chin pushing his lower lip upward to form a seal with the lower edge of the cup, the other	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION
The hand that is resting on the chin pushes the head backward into a mild extension to reduce spillingminimal touching of individual's head and face during the feeding" The QIDP (Qualified Intellectual Disability Professional) was interviewed on 02/17/16 at approximately 2:10 p.m. regarding the 'feeding techniques' for individual # 2. The QIDP voiced that everyone is trained on how to do it (feed) and went on to say that 'we' (facility staff) go to the	W 249	chin pushing his low with the lower edge holds the cup, restin The DSP was aske this technique. The to say that he (DSP program. Individual # 2's clini 02/17/16 at approxiphysician's orders we documented: "He food, give him the sminutes feed him the A document was restricted to the feeder him for the the feeder for solids feeder for liquidss rests on chin pushing a seal with the lower hand holds the cup, The hand that is restricted backward into spillingminimal to face during the feeder for individual to the cup, The QIDP (Qualified Professional) was in approximately 2:10 techniques' for individual that everyone is train	ver lip upward to form a seal of the cup, the other handing it against his lower lip" dif anyone instructed him on a DSP voiced, no and went on by just read it from the cal record was reviewed on mately 1:30 p.m. The current vere reviewed and alp him with 1st bite or two of poon to feed himself, after 20 he rest of his meal" viewed titled, "FEEDING ed February 7, 2001. The financial time 40 hinutes to feed himself, if he plate, then a staff member next 20 minutesposition of sinsiting downposition of the diagnostic his lower lip upward to form redge of the cup, the other resting it against his lower lip. Sting on the chin pushes the a mild extension to reduce uching of individual's head and ling" d Intellectual Disability interviewed on 02/17/16 at p.m. regarding the 'feeding ridual # 2. The QIDP voiced and on how to do it (feed) and		.49			

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day program to observe, but further added that she (QIDP) had not observed the individual

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<u> </u>	10 1 ON MEDIOANE	G MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·		<u> </u>	ND INO. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
		49G017	B. WING	3		02/17/2016
	PROVIDER OR SUPPLIER ON ICF-MR			STREET ADDRESS, CITY, STATE, ZIP CO 1631 VIRGINIA AVENUE HARRISONBURG, VA 22802	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORF IX (EACH CORRECTIVE ACTION S	HOULD	BE COMPLÉTION
W 249	voiced that the day meet regularly and what they are suppo No further informati	day program. The QIDP program staff and house staff that they (day program) know ose to be doing. on or documentation was ne exit conference on	W 2	249		
						1

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