STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME CORRECTED COPY	10144 LAKE JACKSON DRIVE 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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/27/18 through 03/29/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.	E 006	E 006 Plan based on All Hazards Risk Assessment CFR(s): 483.475 (a)(1)-(2). (a)(1) While Community Residences completed a community based risk assessment, utilizing an all hazards approach a risk assessment was not conducted specifically for the Lake Jackson Drive Group Home. - A community based risk assessment, utilizing an all hazards approach will be conducted specifically for the Lake Jackson Drive Group Home, including the Clinical Director and group home staff with specific knowledge of the individuals served at Lake Jackson. - The risk assessment will be reviewed on annual basis to update the Emergency Plan based on current needs of the individuals and maintain compliance with the regulation. - The department of Mission Effectiveness at Community Residences will add review of the Risk Assessment to their periodic audits of clinical documents in the program. (a)(2) Once the community based risk assessment, utilizing all hazards approach is completed in (a)(1) the areas identified as major risks will have program specific strategies for preparing, mitigating and responding to the emergency risks.	5/13/18

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

[signature] Clinical Director 4/30/18

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.

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E 006	Continued From page 1 This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's associated strategies. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's associated strategies. ASM # 1 stated, "We don't have it for this facility." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 006	- Program specific strategies, procedures and/ or protocols will be developed and reviewed on an annual basis. These strategies will be utilized for any emergency drills or actual emergency events and documented when used for drill or actual events. - The department of Mission Effectiveness will add review of the presence of the strategies to their periodic audits of clinical documents in the program.	
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including,	E 007	E 007 EP Program Patient Population CFR(s): 483.475(a)(3) Specific services that Lake Jackson Drive Group Home will be able to provide during an emergency , how the facility would plan to continue to operate during and emergency and the delegation of authority during an emergency will be included in the facility specific emergency plan.	5/13/18

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E 007	Continued From page 2 but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the written emergency plan included the services the facility would be able to provide during an emergency, how the facility would plan to continue to operate during an emergency and the delegation of authority during an emergency. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation that the written emergency plan included the services the facility would be able to provide during an emergency, how the facility would plan to continue to operate during an emergency and the delegation of authority during an emergency. ASM # 1 stated, "We don't have it for this facility." On 03/29/18 at 2:55 p.m., ASM (administrative	E 007	- A multi departmental meeting will be held taking in to account the persons at risk to determine the and document the type of services that can be provided during an emergency and continuity of operations, including delegations of authority and succession plans. - The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	5/13/18

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E 007	Continued From page 3 staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 007		
E 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018	E 018 Procedures for Tracking of Staff and Patients CFR(s):483.475(b)(2) - A formalized tracking system/form will be developed specific to the Lake Jackson Drive Group Home to track the location of on-duty staff and sheltered individuals. - A tracking form specific to Lake Jackson Drive Group Home will be developed and provided to the facility. - A training will occur at the May Lake Jackson team meeting to review the content, utilization of the form during and emergency or drill and mechanism for communicating the content to the Community Residences Emergency Response team. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	5/13/18

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E 018	Continued From page 4 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by:	E 018		

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E 018	Continued From page 5 Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop a tracking system to document locations of patients and staff. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence the development of a tracking system to document locations of patients and staff. ASM # 1 stated, "We don't have a tracking system in the plan for this facility." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 018		
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 020	E 020 Policies for Evacuation and Primary/ Alternative Community CFR(s): 483.475 (b)(3) In addition to the general shelter in place procedures, program specific evacuation procedures for Lake Jackson Drive Group home will be developed including staff responsibilities, transportation to be utilized, identification of evacuation location(s) and primary and alternate means of communication.	5/13/18

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E 020	Continued From page 6 this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff	E 020	The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	

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E 020	Continued From page 7 responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation the emergency plan included policies and procedures for safe evacuation from the facility and that it includes all of the required elements. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation the emergency plan included policies and procedures for safe evacuation from the facility and that it includes all of the required elements. ASM # 1 stated, "We don't have an evacuation plan for this facility." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 020		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 022	E 022 Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4)	5/13/18

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E 022	Continued From page 8 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation of policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. The findings include:	E 022	In addition to the general shelter in place procedures, program specific shelter in place procedures for Lake Jackson Drive Group home will be developed including staff responsibilities, area designated in the home for sheltering in place and primary and alternate means of communication. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	5/13/18

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E 022	Continued From page 9 On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. ASM # 1 stated, "It is not specific to the group home." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 022		
E 023	Policies/Procedures for Medical Documentation CFR(s): 483.475(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects	E 023	E023 Policies/Procedures for Medical Documentation CFR(s):483.475(b)(5) Program specific edits will be made to the agency MIS Disaster Recovery Plan and Health information and confidentiality policy. These edits will specifically name Lake Jackson Drive Group Home and customize specifically to the program. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	5/13/18

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E 023	Continued From page 10 confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation of policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff	E 023		

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E 023	Continued From page 11 member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. ASM # 1 stated, "It's on the agency plan not specific to the group home." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 023		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services	E 025	E025 Arrangement with Other Facilities CFR(s): 483.475(b)(7) A copy of the Memorandum of Understanding with another provider to provide services to individuals in the event of limitations or cessation of operations due to an emergency will be provided to the program. Community Residences also has the ability due to the size of service area to accept individuals from one service area to another. In addition to the CR Emergency Response team program staff will be made aware of the this arrangement and how to execute in an emergency.	5/13/18

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	49G027	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME CORRECTED COPY	10144 LAKE JACKSON DRIVE 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
E 025	Continued From page 12 to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation of the arrangements	E 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 025	Continued From page 13 and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. ASM # 1 stated, "It's on the agency plan not specific to the group home." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 025		
E 029	Development of Communication Plan CFR(s): 483.475(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation of a written communication plan. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to	E 029	E 029 Development of Communication Plan CFR(s): 483.475(c) The CR agency Emergency Preparedness written Communication Plan will be reviewed for compliance to Federal, State and local laws. The agency plan will be edited to be program specific to Lake Jackson Drive Group Home. A training will occur at the May Lake Jackson team meeting to review the content and utilization of the written communication plan. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	5/13/18

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 029	Continued From page 14 evidence documentation of a written communication plan. ASM # 1 stated, "It's not in the plan." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 029		
E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030	E 030 Names and Contact Information CFR(s): 483.475(c)(1) The modified program specific communication plan mentioned in E029 above will include specific names and contact information for Lake Jackson Drive Group Home for the following: Staff; Entities providing services under arrangement; individuals physicians, other (facilities) and volunteers if applicable. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	5/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 030	Continued From page 15 (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 030		

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E 030	Continued From page 16 The facility staff failed to evidence documentation that all required facility contacts are included in the communication plan and was reviewed and updated at least annually. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation all required facility contacts are included in the communication plan and was reviewed and updated at least annually. ASM # 1 stated, "It's part of the corporate plan." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 030		
E 031	Emergency Officials Contact Information CFR(s): 483.475(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff.	E 031	E 031 Emergency Officials Contact Information CFR(s): 483.475(c)(2) The modified program specific communication plan mentioned in E029 above will include specific names and contact information for Lake Jackson Drive Group Home for the following: Federal, State, tribal, regional and local emergency preparedness staff; other sources of assistance; State Licensing and Certification Agency and State Protection and Advocacy Agency.. .	5/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 031	Continued From page 17 (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that all required emergency officials contacts are included in the communication plan and they have reviewed and updated at least annually. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation that all required emergency officials contacts are included in the communication plan and they have reviewed and	E 031	The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	

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E 031	Continued From page 18 updated at least annually. ASM # 1 stated, "It's part of the corporate plan." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 031		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of	E 032	E 032 Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) The modified program specific communication plan mentioned in E029 above include primary and alternate means for communication with facility staff and Federal, State, tribal, regional and local emergency management agencies. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	5/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 032	Continued From page 19 documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. ASM # 1 stated, "It's part of the corporate plan." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 032		
E 033	Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:	E 033	E 033 Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) The modified program specific communication plan mentioned in E029 above will include detailed information with regards to how the the Lake Jackson Drive Group Home shares information and medical information while maintaining confidentiality. Program specific information on the portability of medical information in case of evacuation and a means of providing information about the general condition and location of the individuals.	5/13/18

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E 033	Continued From page 20 (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information and	E 033	The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	

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E 033	Continued From page 21 medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers, to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. ASM # 1 stated, "It's part of the corporate plan." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 033		

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E 034	Information on Occupancy/Needs CFR(s): 483.475(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the	E 034	E 034 Information on Occupancy/Needs CFR(s): 483.475(c)(7) The modified program specific communication plan mentioned in E029 above to include program specific means of providing information about the facility(s) occupancy, needs, and its ability to provide assistance to the authority having jurisdiction. The agency currently does this through a centralized report to the Incident Command (Susan Elmore) with specifics to each program that is operating under active emergency. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	5/13/18

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E 034	Continued From page 23 incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. ASM # 1 stated, "It's part of the corporate plan." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 034		
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal,	E 035	E 035 LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) The modified program specific communication plan mentioned in E029 above to include communication method for sharing information about and from the emergency plan to individuals, families and representatives.	5/13/18

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E 035	Continued From page 24 State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. The findings include: On 03/29/18 at 10:20 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, clinical director. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. ASM # 1 stated, "It's part of the corporate plan." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2,	E 035	Information to be shared to families and representatives by 5/13/18 via email or mail communication. Information to be shared with individuals by staff in person by 5/13/18. The Community Residences Risk Management Committee will review the Emergency Plan specific to Lake Jackson Drive Group Home on annual basis.	

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E 035	Continued From page 25 program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional were informed of the findings. No further information was provided prior to exit.	E 035		
W 000	INITIAL COMMENTS An unannounced annual Medicaid ICF/ID Health Care Certification survey was conducted 03/27/18 through 03/29/18. 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 five bed facility was five at the time of the survey. The survey sample consisted of three current Individual reviews (Individuals #1, #2 and # 3).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. 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 ensure the clinical record was complete and accurate for three of three individuals in the survey sample, Individuals # 1, # 2 and # 3. 1. The facility staff failed to ensure the residential PCP (Person Centered Plan) at (Name of Group	W 111		

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W 111	Continued From page 26 Home) dated 05/01/2017 to 04/30/2018 accurately documented the outcome/goal of Individual # 1's medication management program. 2. The facility staff failed to ensure the PCP (Person Centered Plan) for the prevention of falls was clarified for Individual # 2. 3a. The facility staff failed to ensure an "Agreement of Release and Waiver of Liability for Exercise Class" in the (Name of Day Program) clinical record was dated for Individual # 3. 3b. The facility staff failed to ensure the PCP (Person Centered Plan) quarterly review dated 11/01/2017 through 10/31/18 in the (Name of Day Program) clinical accurately documented Individual # 3's progress. The findings include: 1. The facility staff failed to ensure the PCP (Person Centered Plan) at (Name of Group Home) dated 05/01/2017 to 04/30/2018 accurately documented the outcome/goal of Individual # 1's medication management program. Individual # 1 was a 24 year-old female, who was admitted to (Name of Group Home) on 2/19/13. Diagnoses in the clinical record included but were not limited to: mild intellectual disability, autism (1), seizure disorder (2), scoliosis (3), and post-traumatic stress disorder (4). The PCP (Person Centered Plan) dated 05/01/2017 to 04/30/2018 for Individual #1 documented, "Desired Outcome: Need # 9	W 111		

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W 111	Continued From page 27 Medication Management. Goal # 9: (Individual # 1) is able to identify her medication Depakote (5) by name and the function. (Individual # 1) is able to measure her medication and mix 8oz (eight ounces) of water and 17g (grams) of miralex [sic] (6) respectively, every day, 100% (percent) of the time until 04/30/2018." Review of the facility's MAR (medication administration record) book revealed a document entitled "(Individual # 1's Initials) Medication Goal." It documented, "GOAL: (Individual # 1) identifies her Depakote by name and the reason she takes it. She measures 8oz of water to be mixed with 17 gram of Miralax." On 03/28/18 at 8:25 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. After reviewing the PCP (Person Centered Plan) dated 05/01/2017 to 04/30/2018 and the medication goal in the MAR for Individual # 1, LPN # 1 was asked about the discrepancy of the goal. LPN # 1 stated, "I think there is a miss communication. I developed the medication goal for the MAR and presented it to the IDT (interdisciplinary team) for review and acceptance for the individual's PCP. I assume the goal is accurately transcribed on to the PCP." On 03/28/18 at 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager, OSM # 3, qualified intellectual disabilities professional. After reviewing the PCP (Person Centered Plan) dated 05/01/2017 to 04/30/2018 and the medication goal in the MAR for Individual # 1, ASM # 2 was asked about the discrepancy of the goal. ASM # 2 and OSM # 3 stated, "It is a documentation error. It is not stated correctly on	W 111	WW111- Client records CFR(s):483.410(c)(1). Individual #1. 1-Individual #1's medication goal on the ISP and MAR will be reviewed by the QIDP/ Program Manager/Nurse and updated to sync and reflect the individual's ability to complete and learn from the goal. 2-The ISP medication outcomes for all other individuals in the facility will be reviewed by the QIDP/Program manager/ Nurse to ensure that they all sync with the MAR. 3- Staff will be retrained by the QIDP/ Program manager on the updated medication/other ISP outcomes during the next staff meeting. 4- QIDP/Program Manager and Nurse will review ISP/MAR documentation daily/ monthly/quarterly to ensure that the medication and other ISP outcomes are implemented and documented accordingly. -The Quality Improvement coordinator will audit for clarity of individuals' goals during periodic audits or upon written request by the Clinical Director.	5/13/18

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W 111	Continued From page 28 the PCP." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the 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://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) 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. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html. (3) An abnormal curving of the spine. Your spine is your backbone. It runs straight down your back. Everyone's spine naturally curves a bit. But people with scoliosis have a spine that curves too much. The spine might look like the letter C or S.	W 111		

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W 111	Continued From page 29 This information was obtained from the website: https://medlineplus.gov/ency/article/001241.htm. (4) A disorder that develops in some people who have experienced a shocking, scary, or dangerous event. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml. (5) Depakote (divalproex sodium) affects chemicals in the body that may be involved in causing seizures. Depakote is used to treat various types of seizure disorders. It is sometimes used together with other seizure medications. Depakote is also used to treat manic episodes related to bipolar disorder (manic depression), and to prevent migraine headaches. This information was obtained from the website: https://www.drugs.com/depakote.html. (6) Polyethylene glycol 3350 comes as a powder to be mixed with a liquid and taken by mouth. It is usually taken once a day as needed for up to 2 weeks. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take polyethylene glycol 3350 exactly as directed. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603032.html. 2. The facility staff failed to ensure the PCP (Person Centered Plan) for the prevention of falls was clarified for Individual # 2. Individual # 2 was a 71 year-old male, who was admitted to (Name of Group Home) on 07/26/96.	W 111		

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W 111	Continued From page 30 Diagnoses in the clinical record included but were not limited to: Severe intellectual disability (2), seizure disorder (3), hypertension (4), left lower lung benign (5) granuloma (6), and Parkinson's disease (7). Review of the (Name of Group Home) clinical record for Individual # 2 revealed a physician's order dated 08/25/17. The physician order documented, "Gait belt for transfers." The POSs (physician's order sheets) dated 03/01/18 to 03/31/18 for Individual # 2 documented, "May use gait belt for transfers." The PCP (person-centered plan) dated 08/01/2017 - 07/31/2018 for Individual # 2 documented, "B. (individual # 2) is reminded and supported with his Fall Protocol. 1. Refer to Falls Protocol. 2. (Individual # 2) should be assisted with his adaptive equipment. 3. (Individual # 2's) environment should be free from clutter. 4. All necessary documentation should be done and submitted." The facility's "Fall Protocol" for Individual # 2 dated 08/25/17 documented, "Prevention: (Individual # 3) may use gait belt to assist him transfer from a sitting to a standing position." On 03/28/18 at 1:10 p.m., an interview was conducted with RN (registered nurse) # 1 and LPN (licensed practical nurse) # 1. When asked why a gait belt was not used for Individual # 2's transfer to the bathroom on 11/12/17. LPN # 1 stated, "(Individual # 2) spends time in his room and we (staff) did not know when he got up to go to the bathroom. The gait belt only needs to be used when he is unsteady." When asked about	W 111	WW111- Client records CFR(s):483.410(c)(1). Individual #2. 1-The Physician order for the use of a gait belt for individual #2 will be clarified with the prescribing physician and detail will be included specifically on when/why use the gait belt for the individual. 2- The Physician orders for individual #2 and all other individuals in the facility with adaptive equipment will be reviewed by the RN/LPN for clarity and any applicable adjustments requested from the prescribing physician. 3- During the team meetings, staff will be retrained on how to implement individual #2's updated adaptive equipment orders as well as any changes to adaptive equipment orders for the rest of the individuals in the facility. 4- The QIDP/Program Manager/Nurses will oversee the implementation and documentation of adaptive equipment use or all individuals in the home. -The Quality Improvement coordinator will audit for suitability and clarity of adaptive equipment orders during routine clinical audits or upon written request by the Clinical Director. -Clinical Director will oversee the quality of services for individuals especially those with adaptive equipment.	5/13/18

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W 111	Continued From page 31 the discrepancy in the wording of the physician's order dated 08/25/17 and the POS dated 03/01/18 through 03/31/18, RN # 1 stated, "The word 'May' indicates we can use the gait belt when needed." When the physician's order dated 08/25/17 was reviewed and it was pointed out, the order did not contain the word 'May', RN # 1 stated, "The order should have been clarified." When asked if the PCP for Individual # 2 dated 08/01/2017 - 07/31/2018 was accurate RN # 1 stated, "No." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference: (1) A belt used to transfer a disabled person from one location to another by placing the belt around that person's waist and using it to hold on to while safely transferring the patient. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/transfer+belt. (2) 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	W 111		

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W 111	Continued From page 32 from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (3) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm. (6) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma.	W 111		

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W 111	Continued From page 33 (7) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 3a. The facility staff failed to ensure an "Agreement of Release and Waiver of Liability for Exercise Class" in the (Name of Day Program) clinical record was dated for Individual # 3. Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and anemia (7). Review of the (Name of Day Program) clinical record for Individual # 3 revealed a document entitled "Agreement of Release and Waiver of Liability for Exercise Class." The "Agreement of Release and Waiver of Liability for Exercise Class" documented, Individual # 3's name and signature. Under the heading, "Date" it was blank. On 03/28/18 at 11:00 a.m., an interview was conducted with OSM (other staff member) # 1, program director of clinical services for (Name of Day Program). After reviewing the "Agreement of Release and Waiver of Liability for Exercise Class" form for Individual # 3. When asked if the form was complete and for what period it covered, OSM # 1 stated the "Agreement of Release and Waiver of Liability for Exercise Class" was not complete and could not determine	W 111	WW111- Client records CFR(s):483.410(c)(1). Individual #3a. 1- Individual #3's "Agreement of release and waiver of liability for exercise class" will be updated by the contracted day services provider to include a precise date/period for when the waiver is in effect. 2-An IDT meeting will be held with individual #3's day program representatives to discuss deficiencies from this survey report and other quality control issues there may be. 3-The QIDP, Program Manager or designee will conduct monthly visits to individual #3 and all other individuals' day program settings and audit records to ensure that they are correct and complete. 4-The Quality Assurance Coordinator will conduct periodic audits at individual #3's and other individuals' day services program to ensure that services/records are in compliance with applicable regulations. -The Clinical Director will liaise with day program senior management to enforce contractual agreements for day services in an effort to improve the quality of care for individual #3 and all others served by this provider.	5/13/18

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W 111	Continued From page 34 the time frame because there was not a date. OSM # 1 stated, "It should have been dated when it was signed." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference: (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) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm.	W 111		

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(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 111	Continued From page 35 (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html. 3b. The facility staff failed to ensure the PCP (Person Centered Plan) quarterly review dated 11/01/2017 through 10/31/18 in the (Name of Day Program) clinical accurately documented Individual # 3's progress. Review of the (Name of Day Program) clinical record for Individual # 3 revealed a PCP (person centered plan) quarterly review dated 11/01/2017 through 10/31/18. Under the heading "Desired outcomes" it documented, "2. Community Integration." Under the column, "Start or End" it revealed the box "End" was checked for the outcome "Community Integration. Under the	W 111	WW111- Client records CFR(s):483.410(c)(1). Individual #3b. 1-An IDT meeting will be held between the day program vendor and the residential team to review the quality of documentation of services agreed to in the ISP and updates made accordingly to individual #3's quarterly report. 2- Day program(s) for individual #3 (and other individuals in the facility) will submit quarterly reports to the residential provider in a timely manner for review of deliverables contracted to on individual #3's ISP as well as others served by this provider. 3-The Clinical Director will see to it that contractual deliverables relating to the ISP and other health/safety measures are adequately provided per the contract, otherwise, take compliance measures necessary to obtain the best quality services possible for individual #3 and others served by this provider. 4-Periodic audits of day program services by the residential program manager or designee and/or the Quality Improvement Coordinator will include delivery/ documentation of services according to the agreed to ISP for individual #3 and others.	5/13/18

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	49G027	A. BUILDING _____ B. WING _____	03/29/2018

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W 111	Continued From page 36 column "Describe what will be changed or improved and what will be the same" it documented, "This outcome will continue as written in (Individual # 1's) plan." On 03/28/18 at 11:00 a.m., an interview was conducted with OSM (other staff member) # 1, program director of clinical services for (Name of Day Program). After reviewing the quarterly review dated 11/01/2017 through 10/31/18 OSM # 1 stated, "It's not inaccurate. I'm unable to determine if the goal was met or if it needs to continue." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit.	W 111		
W 112	CLIENT RECORDS CFR(s): 483.410(c)(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. 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 ensure the confidentiality of an individual's clinical record for one of three individuals in the survey sample, Individuals # 1. The facility staff failed to ensure Individual # 1's	W 112		

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W 112	Continued From page 37 clinical record did not contain another individual's clinical information. The findings include: The facility staff failed to ensure Individual # 1's clinical record did not contain another individual's clinical information. Individual # 1 was a 24 year-old female, who was admitted to (Name of Group Home) on 2/19/13. Diagnoses in the clinical record included but were not limited to: mild intellectual disability, autism (1), seizure disorder (2), scoliosis (3), and post-traumatic stress disorder (4). Review of Individual # 1's medical record at (Name of Group Home) revealed a quarterly nursing assessment dated 02/28/18 for Individual # 1. Further review of the quarterly nursing assessment revealed a "Constipation Protocol" with a review date of 03/27/18 for another individual stapled to the quarterly nursing assessment. On 03/29/18 at 2:00 p.m., an interview was conducted with RN (registered nurse) # 1. When asked who was responsible for filing the quarterly nursing assessments and protocols, RN # 1 stated, "The nurse files them." After reviewing the quarterly nursing assessment dated 02/28/18 Individual # 1 with another individual's constipation protocol attached, RN # 1 stated, "It shouldn't be in (Individual # 1's) record." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff	W 112	WW111- Client records CFR(s):483.410(c)(2). Individual #1. 1-The other individual's clinical information will be purged from individual #1's clinical record. 2-During the next team meeting, privacy issues relating to misfiling of individual records will be discussed and staff cautioned to be more careful when filing away individuals' records. 3-The QIDP/Program Manager or designees will periodically audit clinical records for individual #1 and all other individuals in the facility to ensure that there is no misfiling the contravenes privacy regulations. 4- The Clinical Director or Quality Assurance Coordinator will periodically review individual charts for completeness and potential of privacy violations.	5/13/18

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W 112	Continued From page 38 member) # 3, qualified intellectual disabilities professional were informed of the 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://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) 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. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html. (3) An abnormal curving of the spine. Your spine is your backbone. It runs straight down your back. Everyone's spine naturally curves a bit. But people with scoliosis have a spine that curves too much. The spine might look like the letter C or S. This information was obtained from the website: https://medlineplus.gov/ency/article/001241.htm. (4) A disorder that develops in some people who have experienced a shocking, scary, or	W 112		

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W 112	Continued From page 39 dangerous event. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml.	W 112		
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, # 3 and # 2. 1a. The QIDP failed to ensure the residential PCP (Person Centered Plan) at (Name of Group Home) dated 05/01/2017 to 04/30/2018 accurately documented the outcome/goal of Individual # 1's medication management program. 1b. The QIDP failed to ensure Individual # 1's clinical record did not contain another individual's clinical information. 1c. The QIDP failed to ensure the PCP (Person Centered Plan) outcomes for Individual # 1 were developed in measurable terms. 1d, The QIDP failed to ensure the data collection of the PCP (Person Centered Plan) outcomes for Individual # 1 were in measurable terms.	W 159	W159 QIDP:CFR(s):483.430(a)-Individual #1a. 1-Individual #1's medication goal on the ISP and MAR will be reviewed by the QIDP/ Program Manager/Nurse and updated to sync and reflect the individual's ability to complete and learn from the goal. 2-The ISP medication outcomes for all other individuals in the facility will be reviewed by the QIDP/Program manager/Nurse to ensure that they all sync with the MAR. 3- Staff will be retrained by the QIDP/ Program manager on the updated medication/other ISP outcomes during the next staff meeting. 4- QIDP/Program Manager and Nurse will review ISP/MAR documentation daily/ monthly/quarterly to ensure that the medication and other ISP outcomes are implemented and documented accordingly. -The Quality Improvement coordinator will audit for clarity of individuals' goals during periodic audits or upon written request by the Clinical Director.	5/13/18

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W 159	Continued From page 40 2a. The QIDP failed to ensure the physician's order for the use of a gait belt was clarified for Individual # 2. 2b. The QIDP failed to ensure the PCP (Person Centered Plan) for the prevention of falls was clarified for Individual # 2. 2c. The QIDP failed to ensure the PCP (Person Centered Plan) outcomes for Individual # 2 were developed in measurable terms. 2d. The QIDP failed to ensure the data collection of the PCP (Person Centered Plan) outcomes for Individual # 2 were in measurable terms. 3a. The QIDP failed to ensure an "Agreement of Release and Waiver of Liability for Exercise Class" in the (Name of Day Program) clinical record was dated for Individual # 3. 3b. The QIDP failed to ensure the PCP (Person Centered Plan) quarterly review dated 11/01/2017 through 10/31/18 in the (Name of Day Program) clinical accurately documented Individual # 3's progress. 3c. The QIDP failed to ensure (Name of Day Program) staff implemented Individual # 3's PCP outcomes # 1 communication/socialization skills and # 3 sensory stimulation during a (Name of Day Program) activity. 3d. The QIDP failed to ensure (Name of Day Program) staff implemented Individual # 3's PCP outcomes of communication/socialization skills, community integration, sensory stimulation, and self-help-skills from 02/01/18 through 03/27/18.	W 159	W159 QIDP:CFR(s):483.430(a)-Individual #1b. 1-The other individual's clinical information will be purged from individual #1's clinical record. 2-During the next team meeting, privacy issues relating to misfiling of individual records will be discussed and staff cautioned to be more careful when filing away individual records. 3-The QIDP/Program Manager or designees will periodically audit clinical records for individual #1 and all other individuals in the facility to ensure that there is no misfiling the contravenes privacy regulations. 4- The Clinical Director or Quality Assurance Coordinator will periodically review individual charts for completeness and potential of privacy violations.	5/3/18

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W 159	Continued From page 41 3e. The QIDP failed to ensure the PCP (Person Centered Plan) outcomes for Individual # 3 were developed in measurable terms. 3f. The QIDP failed to ensure the data collection of the PCP (Person Centered Plan) outcomes for Individual # 3 were in measurable terms. The findings include: 1a. The QIDP failed to ensure the residential PCP (Person Centered Plan) at (Name of Group Home) dated 05/01/2017 to 04/30/2018 accurately documented the outcome/goal of Individual # 1's medication management program. Individual # 1 was a 24 year-old female, who was admitted to (Name of Group Home) on 2/19/13. Diagnoses in the clinical record included but were not limited to: mild intellectual disability, autism (1), seizure disorder (2), scoliosis (3), and post-traumatic stress disorder (4). The PCP (Person Centered Plan) dated 05/01/2017 to 04/30/2018 for Individual #1 documented, "Desired Outcome: Need # 9 Medication Management. Goal # 9: (Individual # 1) is able to identify her medication Depakote (5) by name and the function. (Individual # 1) is able to measure her medication and mix 8oz (eight ounces) of water and 17g (grams) of miralex [sic] (6) respectively, every day, 100% (percent) of the time until 04/30/2018." Review of the facility's MAR (medication administration record) book revealed a document entitled "(Individual # 1's Initials) Medication Goal." It documented, "GOAL: (Individual # 1)	W 159	W159 QIDP:CFR(s):483.430(a)-Individual #1c. 1- ISP outcomes for individual #1's verbal communication ability, and computer skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes for measurability in their periodic audits of clinical documents in the program.	5/13/18

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W 159	Continued From page 42 identifies her Depakote by name and the reason she takes it. She measures 8oz of water to be mixed with 17 gram of Miralax." On 03/28/18 at 8:25 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. After reviewing the PCP (Person Centered Plan) dated 05/01/2017 to 04/30/2018 and the medication goal in the MAR for Individual # 1, LPN # 1 was asked about the discrepancy of the goal. LPN # 1 stated, "I think there is a miss communication. I developed the medication goal for the MAR and present it to the IDT (interdisciplinary team) for review and acceptance for the individual's PCP. I assume the goal is accurately transcribed on to the PCP." On 03/28/18 at 3:30 p.m., an interview was conducted with program manager, OSM # 3, QIDP (qualified intellectual disabilities professional). When asked to describe the responsibility of the QIDP, OSM # 3 stated, "The QIDP is responsible for the PCP (Person Centered Plan) process, which includes contact with guardians/families, the services they (individuals) are receiving, being part of the individual's assessment and the team assessment. OSM #3 stated it includes, keeping in touch with the day program, which includes visits and observations of the individuals and services they are receiving and review of the individual's day program record. It also includes weekly meetings with the individuals, making sure staff are doing the progress notes, completing monthly reports and quarterly reviews. Supervision of staff to ensure they are following the individual's PCP. A review of the individual residential and day program clinical, medical records, monthly, to ensure the records are	W 159	W159 QIDP:CFR(s):483.430(a)-Individual #1d. 1- ISP data collection for individual #1 verbal communication ability and computer skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4- The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.	5/3/18

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W 159	Continued From page 43 accurate. OSM stated the responsibility of the QIDP, included weekly meetings with the program manager and nurse to identify and correct any problems in the residential and day programs, assist when the program manager is out of the facility and implement and implement PCP programs and assist with individuals." When asked if it was the QIDP's responsibility to ensure documents in the individual's residential and day program clinical and medical records are complete and clarified, OSM # 3 stated, yes. For example if a medical appointment or an order for an individual is not clear it is the job of the QIDP to go to the nurse with the concern and get it clarified." After reviewing the PCP (Person Centered Plan) dated 05/01/2017 to 04/30/2018 and the medication goal in the MAR for Individual # 1, OSM # 3 stated, "It is a documentation error. It is not stated correctly on the PCP." The facility's policy "QMRP/QIDP-ICF" documented in part, "Principal Duties and Responsibilities. Completes all required clinical documentation including progress notes, incident reports, and data tracking according to agency policies." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. References:	W 159		

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W 159	Continued From page 44 (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://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) 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. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html. (3) An abnormal curving of the spine. Your spine is your backbone. It runs straight down your back. Everyone's spine naturally curves a bit. But people with scoliosis have a spine that curves too much. The spine might look like the letter C or S. This information was obtained from the website: https://medlineplus.gov/ency/article/001241.htm. (4) A disorder that develops in some people who have experienced a shocking, scary, or dangerous event. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml. (5) Depakote (divalproex sodium) affects chemicals in the body that may be involved in	W 159		

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W 159	Continued From page 45 causing seizures. Depakote is used to treat various types of seizure disorders. It is sometimes used together with other seizure medications. Depakote is also used to treat manic episodes related to bipolar disorder (manic depression), and to prevent migraine headaches. This information was obtained from the website: https://www.drugs.com/depakote.html. (6) Polyethylene glycol 3350 comes as a powder to be mixed with a liquid and taken by mouth. It is usually taken once a day as needed for up to 2 weeks. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take polyethylene glycol 3350 exactly as directed. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603032.html. 1b. The QIDP failed to ensure Individual # 1's clinical record did not contain another individual's clinical information. On 03/29/18 at 2:00 p.m., an interview was conducted with OSM # 3, QIDP (qualified intellectual disabilities professional). After reviewing the quarterly nursing assessment dated 02/28/18 for Individual # 1 with another individual's constipation protocol attached OSM # 3 stated, "Information of an individual should not be in someone else's record. When asked how often the records are reviewed OSM # 3 stated, "I do reviews monthly." When asked if she was aware of Individual # 1's medical record contained information regarding another individual OSM # 3 stated, "No." On 03/29/18 at 2:55 p.m., ASM (administrative	W 159		

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W 159	Continued From page 46 staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. 1c. The QIDP failed to ensure the PCP (Person Centered Plan) outcomes for Individual # 1 were developed in measurable terms. Individual # 1's current PCP dated 05/01/2017 through 04/30/2018 documented, "Desired Outcome: #2 (Individual # 1) increases her verbal communication ability. Support Activities & Instructions: 1. (Individual # 1) communicates to others 50% (percent) of the time for up to 15 minutes through out [sic] the day by purposefully directing her messages. Support Instructions: a. (Individual # 1) verbally communicates her wants and needs to a specific person. B. (Individual # 1) is prompted by staff to use her words if needed. C. (Individual # 1) is encouraged to communicate in full sentences if clarity is needed. Type: Skill building. Duration: Quarterly. Frequency: Daily. Amount: 15 minutes." "Desired Outcome: Improve Computer Skills. Support Activities & Instructions: (Individual # 1) use the computer for up to 7(seven) days for up to 1 (one) hour per day by 4/30/2018. Support Instructions: a. (Individual # 1) requests to use the computer. b. permission is given to use the computer and a timer is set. C. (Individual # 1) uses the computer until the timer goes off. Type: Routine supports. Duration: Quarterly. Frequency: Daily. Amount: 60 minutes."	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/29/2018

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W 159	Continued From page 47 On 03/28/18 at approximately 1:10 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked to describe the purpose of the PCP's for individuals OSM # 3 stated, "To assess the individual and find better ways to support an individual's needs." OSM # 3 was asked to review Individual # 1's outcomes/goals from the PCP dated 05/01/2017 through 04/30/2018 for outcomes of communication and computer skills. When asked if the outcomes/goals were developed in measurable terms OSM # 3 stated, "No." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. 1d, The QIDP failed to ensure the data collection of the PCP (Person Centered Plan) outcomes for Individual # 1 were in measurable terms. Individual # 1's current PCP dated 05/01/2017 through 04/30/2018 documented, "Desired Outcome: #2 (Individual # 1) increases her verbal communication ability. Support Activities & Instructions: 1. (Individual # 1) communicates to others 50% (percent) of the time for up to 15 minutes through out [sic] the day by purposefully directing her messages. Support Instructions: a. (Individual # 1) verbally communicates her wants and needs to a specific person. B. (Individual # 1) is prompted by staff to	W 159		

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W 159	Continued From page 48 use her words if needed. C. (Individual # 1) is encouraged to communicate in full sentences if clarity is needed. Type: Skill building. Duration: Quarterly. Frequency: Daily. Amount: 15 minutes." "Desired Outcome: Improve Computer Skills. Support Activities & Instructions: (Individual # 1) use the computer for up to 7(seven) days for up to 1 (one) hour per day by 4/30/2018. Support Instructions: a. (Individual # 1) requests to use the computer. b. permission is given to use the computer and a timer is set. C. (Individual # 1) uses the computer until the timer goes off. Type: Routine supports. Duration: Quarterly. Frequency: Daily. Amount: 60 minutes." Review of (Name of Group Home) "Progress Notes" for Individual # 1 dated 03/02/2018 through 03/27/2018 failed to evidence data collection of the outcomes communication and computer skills in measurable terms. On 03/28/18 at approximately 1:10 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). OSM # 3 was asked to review Individual # 1's data collection dated 03/02/2018 through 03/27/2018 for the outcomes communication and computer skills. OSM # 3 stated she did not need to review the progress notes. OSM # 3 further stated that if the outcomes were not written in measurable terms then the data collection could not be obtained in measurable terms. On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home),	W 159	W159 QIDP:CFR(s):483.430(a)-Individual #2a. 1-The Physician order for the use of a gait belt for individual #2 will be clarified with the prescribing physician and detail will be included specifically on when/why use the gait belt for the individual. 2- The Physician orders for individual #2 and all other individuals in the facility with adaptive equipment will be reviewed by the RN/LPN for clarity and any applicable adjustments requested from the prescribing physician. 3- During the team meetings, staff will be retrained on how to implement individual #2's updated adaptive equipment orders as well as any changes to adaptive equipment orders for the rest of the individuals in the facility. 4- The QIDP/Program Manager/Nurses will oversee the implementation and documentation of adaptive equipment use or all individuals in the home. -The Quality Improvement coordinator will audit for suitability and clarity of adaptive equipment orders during routine clinical audits or upon written request by the Clinical Director. -Clinical Director will oversee the quality of services for individuals especially those with adaptive equipment.	5/13/18

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W 159	Continued From page 49 RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional. No further information was provided prior to exit. 2a. The QIDP failed to ensure the physician's order for the use of a gait belt was clarified for Individual # 2. Individual # 2 was a 71 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (2), seizure disorder (3), hypertension (4), left lower lung benign (5) granuloma (6), and Parkinson's disease (7). Review of the (Name of Group Home) clinical record for Individual # 2 revealed a physician's order dated 08/25/17. The physician order documented, "Gait belt for transfers." The POSs (physician's order sheets) dated 03/01/18 to 03/31/18 for Individual # 2 documented, "May use gait belt for transfers." The PCP (person-centered plan) dated 08/01/2017 - 07/31/2018 for Individual # 2 documented, "B. (individual # 2) is reminded and supported with his Fall Protocol. 1. Refer to Falls Protocol. 2. (Individual # 2) should be assisted with his adaptive equipment. 3. (Individual # 2's) environment should be free from clutter. 4. All necessary documentation should be done and submitted." The facility's "Fall Protocol" for Individual # 2 dated 08/25/17 documented, "Prevention:	W 159		

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W 159	Continued From page 50 (Individual # 3) may use gait belt to assist him transfer from a sitting to a standing position." On 03/28/18 at 1:10 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional) and RN (registered nurse) # 1 and LPN (licensed practical nurse) # 1. When asked why a gait belt was not used for Individual # 2's transfer to the bathroom on 11/12/17. LPN # 1 stated, "(Individual # 2) spends time in his room and we (staff) did not know when he got up to go to the bathroom. The gait belt only needs to be used when he is unsteady." When asked about the discrepancy in the wording of the physician's order dated 08/25/17 and the POS dated 03/01/18 through 03/31/18, RN # 1 stated, "The word 'May' indicates we can use the gait belt when needed." When the physician's order dated 08/25/17 was reviewed and it was pointed out, the order did not contain the word 'May', RN # 1 stated, "The order should have been clarified." When asked if it was the responsibility of the QIDP to identify the discrepancy of the physician's order and notify the nurse(s), OSM # 3 stated, yes." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference: (1) A belt used to transfer a disabled person from one location to another by placing the belt around	W 159		

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W 159	Continued From page 51 that person's waist and using it to hold on to while safely transferring the patient. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/transfer+belt. (2) 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. (3) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm.	W 159		

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W 159	Continued From page 52 (6) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma. (7) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 2b. The QIDP failed to ensure the PCP (Person Centered Plan) for the prevention of falls was clarified for Individual # 2. Review of the (Name of Group Home) clinical record for Individual # 2 revealed a physician's order dated 08/25/17. The physician order documented, "Gait belt for transfers." The POSs (physician's order sheets) dated 03/01/18 to 03/31/18 for Individual # 2 documented, "May use gait belt for transfers." The PCP (person-centered plan) dated 08/01/2017 - 07/31/2018 for Individual # 2 documented, "B. (individual # 2) is reminded and supported with his Fall Protocol. 1. Refer to Falls Protocol. 2. (Individual # 2) should be assisted	W 159	W159 QIDP:CFR(s):483.430(a)-Individual #2b. 1-The Physician order for the use of a gait belt for individual #2 will be clarified with the prescribing physician and detail will be included specifically on when/why use the gait belt for the individual. 2- The Physician orders for individual #2 and all other individuals in the facility with adaptive equipment will be reviewed by the RN/LPN for clarity and any applicable adjustments requested from the prescribing physician. 3- During the team meetings, staff will be retrained on how to implement individual #2's updated adaptive equipment orders as well as any changes to adaptive equipment orders for the rest of the individuals in the facility. 4- The QIDP/Program Manager/Nurses will oversee the implementation and documentation of adaptive equipment use or all individuals in the home. -The Quality Improvement coordinator will audit for suitability and clarity of adaptive equipment orders during routine clinical audits or upon written request by the Clinical Director. -Clinical Director will oversee the quality of services for individuals especially those with adaptive equipment.	5/13/18

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W 159	Continued From page 53 with his adaptive equipment. 3. (Individual # 2's) environment should be free from clutter. 4. All necessary documentation should be done and submitted." The facility's "Fall Protocol" for Individual # 2 dated 08/25/17 documented, "Prevention: (Individual # 3) may use gait belt to assist him transfer from a sitting to a standing position." On 03/28/18 at 1:10 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked about the discrepancy in the wording of the physician's order dated 08/25/17 and the POS dated 03/01/18 through 03/31/18 RN # 1 stated, "The word 'May' indicates we can use the gait belt when needed." When the physician's order dated 08/25/17 was reviewed and pointed out the order did not contain the word 'May' OSM # 3 stated, "The order should have been clarified." When asked if the PCP for Individual # 2 dated 08/01/2017 - 07/31/2018 was accurate OSM # 3 stated, "No." When asked if was the QIDPs responsibility to review the clinical record, identify the physician's order discrepancy and have the order clarified, OSM # 3 stated, "Yes." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. 2c. The QIDP failed to ensure the PCP (Person	W 159		

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W 159	Continued From page 54 Centered Plan) outcomes for Individual # 2 were developed in measurable terms. Individual # 2's current PCP dated 08/17/2017 - 07/31/2018 documented, "Desired Outcome: Need #7 Activities of Daily Living. Goal #7 (Individual # 2) independently participates in activities of daily living skills at least 2 (two) out of 4 (four) times per day for 50% (percent) of the time until 07/31/2018. Support Activities & Instructions: 1.) (Individual # 2) is assisted with his activities of daily living two times out of four times per day for 50% of the times until 07/31/2018. A) (Individual # 2) is reminded when it is time for his ADLs (Activities of Daily Living). B) (Individual # 2) is encouraged to do his ADLs. C) (Individual # 2) is given an extended assist when needed. D) (Individual # 2) is praised for doing a good job. Type: Routine supports. Duration: Annually. Frequency: Daily." On 03/28/18 at approximately 1:10 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked to describe the purpose of the PCP's for individuals OSM # 3 stated, "To assess the individual and find better ways to support an individual's needs." OSM # 3 was asked to review Individual # 2's outcome/goal from the PCP dated 08/17/2017-07/31/2018 of outcome # 7, ADLs. When asked if the outcome/goal was developed in measurable terms, OSM # 3 stated, "No." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities	W 159	W159 QIDP:CFR(s):483.430(a)-Individual #2c. 1- ISP outcomes for individual #2's "activity of daily living" will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes for measurability in their periodic audits of clinical documents in the program	5/13/18

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W 159	Continued From page 55 professional, were informed of the findings. No further information was provided prior to exit. 2d. The QIDP failed to ensure the outcome/goal "Community Integration" and "Self-help" on the PCP (person centered plan) dated 08/01/2017 - 07/31/2018 in the (Name of Day Program) clinical record for Individual # 2. Individual # 2's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: Community Integration. Support Activities: Outcome # 2A. (Individual # 2) develops relationships in the community. Skill Building: Yes. How Often: 4XMONTH (four times per month)." "Desired Outcome: Self-help. Support Activities: Outcome # 6A. (Individual # 2) improves self-sufficiency in his daily life. Skill Building: Yes. How Often: DAILY." On 03/28/18 at approximately 1:10 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked to describe the purpose of the PCP's for individuals OSM # 3 stated, "To assess the individual and find better ways to support an individual's needs." OSM # 3 was asked to review Individual # 2's PCP (person centered plan) outcomes/goals of community integration and self-help skills from (Name of Day Program) clinical record dated 08/01/2017 - 07/31/2018. When asked if the outcomes/goals were developed in measurable terms, OSM # 3 and ASM # 1stated, "No."	W 159	For Individual #2d. 1- ISP outcomes for individual #2's community integration and self-help skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes for measurability in their periodic audits of clinical documents in the program.	5/13/18

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W 159	Continued From page 56 On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. 2e. The QIDP failed to ensure the data collection of the PCP (Person Centered Plan) outcomes for Individual # 2 were in measurable terms. Individual # 2's current PCP dated 08/17/2017 - 07/31/2018 documented, "Desired Outcome: Need #7 Activities of Daily Living. Goal #7 (Individual # 2) independently participates in activities of daily living skills at least 2 (two) out of 4 (four) times per day for 50% (percent) of the time until 07/31/2018. Support Activities & Instructions: 1.) (Individual # 2) is assisted with his activities of daily living two times out of four times per day for 50% of the times until 07/31/2018. A) (Individual # 2) is reminded when it is time for his ADLs (Activities of Daily Living). B) (Individual # 2) is encouraged to do his ADLs. C) (Individual # 2) is given an extended assist when needed. D) (Individual # 2) is praised for doing a good job. Type: Routine supports. Duration: Annually. Frequency: Daily." Review of (Name of Group Home) "Progress Notes" for Individual # 2 dated 03/01/2018 through 03/27/2018 failed to evidence data collection of the outcome activities of daily living in measurable terms. On 03/28/18 at approximately 1:10 p.m., an	W 159	For Individual #2e. 1- ISP data collection for individual #2's activities of daily living skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes and data collection in a measurable manner. 3- ISP outcomes and data collection 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes for measurability in their periodic audits of clinical documents in the program.	5/3/18

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W 159	Continued From page 57 interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). OSM # 3 was asked to review Individual # 2's data collection dated 03/01/2018 through 03/27/2018 for the outcome of activities daily living. OSM # 3 stated she did not need to review the progress notes. OSM # 3 further stated that if the outcome were not written in measurable terms then the data collection could not be obtained in measurable terms. On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. 3a. The QIDP failed to ensure an "Agreement of Release and Waiver of Liability for Exercise Class" in the (Name of Day Program) clinical record was dated for Individual # 3. Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and anemia (7). Review of the (Name of Day Program) clinical record for Individual # 3 revealed a document entitled "Agreement of Release and Waiver of Liability for Exercise Class." The "Agreement of Release and Waiver of Liability for Exercise Class" documented, Individual # 3's name and	W 159	For individual #3a. 1- Individual #3's "Agreement of release and waiver of liability for exercise class" will be updated by the contracted day services provider to include a precise date/period for when the waiver is in effect. 2-An IDT meeting will be held with individual #3's day program representatives to discuss deficiencies from this survey report and other quality control issues there may be. 3-The QIDP, Program Manager or designee will conduct monthly visits to individual #3 and all other individuals' day program settings and audit records to ensure that they are correct and complete. 4-The Quality Assurance Coordinator will conduct periodic audits at individual #3's and other individuals' day services program to ensure that services/records are in compliance with applicable regulations. -The Clinical Director will liaise with day program senior management to enforce contractual agreements for day services in an effort to improve the quality of care for individual #3 and all others served by this provider.	5/3/18

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W 159	Continued From page 58 signature. Under the heading, "Date" it was blank. On 03/29/18 at 2:00 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). After reviewing the "Agreement of Release and Waiver of Liability for Exercise Class" form for Individual # 3 OSM # 3 was asked if the form was complete and for what period it covered. OSM # 3 stated the "Agreement of Release and Waiver of Liability for Exercise Class" was not complete and could not determine the time frame because there was not a date. OSM # 3 stated, "It should have been dated when it was signed." When asked if it was the responsibility of the QIDP to ensure the form was complete, OSM # 3 stated, "Yes." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference: (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:	W 159		

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W 159	Continued From page 59 https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye.This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html	W 159		

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W 159	Continued From page 60 3b. The QIDP failed to ensure the PCP (Person Centered Plan) quarterly review dated 11/01/2017 through 10/31/18 in the (Name of Day Program) clinical accurately documented Individual # 3's progress. Review of the (Name of Day Program) clinical record for Individual # 3 revealed a PCP (person-centered plan) quarterly review dated 11/01/2017 through 10/31/18. Under the heading "Desired outcomes" it documented, "2. Community Integration." Under the column, "Start or End" it revealed the box "End" was checked for the outcome "Community Integration. Under the column "Describe what will be changed or improved and what will be the same" it documented, "This outcome will continue as written in (Individual # 1's) plan." On 03/29/18 at 2:00 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). After reviewing the quarterly review dated 11/01/2017 through 10/31/18, OSM # 3 stated, "It's not accurate." When asked if it was the responsibility of the QIDP to ensure the quarterly review was accurate, OSM # 3 stated, "Yes." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit.	W 159	W159- For individual #3b 1-An IDT meeting will be held between the day program vendor and the residential team to review the quality of documentation of services agreed to in the ISP and updates made accordingly to individual #3's quarterly report. 2- Day program(s) for individual #3 (and other individuals in the facility) will submit quarterly reports to the residential provider in a timely manner for review of deliverables contracted to on individual #3's ISP as well as others served by this provider. 3-The Clinical Director will see to it that contractual deliverables relating to the ISP and other health/safety measures are adequately provided per the contract, otherwise, take compliance measures necessary to obtain the best quality services possible for individual #3 and others served by this provider. 4-Periodic audits of day program services by the Quality Improvement Coordinator will include delivery/documentation of services according to the agreed to ISP for individual #3 and others.	4/3/18

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W 159	Continued From page 61 3c. The QIDP failed to ensure (Name of Day Program) staff implemented Individual # 3's PCP outcomes # 1 communication/socialization skills and # 3 sensory stimulation during a (Name of Day Program) activity. On 03/27/18 at 11:00 a.m. to 11:30 a.m., an observation of Individual # 3 was conducted at (Name of Day Program). Individual # 3 was observed siting in his wheelchair, dressed, neat and clean. He was in a large day/activity room at the (Name of Day Program) watching a staff run skit/play. The skit/play consisted of the players/actors initiating audience (individual's) participation with numerous individuals that included, singing, dancing, body movement, counting and clapping. Individual # 3 was observed positioned in his wheelchair off to the left of the group approximately eight to ten feet away watching the players/actors actively engaging individuals from the audience. Further observation of Individual # 3 revealed there was a short wall approximately three and a half feet high and 12 feet long in front of Individual # 3 separating him from the audience and the player/actors. During the observation period, Individual # 3 was observed to be smiling and looking toward the activity, however facility staff failed to reposition Individual # 3 closer to the skit/play to have an unobstructed view and an opportunity to be involved. Individual # 3's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: # 1 Communication/Socialization Skills. Support	W 159	W159 for individual #3c. 1-An IDT meeting will be held between the day program vendor and the residential team for individual #3 to review the implementation of the communication/ socialization and sensory stimulation outcomes on his ISP and updates made accordingly 2- Day program(s) for individual #3 (and other individuals in the facility) will submit quarterly reports to the residential provider in a timely manner for review of deliverables contracted to on individual #3's ISP as well as others served by this provider. 3-The Clinical Director will see to it that contractual deliverables relating to the ISP and other health/safety measures are adequately provided per the contract, otherwise, take compliance measures necessary to obtain the best quality services possible for individual #3 and others served by this provider. 4-Periodic audits of day program services by the Program Manager/designee and/or the Quality Improvement Coordinator will include delivery/documentation of services according to the agreed to ISP for individual #3 and others.	5/13/18

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W 159	Continued From page 62 Activities: # 1 Communication/Socialization Skills. (Individual # 3) communicates his wants, needs, and preferences. (Individual # 3) will be encouraged by staff to make eye contact with the person he is socializing with and smile or clap his hands. How often: Daily through 7/31/2018." "Desired Outcome: # 3 Sensory Stimulation. (Individual # 3) participates in a variety of stimulation activities to increase his engagement level and awareness. How often: Daily through 7/31/2018." On 03/29/18 at 2:00 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional) regarding the observation of Individual # 3 at the facility's play/skit. OSM # 3 agreed Individual # 3 was involved in the activity. OSM # 3 was asked to review Individual # 3's outcomes/goals from the (Name of Day Program) PCP dated 08/01/2017 - 07/31/2018 for outcomes # 1 Communication/Socialization Skills and # 3 Sensory Stimulation. When asked if the PCP was implemented for communication/socialization and sensory, stimulation based on the observation at (Name of Day Program), OSM # 3 stated, "No." When asked who was responsible for ensuring the PCP outcomes are implemented at (Name of Day Program), OSM # 3 stated, "The QIDP." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings.	W 159		

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W 159	Continued From page 63 No further information was provided prior to exit. 3d. The QIDP failed to ensure (Name of Day Program) staff implemented Individual # 3's PCP outcomes of communication/socialization skills, community integration, sensory stimulation, and self-help-skills from 02/01/18 through 03/27/18. Individual # 3's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: # 1 Communication/Socialization Skills. Support Activities: # 1 Communication/Socialization Skills. (Individual # 3) communicates his wants, needs, and preferences. (Individual # 3) will be encouraged by staff to make eye contact with the person he is socializing with and smile or clap his hands. How often: Daily through 7/31/2018." "Desired Outcome: Outcome # 2 Community Integration. Support Activities: (Individual # 3) actively participates in a community outing 1x (one time) a month. How often: 1x per month 7/31/2018." "Desired Outcome: # 3 Sensory Stimulation. (Individual # 3) participates in a variety of stimulation activities to increase his engagement level and awareness. How often: Daily through 7/31/2018." "Desired Outcome: # 4 Self Help Skill. (Individual # 3) increases his self-help skills throughout the day. How often: Daily through 7/31/2018." On 03/27/18 at approximately 12:00 p.m., a review of (Name of Day Program) data collection	W 159	W159 For individual #3d 1-An IDT meeting will be held between the day program vendor and the residential team to review the quality of documentation of the communication/socialization and sensory stimulation services agreed to in the ISP and updates made accordingly to individual #3's quarterly report. 2- Day program(s) for individual #3 (and other individuals in the facility) will submit quarterly reports to the residential provider in a timely manner for review of deliverables contracted to on individual #3's ISP as well as others served by this provider. 3-The Clinical Director will see to it that contractual deliverables relating to the ISP and other health/safety measures are adequately provided per the contract, otherwise, take compliance measures necessary to obtain the best quality services possible for individual #3 and others served by this provider. 4-Periodic audits of day program services by the Program manager/designee and/or the Quality Improvement Coordinator will include delivery/documentation of services according to the agreed to ISP for individual #3 and others.	5/13/18

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W 159	Continued From page 64 of Individual # 3's outcomes/goals communication/socialization skills, community integration, sensory stimulation, and self-help-skills outcomes dated 02/01/2018 through 03/27/2018 was conducted. Under the outcome "# 1 Communication/Socialization Skills" the following statement, "DSP (Direct Support Professional) provide (Individual # 3) with encouragement to communicate with his peers and staffs at his day program. DSP also encouraged (Individual # 3) to use his body language, vocalizations and gesture to communicate his wants, needs and desires to others. (Individual # 3) is encouraged to socialize with his peers by clapping his hands together, smiling and making eye contact" was documented 20 of 39 days at (Name of Day Program). Further review of the data collection documentation, dated 02/01/2018 through 03/27/2018 revealed the statement: "DSP provide (Individual # 3) with encouragement to communicate to his peers and staffs, he is encouraged to use his body language, vocalizations and gestures to communicate his wants, needs and desires to others" was documented five of 39 days at (Name of Day Program). The data collection from 01/01/2018 through 03/27/2018 failed to evidence the active treatment program was implemented. Under the outcome "# 2 Community Integration" the data collection from 01/01/2018 through 03/27/2018 failed to evidence the active treatment program was implemented. Under the outcome "# 3 Sensory Stimulation", the data collection from 02/01/2018 through 03/27/2018 documented the statement, "DSP offered (Individual # 3) the opportunity to	W 159		

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W 159	Continued From page 65 participate in sensory activities of his choice and interest, and also encouraged him to choose his preferred sensory activity." The data collection from 01/01/2018 through 03/27/2018 failed to evidence the active treatment program was implemented. Under the outcome "# 4 Self Help Skill" the data collection from 02/01/2018 through 03/27/2018 documented the statement, "DSP provide (Individual # 3) with encouragement to increase his self-help skills throughout the day at his support program. (Individual # 3) is given assistance as needed to ensure his self-help tasks are completed." The data collection from 01/01/2018 through 03/27/2018 failed to evidence the active treatment program was implemented. On 03/29/18 at 2:00 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional) regarding the data collection of Individual # 3's active treatment program at (Name of Day Program). After review the documentation of Individual # 3's outcome of community integration, OSM # 3 stated, "The notes are repeated. Can't say if the programs were implemented" When asked who was responsible for ensuring the PCP outcomes are implemented at (Name of Day Program), OSM # 3 stated, "The QIDP." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings.	W 159		

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W 159	Continued From page 66 No further information was provided prior to exit. 3e. The QIDP failed to ensure the PCP (Person Centered Plan) outcomes for Individual # 3 were developed in measurable terms. Individual # 3's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: # 1 Communication/Socialization Skills. Support Activities: # 1 Communication/Socialization Skills. (Individual # 3) communicates his wants, needs, and preferences. (Individual # 3) will be encouraged by staff to make eye contact with the person he is socializing with and smile or clap his hands. How often: Daily through 7/31/2018." "Desired Outcome: Outcome # 2 Community Integration. Support Activities: (Individual # 3) actively participates in a community outing 1x (one time) a month. How often: 1x per month 7/31/2018." "Desired Outcome: # 3 Sensory Stimulation. (Individual # 3) participates in a variety of stimulation activities to increase his engagement level and awareness. How often: Daily through 7/31/2018." "Desired Outcome: # 4 Self Help Skill. (Individual # 3) increases his self-help skills throughout the day. How often: Daily through 7/31/2018." On 03/29/18 at 2:00 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked to describe the	W 159	W 159 For individual #3e 1- ISP outcomes for Communication/ Socialization and self-help skills for individual #3 will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4- The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.	5/13/18

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W 159	Continued From page 67 purpose of the PCP's for individuals, OSM # 3 stated, "To assess the individual and find better ways to support an individual's needs." OSM # 3 was asked to review Individual # 3's PCP (person centered plan) outcomes/goals of communication/socialization skills, community integration, sensory stimulation, and self-help-skills from (Name of Day Program) clinical record dated 08/01/2017 - 07/31/2018. When asked if the outcomes/goals were developed in measurable terms, OSM # 3 stated, "No." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. 3f. The QIDP failed to ensure the data collection of the PCP (Person Centered Plan) outcomes for Individual # 3 were in measurable terms. Individual # 3's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: # 1 Communication/Socialization Skills. Support Activities: # 1 Communication/Socialization Skills. (Individual # 3) communicates his wants, needs, and preferences. (Individual # 3) will be encouraged by staff to make eye contact with the person he is socializing with and smile or clap his hands. How often: Daily through 7/31/2018."	W 159	W 159 For individual #3f. 1- ISP data collection for individual #3's communication, socialization and self-help skill will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4- The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.	5/13/18

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W 159	Continued From page 68 "Desired Outcome: Outcome # 2 Community Integration. Support Activities: (Individual # 3) actively participates in a community outing 1x (one time) a month. How often: 1x per month 7/31/2018." "Desired Outcome: # 3 Sensory Stimulation. (Individual # 3) participates in a variety of stimulation activities to increase his engagement level and awareness. How often: Daily through 7/31/2018." "Desired Outcome: # 4 Self Help Skill. (Individual # 3) increases his self-help skills throughout the day. How often: Daily through 7/31/2018." Review of (Name of Day Program) data collection of Individual # 3's outcomes/goals communication/socialization skills, community integration, sensory stimulation, and self-help-skills dated 02/01/2018 through 03/27/2018 failed to evidence data collection of the outcomes in measurable terms. On 03/29/18 at 2:00 p.m., an interview was conducted with OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). OSM # 3 was asked to review Individual # 3's data collection sheets from (Name of Day Program) dated 02/01/2018 through 03/27/2018 for the outcome of communication/socialization skills, community integration, sensory stimulation, and self-help-skills. OSM # 3 stated she did not need to review the progress notes. OSM # 3 further stated that if the outcome were not written in measurable terms then the data collection could not be obtained in measurable terms.	W 159		

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W 159	Continued From page 69 On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the 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 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 that the facility staff failed to develop objectives in measurable terms for three of three individuals in the survey sample, Individuals # 1, # 2 and # 3. 1. The facility staff failed to define the outcomes/goals "Communication" and "Computer skills" on the PCP (person-centered plan) dated 05/01/2017 through 04/30/2018 in the (Name of Group Home) clinical record for Individual # 1. 2a. The facility staff failed to define the outcome/goal "Activities of Daily Living" on the PCP (person centered plan) dated 08/17/2017 - 07/31/2018 in the (Name of Group Home) clinical record for Individual # 2. 2b. The facility staff failed to define the outcome/goal "Community Integration" and	W 231		

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W 231	Continued From page 70 "Self-help" on the PCP (person centered plan) dated 08/01/2017 - 07/31/2018in the (Name of Day Program) clinical record for Individual # 2. 3. The facility staff failed to define the outcomes/goals "Communication/Socialization Skills, Community Integration, Sensory Stimulation, and Self-help-skills" on the PCP (person centered plan) dated 08/01/2017 - 07/31/2018 in the (Name of Day Program) clinical record for Individual # 3. The findings include: 1. The facility staff failed to define the outcomes/goals "Communication" and "Computer skills" on the PCP (person-centered plan) dated 05/01/2017 through 04/30/2018 in the (Name of Group Home) clinical record for Individual # 1. Individual # 1 was a 24 year-old female, who was admitted to (Name of Group Home) on 2/19/13. Diagnoses in the clinical record included but were not limited to: mild intellectual disability, autism (1), seizure disorder (2), scoliosis (3), and post-traumatic stress disorder (4). Individual # 1's current PCP dated 05/01/2017 through 04/30/2018 documented, "Desired Outcome: #2 (Individual # 1) increases her verbal communication ability. Support Activities & Instructions: 1. (Individual # 1) communicates to others 50% (percent) of the time for up to 15 minutes through out [sic] the day by purposefully directing her messages. Support Instructions: a. (Individual # 1) verbally communicates her wants and needs to a specific	W 231	W 231 For individual #1. 1- ISP data collection for individual #1 verbal communication ability and computer skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes and data collection in a measurable manner. 3- ISP outcomes and data collection 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 measurable if they are not. 4- The department of Mission Effectiveness will add measurability of ISP outcomes and data collection in their periodic audits of clinical documents in the program.	5/13/18

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W 231	Continued From page 71 person. B. (Individual # 1) is prompted by staff to use her words if needed. C. (Individual # 1) is encouraged to communicate in full sentences if clarity is needed. Type: Skill building. Duration: Quarterly. Frequency: Daily. Amount: 15 minutes." "Desired Outcome: Improve Computer Skills. Support Activities & Instructions: (Individual # 1) use the computer for up to 7(seven) days for up to 1 (one) hour per day by 4/30/2018. Support Instructions: a. (Individual # 1) requests to use the computer. b. permission is given to use the computer and a timer is set. C. (Individual # 1) uses the computer until the timer goes off. Type: Routine supports. Duration: Quarterly. Frequency: Daily. Amount: 60 minutes." On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked to describe the purpose of the PCP's for individuals, OSM # 3 stated, "To assess the individual and find better ways to support an individual's needs." When asked if the PCP is developed to improve the individual's skills to become more independent, ASM # 2 stated, "Yes." OSM # 3 and ASM # 2 were then asked to review Individual # 1's outcomes/goals from the PCP dated 05/01/2017 through 04/30/2018 for outcomes of communication and computer skills. When asked if the outcomes/goals were developed in measurable terms, OSM # 3 and ASM # 1 stated, "No." The facility's policy "4.1 Individual Service Plan	W 231		

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W 231	Continued From page 72 (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 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the 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://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) 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. This information was obtained from	W 231		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 231	Continued From page 73 the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html. (3) An abnormal curving of the spine. Your spine is your backbone. It runs straight down your back. Everyone's spine naturally curves a bit. But people with scoliosis have a spine that curves too much. The spine might look like the letter C or S. This information was obtained from the website: https://medlineplus.gov/ency/article/001241.htm. (4) A disorder that develops in some people who have experienced a shocking, scary, or dangerous event. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml. 2a. The facility staff failed to define the outcome/goal "Activities of Daily Living" on the PCP (person centered plan) dated 08/17/2017 - 07/31/2018 in the (Name of Group Home) clinical record for Individual # 2. Individual # 2 was a 71 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: Severe intellectual disability (1), seizure disorder (2), hypertension (3), left lower lung benign (4) granuloma (5), and Parkinson's disease (6). Individual # 2's current PCP dated 08/17/2017 - 07/31/2018 documented, "Desired Outcome: Need #7 Activities of Daily Living. Goal #7 (Individual # 2) independently participates in activities of daily living skills at least 2 (two) out of 4 (four) times per day for 50%	W 231	W231 For Individual #2a. 1- ISP data collection for individual #2's activities of daily living skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- ISP outcomes and data collection 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes and data collection for measurability in their periodic audits of clinical documents in the program.	5/13/18

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W 231	Continued From page 74 (percent) of the time until 07/31/2018. Support Activities & Instructions: 1.) (Individual # 2) is assisted with his activities of daily living two times out of four times per day for 50% of the times until 07/31/2018. A) (Individual # 2) is reminded when it is time for his ADLs (Activities of Daily Living). B) (Individual # 2) is encouraged to do his ADLs. C) (Individual # 2) is given an extended assist when needed. D) (Individual # 2) is praised for doing a good job. Type: Routine supports. Duration: Annually. Frequency: Daily." On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked to describe the purpose of the PCP's for individuals, OSM # 3 stated, "To assess the individual and find better ways to support an individual's needs." When asked if the PCP is developed to improve the individual's skills to become more independent, ASM # 2 stated, "Yes." OSM # 3 and ASM # 2 were asked to review Individual # 2's outcome/goal from the PCP dated 08/17/2017-07/31/2018 or outcome # 7, ADLs. When asked if the outcome/goal was developed in measurable terms, OSM # 3 and ASM # 1 stated, "No." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit.	W 231		

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W 231	Continued From page 75 Reference: (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) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm. (5) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of	W 231		

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W 231	Continued From page 76 modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma. (6) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 2b. The facility staff failed to define the outcome/goal "Community Integration" and "Self-help" on the PCP (person-centered plan) dated 08/01/2017 - 07/31/2018in the (Name of Day Program) clinical record for Individual # 2. Individual # 2's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: Community Integration. Support Activities: Outcome # 2A. (Individual # 2) develops relationships in the community. Skill Building: Yes. How Often: 4XMONTH (four times per month)." "Desired Outcome: Self-help. Support Activities: Outcome # 6A. (Individual # 2) improves self-sufficiency in his daily life. Skill Building: Yes. How Often: DAILY." On 03/28/18 at approximately 1:10 p.m., an	W 231	W 231 For individual #2b. 1- ISP outcomes for individual #2's community integration and self-help skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes for measurability in their periodic audits of clinical documents in the program.	5/13/18

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W 231	Continued From page 77 interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked to describe the purpose of the PCP's for individuals, OSM # 3 stated, "To assess the individual and find better ways to support an individual's needs." When asked if the PCP is developed to improve the individual's skills to become more independent, ASM # 2 stated, "Yes." OSM # 3 and ASM # 2 were asked to review Individual # 2's PCP (person centered plan) outcomes/goals of community integration and self-help skills from (Name of Day Program) clinical record dated 08/01/2017 - 07/31/2018. When asked if the outcomes/goals were developed in measurable terms, OSM # 3 and ASM # 1 stated, "No." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. 3. The facility staff failed to define the outcomes/goals "Communication/Socialization Skills, Community Integration, Sensory Stimulation, and Self-help-skills" on the PCP (person centered plan) dated 08/01/2017 - 07/31/2018 in the (Name of Day Program) clinical record for Individual # 3. Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were	W 231		

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W 231	Continued From page 78 not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and anemia (7). Individual # 3's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: # 1 Communication/Socialization Skills. Support Activities: # 1 Communication/Socialization Skills. (Individual # 3) communicates his wants, needs, and preferences. (Individual # 3) will be encouraged by staff to make eye contact with the person he is socializing with and smile or clap his hands. How often: Daily through 7/31/2018." "Desired Outcome: Outcome # 2 Community Integration. Support Activities: (Individual # 3) actively participates in a community outing 1x (one time) a month. How often: 1x per month 7/31/2018." "Desired Outcome: # 3 Sensory Stimulation. (Individual # 3) participates in a variety of stimulation activities to increase his engagement level and awareness. How often: Daily through 7/31/2018." "Desired Outcome: # 4 Self Help Skill. (Individual # 3) increases his self-help skills throughout the day. How often: Daily through 7/31/2018." On 03/27/18 at 12:15 p.m., an interview was conducted with OSM (other staff member) # 1, (Name of Day Program) program manager clinical services. OSM # 1 was asked to review Individual # 3's outcomes/goals from the (Name	W 231	W231for individual #3 1- ISP outcomes for Communication/ Socialization sensory stimulation and self-help skills for individual #3 will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4- The department of Mission Effectiveness will add measurability of ISP outcomes in their periodic audits of clinical documents in the program.	5/13/17

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W 231	Continued From page 79 of Day Program) PCP dated 08/01/2017 - 07/31/2018 for outcomes # 1 Communication/Socialization Skills, # 2 Community Integration, # 3 Sensory Stimulation, and # 4 Self-help-skills. When asked to identify the specific skills being measured for the outcomes/goals of communication/socialization skills, community integration, sensory stimulation, and self-help-skills, OSM # 1 could not identify what skills was being taught or measured. When asked if the outcomes of community integration and self-help skills were developed in measurable terms, OSM # 1 stated, "No." On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked to describe the purpose of the PCP's for individuals, OSM # 3 stated, "To assess the individual and find better ways to support an individual's needs." When asked if the PCP is developed to improve the individual's skills to become more independent, ASM # 2 stated, "Yes." OSM # 3 and ASM # 2 were asked to review Individual # 3's PCP (person centered plan) outcomes/goals of communication/socialization skills, community integration, sensory stimulation, and self-help-skills from (Name of Day Program) clinical record dated 08/01/2017 - 07/31/2018. When asked if the outcomes/goals were developed in measurable terms, OSM # 3 and ASM # 1stated, "No." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home),	W 231		

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(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 80 RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference: (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) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye.This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium.	W 231		

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	49G027	A. BUILDING _____ B. WING _____	03/29/2018

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W 231	Continued From page 81 This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .	W 231		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the residential staff failed to ensure an Individual was receiving services consistent with the Person Centered Plan (PCP) for one of three individuals in the survey sample, Individual # 3.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 82 1a. The facility staff failed to implement Individual # 3's PCP outcomes # 1 communication/socialization skills and # 3 sensory stimulation during a (Name of Day Program) activity. b. The facility staff failed to implement Individual # 3's PCP outcomes of communication/socialization skills, community integration, sensory stimulation, and self-help-skills from 02/01/18 through 03/27/18. The findings include: 1a. The facility staff failed to implement Individual # 3's PCP outcomes # 1 communication/socialization skills and # 3 sensory stimulation during a (Name of Day Program) activity. Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and anemia (7). On 03/27/18 at 11:00 a.m. to 11:30 a.m., an observation of Individual # 3 was conducted at (Name of Day Program). Individual # 3 was observed siting in his wheelchair, dressed, neat and clean. He was in a large day/activity room at the (Name of Day Program) watching a staff run skit/play. The skit/play consisted of the players/actors initiating audience (individual's) participation with numerous individuals that included, singing, dancing, body movement,	W 249	W 249 For individual #3,1a 1- The implementation of ISP outcomes for Communication/ Socialization and self-help skills for individual #3 will be discussed in an IDT meeting with his day program. 2- QIDP and program manager will visit day program once per month to ensure that ISP outcomes for individual #3 and others are implemented according to contract. 3- ISP outcomes for all other individuals in the day program will be periodically observed by the Clinical Director or designee to ensure that they implemented and documented accordingly . 4- The department of Mission Effectiveness will add implementation of ISP outcomes in their periodic audits of clinical documents in the program.	5/13/18

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W 249	Continued From page 83 counting and clapping. Individual # 3 was observed positioned in his wheelchair off to the left of the group approximately eight to ten feet away watching the players/actors actively engaging individuals from the audience. Further observation of Individual # 3 revealed there was a short wall approximately three and a half feet high and 12 feet long in front of Individual # 3 separating him from the audience and the player/actors. During the observation period, Individual # 3 was observed to be smiling and looking toward the activity, however facility staff failed to reposition Individual # 3 closer to the skit/play to have a unobstructed view and an opportunity to be involved. Individual # 3's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: # 1 Communication/Socialization Skills. Support Activities: # 1 Communication/Socialization Skills. (Individual # 3) communicates his wants, needs, and preferences. (Individual # 3) will be encouraged by staff to make eye contact with the person he is socializing with and smile or clap his hands. How often: Daily through 7/31/2018." "Desired Outcome: # 3 Sensory Stimulation. (Individual # 3) participates in a variety of stimulation activities to increase his engagement level and awareness. How often: Daily through 7/31/2018." On 03/27/18 at 12:15 p.m., an interview was conducted with OSM (other staff member) # 1, (Name of Day Program) program manager clinical services regarding the observation of	W 249		

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W 249	Continued From page 84 Individual # 3 at the facility's play/skit. OSM # 1 agreed Individual # 3 was involved in the activity. OSM # 1 stated, "He was on the outside of the group. He should have been in the group. He could not see or engage with the performance." OSM # 1 was asked to review Individual # 3's outcomes/goals from the (Name of Day Program) PCP dated 08/01/2017 - 07/31/2018 for outcomes # 1 Communication/Socialization Skills and # 3 Sensory Stimulation. OSM # 1 stated, "The outcomes were not implemented and could have been addressed by the activity." When asked who was responsible for getting Individual involved in the activity to implement his PCP outcomes, OSM # 1 stated, "The program manager or someone should have moved (Individual # 3) so he could be involved." On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When informed of the observation of Individual # 3 and the (Name of Day Program) activity on 03/27/18, OSM # 5 and ASM # 2 stated the active treatment program was not implemented. On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference:	W 249		

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W 249	Continued From page 85 (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) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This membrane lines the eyelids and covers the white part of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down	W 249		

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W 249	Continued From page 86 through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website: https://medlineplus.gov/ency/article/001228.htm. (7) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . b. The facility staff failed to implement Individual # 3's PCP outcomes of communication/socialization skills, community integration, sensory stimulation, and self-help-skills from 02/01/18 through 03/27/18. Individual # 3's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: # 1 Communication/Socialization Skills. Support Activities: # 1 Communication/Socialization Skills. (Individual # 3) communicates his wants, needs, and preferences. (Individual # 3) will be encouraged by staff to make eye contact with the person he is socializing with and smile or clap his hands. How often: Daily through 7/31/2018." "Desired Outcome: Outcome # 2 Community Integration. Support Activities: (Individual # 3) actively participates in a community outing 1x (one time) a month. How often: 1x per month 7/31/2018." "Desired Outcome: # 3 Sensory Stimulation. (Individual # 3) participates in a variety of stimulation activities to increase his engagement	W 249	W 249 For individual #3,1b 1- The implementation of ISP outcomes for Communication/ Socialization and self-help skills for individual #3 will be discussed in an IDT meeting with his day program. 2- QIDP and program manager will visit day program once per month to ensure that ISP outcomes for individual #3 and others are implemented according to contract. 3- ISP outcomes for all other individuals in the day program will be periodically observed by the Clinical Director or designee to ensure that they implemented and documented accordingly . 4- The department of Mission Effectiveness will add implementation of ISP outcomes in their periodic audits of clinical documents in the program.	5/13/18

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W 249	Continued From page 87 level and awareness. How often: Daily through 7/31/2018." "Desired Outcome: # 4 Self Help Skill. (Individual # 3) increases his self-help skills throughout the day. How often: Daily through 7/31/2018." On 03/27/18 at approximately 12:00 p.m., a review of (Name of Day Program) data collection of Individual # 3's outcomes/goals communication/socialization skills, community integration, sensory stimulation, and self-help-skills outcomes dated 02/01/2018 through 03/27/2018 was conducted. Under the outcome "# 1 Communication/Socialization Skills" the following statement, "DSP (Direct Support Professional) provide (Individual # 3) with encouragement to communicate with his peers and staffs at his day program. DSP also encouraged (Individual # 3) to use his body language, vocalizations and gesture to communicate his wants, needs and desires to others. (Individual # 3) is encouraged to socialize with his peers by clapping his hands together, smiling and making eye contact" was documented 20 of 39 days at (Name of Day Program). Further review of the data collection documentation dated 02/01/2018 through 03/27/2018 revealed the statement "DSP provide (Individual # 3) with encouragement to communicate to his peers and staffs, he is encouraged to use his body language, vocalizations and gestures to communicate his wants, needs and desires to others" was documented only five of 39 days at (Name of Day Program). The data collection from 01/01/2018 through 03/27/2018 failed to evidence the active treatment program was implemented.	W 249		

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W 249	Continued From page 88 Under the outcome "# 2 Community Integration" the data collection from 01/01/2018 through 03/27/2018 failed to evidence the active treatment program was implemented. Under the outcome "# 3 Sensory Stimulation", the data collection from 02/01/2018 through 03/27/2018 documented the statement, "DSP offered (Individual # 3) the opportunity to participate in sensory activities of his choice and interest, and also encouraged him to choose his preferred sensory activity." The data collection from 01/01/2018 through 03/27/2018 failed to evidence the active treatment program was implemented. Under the outcome "# 4 Self Help Skill" the data collection from 02/01/2018 through 03/27/2018 documented the statement, "DSP provide (Individual # 3) with encouragement to increase his self-help skills throughout the day at his support program. (Individual # 3) is given assistance as needed to ensure his self-help tasks are completed." The data collection from 01/01/2018 through 03/27/2018 failed to evidence the active treatment program was implemented. On 03/27/18 at 12:15 p.m., an interview was conducted with OSM (other staff member) # 1, (Name of Day Program) program manager clinical services regarding the data collection of Individual # 3's active treatment program at (Name of Day Program). After review the documentation of Individual # 3's outcome of community integration, OSM # 1 stated, "The lack of documentation for community integration indicates it was not implemented." When asked about the repeated statements documented for	W 249		

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W 249	Continued From page 89 outcomes of communication/socialization skills, sensory stimulation, and self-help-skills, OSM # 1 stated, "It was cut and paste." When asked if the active treatment for communication/socialization skills, sensory stimulation, and self-help-skills was implemented, OSM # 1 stated, "You can't tell." On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). When asked if the active treatment for communication/socialization skills, sensory stimulation, and self-help-skills were implemented 03/27/18, OSM # 5 and ASM # 2 stated the active treatment program was not implemented. On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit.	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.	W 252		

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W 252	Continued From page 90 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 collect data in measurable terms for three of three individuals in the survey sample, Individuals # 1, # 2 and # 3. 1. The Facility staff failed to document the data collection of Individual # 1's PCP (person-centered plan) outcomes/goals "Communication" and "Computer skills" in measurable terms. 2a. The Facility staff failed to document the data collection of Individual # 2's PCP (person-centered plan) outcome/goal "Activities of Daily Living" in measurable terms. 2b. The facility staff failed to document the data collection of Individual # 2's PCP (person-centered plan) outcomes/goals "Community Integration" and "Self-help" in the (Name of Day Program) clinical record in measurable terms. 3. The facility staff failed to document the data collection of Individual # 3's PCP (person centered plan) outcomes/goals "Communication/Socialization Skills, Community Integration, Sensory Stimulation, and Self-help-skills" in the (Name of Day Program) clinical record in measurable terms. The findings include: 1. Facility staff failed to document the data collection of Individual # 1's PCP (person-centered plan) outcomes/goals "Communication" and "Computer skills" in	W 252	W 252 For Individual #1. 1- ISP data collection for individual #1's communication and computer skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes for measurability in their periodic audits of clinical documents in the program.	5/13/18

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W 252	Continued From page 91 measurable terms. Individual # 1 was a 24 year-old female, who was admitted to (Name of Group Home) on 2/19/13. Diagnoses in the clinical record included but were not limited to: mild intellectual disability, autism (1), seizure disorder (2), scoliosis (3), and post-traumatic stress disorder (4). Individual # 1's current PCP dated 05/01/2017 through 04/30/2018 documented, "Desired Outcome: #2 (Individual # 1) increases her verbal communication ability. Support Activities & Instructions: 1. (Individual # 1) communicates to others 50% (percent) of the time for up to 15 minutes through out [sic] the day by purposefully directing her messages. Support Instructions: a. (Individual # 1) verbally communicates her wants and needs to a specific person. B. (Individual # 1) is prompted by staff to use her words if needed. C. (Individual # 1) is encouraged to communicate in full sentences if clarity is needed. Type: Skill building. Duration: Quarterly. Frequency: Daily. Amount: 15 minutes." "Desired Outcome: Improve Computer Skills. Support Activities & Instructions: (Individual # 1) use the computer for up to 7(seven) days for up to 1 (one) hour per day by 4/30/2018. Support Instructions: a. (Individual # 1) requests to use the computer. b. permission is given to use the computer and a timer is set. C. (Individual # 1) uses the computer until the timer goes off. Type: Routine supports. Duration: Quarterly. Frequency: Daily. Amount: 60 minutes." Review of (Name of Group Home) "Progress	W 252		

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W 252	Continued From page 92 Notes" for Individual # 1 dated 03/02/2018 through 03/27/2018 failed to evidence data collection of the outcomes communication and computer skills in measurable terms. On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). OSM # 3 and ASM # 2 were asked to review Individual # 1's data collection dated 03/02/2018 through 03/27/2018 for the outcomes communication and computer skills. OSM # 3 and ASM # 2 stated they did not need to review the progress notes. OSM # 3 and ASM # 2 further stated that if the outcomes were not written in measurable terms then the data collection could not be obtained in measurable terms. 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 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 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home),	W 252		

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(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 93 RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the 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://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) 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. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html. (3) An abnormal curving of the spine. Your spine is your backbone. It runs straight down your back. Everyone's spine naturally curves a bit. But people with scoliosis have a spine that curves too much. The spine might look like the letter C or S. This information was obtained from the website: https://medlineplus.gov/ency/article/001241.htm. (4) A disorder that develops in some people who have experienced a shocking, scary, or	W 252		

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W 252	Continued From page 94 dangerous event. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml. 2a. The facility staff failed to define the outcome/goal "Activities of Daily Living" on the PCP (person centered plan) dated 08/17/2017 - 07/31/2018 in the (Name of Group Home) clinical record for Individual # 2. Individual # 2 was a 71 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: Severe intellectual disability (1), seizure disorder (2), hypertension (3), left lower lung benign (4) granuloma (5), and Parkinson's disease (6). Individual # 2's current PCP dated 08/17/2017 - 07/31/2018 documented, "Desired Outcome: Need #7 Activities of Daily Living. Goal #7 (Individual # 2) independently participates in activities of daily living skills at least 2 (two) out of 4 (four) times per day for 50% (percent) of the time until 07/31/2018. Support Activities & Instructions: 1.) (Individual # 2) is assisted with his activities of daily living two times out of four times per day for 50% of the times until 07/31/2018. A) (Individual # 2) is reminded when it is time for his ADLs (Activities of Daily Living). B) (Individual # 2) is encouraged to do his ADLs. C) (Individual # 2) is given an extended assist when needed. D) (Individual # 2) is praised for doing a good job. Type: Routine supports. Duration: Annually. Frequency: Daily." Review of (Name of Group Home) "Progress	W 252	W 252 For Individual #2a. 1- ISP data collection for individual #2's activities of daily living skills will be updated to be quantifiable and measurable. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner. 3- 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes for measurability in their periodic audits of clinical documents in the program.	5/13/18

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W 252	Continued From page 95 Notes" for Individual # 2 dated 03/01/2018 through 03/27/2018 failed to evidence data collection of the outcome activities of daily living in measurable terms. On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). OSM # 3 and ASM # 2 were asked to review Individual # 2's data collection dated 03/01/2018 through 03/27/2018 for the outcome of activities daily living. OSM # 3 and ASM # 2 stated they did not need to review the progress notes. OSM # 3 and ASM # 2 further stated that if the outcome were not written in measurable terms then the data collection could not be obtained in measurable terms. On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference: (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	W 252		

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W 252	Continued From page 96 from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm. (5) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma.	W 252		

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W 252	Continued From page 97 (6) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 2b. The facility staff failed to define the outcome/goal "Community Integration" and "Self-help" on the PCP (person-centered plan) dated 08/01/2017 - 07/31/2018in the (Name of Day Program) clinical record for Individual # 2. Individual # 2's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented, "Desired Outcome: Community Integration. Support Activities: Outcome # 2A. (Individual # 2) develops relationships in the community. Skill Building: Yes. How Often: 4XMONTH (four times per month)." "Desired Outcome: Self-help. Support Activities: Outcome # 6A. (Individual # 2) improves self-sufficiency in his daily life. Skill Building: Yes. How Often: DAILY." Review of (Name of Day Program) "Monthly Support Tracking Log" dated 03/28/2018 for the outcome of community integration and self-help failed to evidence data collection of the outcome activities of daily living in measurable terms. On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities	W 252	For Individual #2b. 1- ISP goals for community integration and self-help will be updated to be quantifiable and measurable after consult with day program service provider. 2- QIDP will receive additional in-service training from the Clinical Director on how to write ISP outcomes in a measurable manner and implement strategies with day program provider to ensure that all ISP outcomes are written in measurable terms. 3- 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 measurable if they are not. 4-The Department of Mission Effectiveness will review ISP outcomes for measurability in their periodic audits of clinical documents in the program.	5/13/18

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W 252	Continued From page 98 Professional). OSM # 3 and ASM # 2 were asked to review Individual # 2's data collection Form entitled "Monthly Support Tracking Log" dated 03/28/2018 for the outcome of activities daily living. OSM # 3 and ASM # 2 stated they did not need to review the progress notes. OSM # 3 and ASM # 2 further stated that if the outcome were not written in measurable terms then the data collection could not be obtained in measurable terms. On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. 3. The facility staff failed to define the outcomes/goals "Communication/Socialization Skills, Community Integration, Sensory Stimulation, and Self-help-skills" on the PCP (person centered plan) dated 08/01/2017 - 07/31/2018 in the (Name of Day Program) clinical record for Individual # 3. Individual # 3 was a 58 year-old male, who was admitted to (Name of Group Home) on 06/15/10. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), seizure disorder (2), conjunctivitis (3), hypertension (4), vitamin D deficiency (5), club feet (6) and anemia (7). Individual # 3's current PCP for (Name of Day Program) dated 08/01/2017 - 07/31/2018 documented,	W 252	1-An IDT meeting will be held between the day program vendor and the residential team for individual #3 to review the implementation of the communication/ socialization and sensory stimulation and self-help skills outcomes on his ISP and updates made accordingly 2- Day program(s) for individual #3 (and other individuals in the facility) will submit quarterly reports to the residential provider in a timely manner for review of deliverables contracted to on individual #3's ISP as well as others served by this provider. 3-The Clinical Director will see to it that contractual deliverables relating to the ISP and other health/safety measures are adequately provided per the contract, otherwise, take compliance measures necessary to obtain the best qualityservices possible for individual #3 and others served by this provider. 4-Periodic audits of day program services by the Quality Improvement Coordinator will include delivery/documentation of services according to the agreed to ISP for individual #3 and others.	5/13/18

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W 252	Continued From page 99 "Desired Outcome: # 1 Communication/Socialization Skills. Support Activities: # 1 Communication/Socialization Skills. (Individual # 3) communicates his wants, needs, and preferences. (Individual # 3) will be encouraged by staff to make eye contact with the person he is socializing with and smile or clap his hands. How often: Daily through 7/31/2018." "Desired Outcome: Outcome # 2 Community Integration. Support Activities: (Individual # 3) actively participates in a community outing 1x (one time) a month. How often: 1x per month 7/31/2018." "Desired Outcome: # 3 Sensory Stimulation. (Individual # 3) participates in a variety of stimulation activities to increase his engagement level and awareness. How often: Daily through 7/31/2018." "Desired Outcome: # 4 Self Help Skill. (Individual # 3) increases his self-help skills throughout the day. How often: Daily through 7/31/2018." Review of (Name of Day Program) data collection of Individual # 3's outcomes/goals communication/socialization skills, community integration, sensory stimulation, and self-help-skills dated 02/01/2018 through 03/27/2018 failed to evidence data collection of the outcomes in measurable terms. On 03/27/18 at 12:15 p.m., an interview was conducted with OSM (other staff member) # 1, (Name of Day Program) program manager clinical services. OSM # 1 was asked to review Individual # 3's data collection for outcomes # 1	W 252		

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W 252	Continued From page 100 Communication/Socialization Skills, # 2 Community Integration, # 3 Sensory Stimulation, and # 4 Self-help-skills. After reviewing the monthly data collection notes dated 02/01/2018 through 03/27/2018, OSM # 1 stated the data was not collected in measurable term. On 03/28/18 at approximately 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, program manager for (Name of Group Home) and OSM (other staff member) # 3, QDIP (Qualified Intellectual Disabilities Professional). OSM # 3 and ASM # 2 were asked to review Individual # 3's data collection sheets from (Name of Day Program) dated 02/01/2018 through 03/27/2018 for the outcome of communication/socialization skills, community integration, sensory stimulation, and self-help-skills. OSM # 3 and ASM # 2 stated they did not need to review the progress notes. OSM # 3 and ASM # 2 further stated that if the outcome were not written in measurable terms then the data collection could not be obtained in measurable terms. On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference: (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.	W 252		

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W 252	Continued From page 101 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) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swelling (inflammation) or infection of the conjunctiva. This is the membrane that lines the eyelids and covers the white part of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001010.htm (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html. (6) Clubfoot is when the foot turns inward and downward. It is a congenital condition, which means it is present at birth. The cause is not known, but the condition may be passed down through families in some cases. Risk factors include a family history of the disorder and being male. This information was obtained from the website:	W 252		

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W 252	Continued From page 102 https://medlineplus.gov/ency/article/001228.htm. (7) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .	W 252		
W 332	NURSING SERVICES CFR(s): 483.460(c)(1) Nursing services must include participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the residential staff failed to follow nursing services for one of three individuals in the survey sample, Individual # 2. The facility staff failed to clarify the physician's order for the use of a gait belt (1). The findings include: Individual # 2 was a 71 year-old male, who was admitted to (Name of Group Home) on 07/26/96. Diagnoses in the clinical record included but were not limited to: Severe intellectual disability (2), seizure disorder (3), hypertension (4), left lower lung benign (5) granuloma (6), and Parkinson's disease (7). Review of the (Name of Group Home) clinical record for Individual # 2 revealed a physician's order dated 08/25/17. The physician order documented, "Gait belt for transfers."	W 332		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 332	Continued From page 103 Review of the (Name of Group Home) clinical record for Individual # 3 revealed a facility's "Incident Report" dated 11/12/2017 for Individual # 2. Further review of the "Incident Report" revealed Individual # 2 had a fall in the bathroom at (Name of Group Home) on 11/12/17. Individual # 2 suffered a "nondisplaced" fractured right hip. Further review of the "Incident Report" documented, "Incident/Behavior (Describe the Incident, WHAT happened and WHO was involved): Staff went to the bathroom to discover (Individual # 2's Initials) on the ground of the bathroom. There was urine on the floor and it seemed as if (Individual # 2's Initials) slipped while trying to leave the bathroom. (Individual # 2's Initials) walker was in his room." Further review of the incident report failed to evidence the use of a gait belt during Individual # 2's transfer to the bathroom. The POSs (physician's order sheets) dated 03/01/18 to 03/31/18 for Individual # 2 documented, "May use gait belt for transfers." The PCP (person centered plan) dated 08/01/2017 - 07/31/2018 for Individual # 2 documented, "B. (individual # 2) is reminded and supported with his Fall Protocol. 1. Refer to Falls Protocol. 2. (Individual # 2) should be assisted with his adaptive equipment. 3. (Individual # 2's) environment should be free from clutter. 4. All necessary documentation should be done and submitted." The facility's "Fall Protocol" for Individual # 2 dated 08/25/17 documented, "Prevention: (Individual # 3) may use gait belt to assist him	W 332	1-The Physician order for the use of a gait belt for individual #2 will be clarified with the prescribing physician and detail will be included specifically on when/why use the gait belt for the individual. 2- The Physician orders for individual #2 and all other individuals in the facility with adaptive equipment will be reviewed by the RN/LPN for clarity and any applicable adjustments requested from the prescribing physician. 3- During the team meetings, staff will be retrained on how to implement individual #2's updated adaptive equipment orders as well as any changes to adaptive equipment orders for the rest of the individuals in the facility. 4- The QIDP/Program Manager/Nurses will oversee the implementation and documentation of adaptive equipment use or all individuals in the home. -The Quality Improvement coordinator will audit for suitability and clarity of adaptive equipment orders during routine clinical audits or upon written request by the Clinical Director. -Clinical Director will oversee the quality of services for individuals especially those with adaptive equipment.	5/13/18

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W 332	Continued From page 104 transfer from a sitting to a standing position." On 03/28/18 at 1:10 p.m., an interview was conducted with RN (registered nurse) # 1 and LPN (licensed practical nurse) # 1. When asked why a gait belt was not used for Individual # 2's transfer to the bathroom on 11/12/17, LPN # 1 stated, "(Individual # 2) spends time in his room and we (staff) did not know when he got up to go to the bathroom. The gait belt only needs to be used when he is unsteady." When asked about the discrepancy in the wording of the physician's order dated 08/25/17 and the POS dated 03/01/18 through 03/31/18, RN # 1 stated, "The word 'May' indicates we can use the gait belt when needed." When the physician's order dated 08/25/17 was reviewed and pointed out the order did not contain the word 'May', RN # 1 stated, "The order should have been clarified." On 03/29/18 at 2:55 p.m., ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager for (Name of Group Home), RN (registered nurse) # 1, and OSM (other staff member) # 3, qualified intellectual disabilities professional, were informed of the findings. No further information was provided prior to exit. Reference: (1) A belt used to transfer a disabled person from one location to another by placing the belt around that person's waist and using it to hold on to while safely transferring the patient. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/transfer+belt. (2) Refers to a group of disorders characterized	W 332		

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(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 332	Continued From page 105 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. (3) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Benign refers to a condition, tumor, or growth that is not cancerous. This means that it does not spread to other parts of the body. It does not invade nearby tissue. Sometimes, a condition is called benign to suggest it is not dangerous or serious. This information was obtained from the website: https://medlineplus.gov/ency/article/002236.htm. (6) An imprecise term applied to (1) any small nodular, delimited aggregation of mononuclear inflammatory cells, or (2) a similar collection of modified macrophages resembling epithelial cells, usually surrounded by a rim of lymphocytes, often with multinucleated giant cells. Some	W 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/29/2018

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W 332	Continued From page 106 granulomas contain eosinophils and plasma cells, and fibrosis is commonly seen around the lesion. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/granuloma. (7) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.	W 332		