STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VAICFID82	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE STREET ICF ID	815 WOLFE STREET FREDERICKSBURG, VA 22401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		

An unannounced initial Medicaid ICF/ID Health Care Certification survey was conducted 3/22/16 through 3/24/16. 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 four bed facility was four at the time of the survey. The survey sample consisted of two current Individual reviews (Individuals #1 and # 2).

RECEIVED
APR 18 2016
VDH/OLC

W 111 483.410(c)(1) CLIENT RECORDS

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, clinical record review and facility document review it was determined that the facility staff failed to ensure the clinical record was complete and accurate for two of two individuals in the survey sample, Individuals # 1 and # 2.

1a. Facility staff failed to ensure Individual # 1's speech therapy assessment, physical therapy assessment, consent for a behavioral support plan and a seizure protocol were in the day program clinical record.

1b. Facility staff failed to ensure the physician's order for Centrum (1) [multivitamin] was in Individual # 1's residential medical record at

W 111

1a) Corrective action taken:
•QIDP uploaded the speech therapy assessment, physical therapy assessment, consent for service (psychological/behavior support plan) and seizure protocol for Individual #1 in the day program clinical electronic health record (EHR).
Ensure that other residents are protected from the possibility of this deficiency:
•QIDP will review each the ICF resident's EHR record for each service (episode) the resident receives to ensure the current documents are present.
Prevention of future occurrences:
•The EHR file of each individual will be reviewed quarterly and at the time of the annual plan review by the ICF QIDP to ensure that the day program facility staff have current documentation on record.
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to insure compliance is maintained.
•Completion: 3/24/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ID Residential Coordinator	4/13/16

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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WOLFE STREET ICF ID	815 WOLFE STREET FREDERICKSBURG, VA 22401

(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 1

(Name of Group Home).
1c. Facility staff failed to ensure Individual # 1's seizure protocol was in the residential clinical record at (Name of Group Home).

2a. Facility staff failed to ensure Individual # 2's speech therapy assessment, physical therapy assessment, oral hygiene guidelines and a seizure protocol were in the day program clinical record.

2b. Facility staff failed to ensure the physician's order for Colace (2) [stool softener] was in Individual # 2's residential medical record at (Name of Group Home).

2c. Facility staff failed to ensure Individual # 2's seizure protocol was in the residential clinical record at (Name of Group Home).

The findings include:

1a. Facility staff failed to ensure Individual # 1's speech therapy assessment, physical therapy assessment, consent for a behavioral support plan and a seizure protocol were in the day program clinical record.

Individual # 1 was a 60 year old female, who was admitted to (Name of Group Home) on 1/12/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (3) [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

W 111
1b) Corrective action taken:
•The missing prescription for individual #1 was printed from the computer and placed into the Medication Administration Record (MAR) books by the RN nurse manager.
Assurance that other residents are protected from the possibility of this deficiency:
•All resident's prescriptions will be reviewed for accuracy to ensure they are current and present by the RN nurse manager.
Prevention of future occurrence:
•MAR's & scripts will be reviewed monthly to ensure all are present by the RN nurse manager.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to insure compliance is maintained.
•Completion: 3/ 28/ 2016

1c) Corrective action taken:
•QIDP uploaded the seizure protocol for Individual #1 in the ICF residential clinical record (EHR).
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will review each the ICF resident's EHR record for each service (episode) the resident receives to ensure the current seizure documents are present.
Prevention of future occurrences:
•The EHR file of every resident will be reviewed by the QIDP quarterly and at the time of the annual support plan review to ensure that current seizure documentation is present. Internal EHR file audits will be conducted by the residential department.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to insure compliance is maintained.
•Completion: 3/24/2016

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 111	Continued From page 2	W 111		

as lack of stimulation and adult responsiveness.], myopia (4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia (5) [a swallowing disorder.], osteoporosis (6) [makes your bones weak and more likely to break], epilepsy(7) [a brain disorder that causes people to have recurring seizures] and hypothyroidism (8) [not enough thyroid hormone to meet your body's needs].

On 3/23/16 Individual # 1's day program clinical record was reviewed at (Name of Day Program). Individual # 1's day program clinical record failed to evidence Individual # 1's speech therapy assessment dated 1/29/2016, physical therapy assessment dated 1/18/2016, consent for a behavioral support plan dated 2/12/2016 and a seizure protocol.

On 3/23/16 at 11:35 a.m. an interview was conducted with OSM (other staff member) # 4, lead day support specialist regarding Individual # 1's current speech therapy assessment dated 1/29/2016, physical therapy assessment dated 1/18/2016, consent for a behavioral support plan dated 2/12/2016 and a seizure protocol. When asked why the documents were not in Individual # 1's day program clinical record OSM # 4 stated, "We don't have it. It should be part of the day program record." When asked about the consent for Individual # 1's behavioral support plan OSM # 4 sated, "I wasn't aware there was one."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

W 111

2a) Corrective action taken:
•QIDP uploaded the speech therapy assessment, physical therapy assessment, oral hygiene guidelines and seizure protocol for Individual #2 in the day program clinical record (EHR).
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will review each the ICF residents EHR record for each service (episode) the resident receives to ensure the current documents are present.
Prevention of future occurrences:
•The EHR file of each individual will be reviewed by the QIDP quarterly and at the time of the annual plan review, to ensure that the day program facility staff have current documentation on record.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to insure compliance is maintained.
•Completion: 3/24/2016

2b) Corrective action taken:
•The missing prescription for individual #2 was printed from the computer and placed into the MAR books by the RN nurse manager.
Assurance that other residents are protected from the possibility of this deficiency:
•All prescriptions will be reviewed for accuracy to ensure they are current and present by the RN nurse manager.
Prevention of future occurrence:
•MARs & scripts will be reviewed monthly to ensure all are present by the RN nurse manager.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits to ensure compliance is maintained.
•Completion: 3/28/ 2016

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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 3 References: (1) This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/16877067 (3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100 (4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001023.htm (5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html (6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html (7) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/epilepsy.html (8) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html 1b. Facility staff failed to ensure the physician's order for Centrum (1) [multivitamin] was in Individual # 1's Group Home medical record.	W 111	2c) Corrective action taken: •QIDP uploaded seizure protocol for Individual #2 in the ICF residential clinical record (EHR) Assurance that other residents are protected from the possibility of this deficiency: •QIDP will review each the ICF residents EHR record for each service (episode) the resident receives to ensure the current seizure documents are present. Prevention of future occurrences: •The EHR file of every resident will be reviewed quarterly and at the time of the annual support plan review by the QIDP to ensure that current documentation is present. Internal EHR file audits will be conducted by the residential department. Measures to maintain compliance: •The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained. •Completion: 3/24/2016	

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Review of Individual # 1's MAR (medication administration record) dated 3/2016 documented, "Centrum Silver tab (tablet): Take 1 (one) tablet by mouth daily with food." Further review of the MAR revealed Individual # 1 received Centrum from 3/1/16 through 3/21/16 one time a day.

Review of Individual # 1's Group Home medical record failed to evidence a physician's order for centrum silver.

On 3/23/16 at 10:25 a.m. an interview was conducted with RN (registered nurse) # 1, nurse manager. When asked about the missing physician's order for Individual # 1's multivitamin RN # 1 stated, "I couldn't find it so I called the pharmacy and got a copy of it this morning. The prescription should have been in the medical record, it was there I don't know what happened to it."

The facility's policy "Section 1-4; Record Keeping" documented, "The records will contain and document the resident's relevant personal information, health care information, active treatment documentation, social information and protection of the individual's rights such as communications, correspondence, program plan (including outside service programs), progress summaries, activity plans and participation, incidents consent forms, and all medical informations [sic]. This information will be accurate and functional ..."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

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W 111	Continued From page 5	W 111		

1c. Facility staff failed to ensure Individual # 1's seizure protocol was in the Group Home residential clinical record.

On 3/23/16 Individual # 1's residential Group Home clinical record was reviewed and failed to evidence Individual # 1's seizure protocol.

On 3/23/16 at 10:20 a.m. ASM (administrative staff member) # 2, intermediate care facility manager, provided this surveyor with a copy of Individual # 1's seizure protocol. When asked where she found Individual # 1's seizure protocol ASM # 2 stated, "It was in the filing cabinet in the office." When asked if the seizure protocol was part of Individual # 1's clinical record ASM # 2 stated, "Yes. It should have been in the books."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

2a. Facility staff failed to ensure Individual # 2's speech therapy assessment, physical therapy assessment, oral hygiene guidelines and a seizure protocol were in the day program clinical record.

Individual # 2 was a 42 year old male, who was admitted to (Name of Group Home) on 1/14/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (3) [refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive

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W 111	Continued From page 6	W 111		

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.], cerebral palsy(9) [a group of disorders that affect a person's ability to move and to maintain balance and posture.], myopia(4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia(5) [a swallowing disorder.], osteoporosis(6) [makes your bones weak and more likely to break], seizures(10) [seizure disorder (symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain.], nephrolithiasis (11) [kidney stones result when urine becomes too concentrated and substances in the urine crystalize to form stones.] and scoliosis (12) [a sideways curve of your backbone, or spine.].

On 3/23/16 Individual # 2's day program clinical record was reviewed. Individual # 2's day program clinical record failed to evidence Individual # 2's speech therapy assessment dated 1/29/2016, physical therapy assessment dated 10/28/2015, oral hygiene guidelines dated 2/12/2016 and a seizure protocol.

On 3/22/16 at 2:35 p.m. an interview was conducted with ASM (administrative staff member) # 5, assistant coordinator of (Name of Day Program). When asked about the missing oral hygiene guidelines from the (name of Day Program) clinical record for Individual # 2, ASM # 3 stated, "We're checking for it." At 1:00 p.m. ASM # 5 provided this surveyor with a copy of Individual # 2's oral hygiene guidelines. When

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W 111	Continued From page 7	W 111		

asked where she obtained Individual # 2's oral hygiene guidelines, ASM # 5 stated, "They were in the building but not in the clinical record. They should have been in the record."

On 3/23/16 at 11:35 a.m. an interview was conducted with OSM (other staff member) # 4, lead day support specialist regarding Individual # 2's current 2's speech therapy assessment dated 1/29/2016, physical therapy assessment dated 0/28/2015 and a seizure protocol. When asked why the documents were not in Individual # 2's day program clinical record OSM # 4 stated, "We don't have it. It should be part of the day program record."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

References:

(2) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601113.html
(3) This information was obtained from the website:
https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100

(5) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html
(6) This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/osteoporosis.html

(9) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html
(10) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html
(11) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/imagepages/17091.htm
(12) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/scoliosis.html

2b. Facility staff failed to ensure the physician's order for Colace (2) [stool softener] was in Individual # 2's Group Home medical record.

Review of Individual # 2's MAR (medication administration record) documented, "Colace 100 MG (milligrams) cap (capsule): Take 1(one) capsule by mouth three times a day." Further review of the MAR revealed Individual # 2 received Colace from 3/1/16 through 3/21/16 three times a day.

Review of Individual # 2's Group Home medical record at failed to evidence a physician's order for Colace.

On 3/23/16 at 10:25 a.m. an interview was conducted with RN (registered nurse) # 1, nurse

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W 111	Continued From page 9 manager. When asked about the missing physician's order for Individual # 2's Colace RN # 1 stated, "I couldn't find it so I called the pharmacy and got a copy of it this morning. The prescription should have been in the medical record, it was there I don't know what happened to it." On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings. No further information was provided prior to exit. 2c. Facility staff failed to ensure Individual # 2's seizure protocol was in the Group Home residential clinical record. On 3/23/16 Individual # 2's residential clinical record was reviewed and failed to evidence Individual # 2's seizure protocol. On 3/23/16 at 10:20 a.m. ASM (administrative staff member) # 2, intermediate care facility manager, provided this surveyor with a copy of Individual # 2's seizure protocol. When asked where she found Individual # 2's seizure protocol, ASM # 2 stated, "It was in the filing cabinet in the office." When asked if the seizure protocol was part of Individual # 2's clinical record, ASM # 2 stated, "Yes. It should have been in the books." On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings. No further information was provided prior to exit.	W 111		

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W 111	Continued From page 10 References: (3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100 (5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html (6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html (9) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html (10) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html (11) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/imagepages/17091.htm (12) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/scoliosis.html	W 111		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.	W 114		

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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 individual's comprehensive assessments were signed for two of two individuals in the survey sample, Individuals # 1 and # 2.

1. Facility staff failed to ensure Individual # 1's speech therapy assessment dated 1/29/2016 and physical therapy assessment dated 1/18/2016 were signed by the clinicians.

2. Facility staff failed to ensure Individual # 2's speech therapy assessment dated 1/29/2016, and physical therapy assessment dated 10/28/2015 were signed by the clinicians.

The findings include:

1. Individual # 1 was a 60 year old female, who was admitted to (Name of Group Home) on 1/12/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (3) [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.], myopia (4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia (5) [a swallowing disorder.], osteoporosis (6) [makes your bones weak and more likely to break], epilepsy (7) [a brain disorder that causes people to have recurring

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1)Corrective Action Taken:
•Individual #1's speech therapy assessment (dated 1/29/16) will be dated and signed by the speech and language pathologist who provided the assessment. Individual #1's physical therapy assessment (1/18/16) will be dated and signed by the physical therapist that provided the assessment.
Assurance that other residents are protected from the possibility of this deficiency:
•The review of all ICF resident clinical assessments will be completed by the QIDP. Signatures from the assessing clinician will be sought for any assessment found to be without signatures.
Prevention of future occurrences:
•All assessments will be reviewed by the QIDP to ensure there is a signature and date by the clinician prior to uploading in the electronic records.
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
Completion: 4/13/2016

2) Corrective Action Taken:
•Individual #2's speech therapy assessment (dated 1/29/16) will be dated and signed by the speech and language pathologist who provided the assessment. Individual #2's physical therapy assessment (10/28/15) will be dated and signed by the physical therapist that provided the assessment.
Assurance that other residents are protected from the possibility of this deficiency:
•The review of all ICF resident clinical assessments will be completed by the QIDP. Signatures from the assessing clinician will be sought for any assessment found to be without signatures.
Prevention of future occurrences:
•All assessments will be reviewed by the QIDP to ensure there is a signature and date by the clinician prior to uploading in the electronic records.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
•Completed by 4/13/20216

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seizures] and hypothyroidism (8) [not enough thyroid hormone to meet your body's needs].

On 3/23/16 Individual # 1's Group Home residential clinical record was reviewed and revealed, Individual # 1's speech therapy assessment dated 1/29/2016 and physical therapy assessment dated 1/18/2016. Further review of the speech therapy and physical therapy assessments failed to evidence written signatures or documentation that the typed name by the clinicians was an electronic signature.

On 3/24/16 at 8:40 a.m. a phone interview was conducted with OSM (other staff member) # 3, speech therapist. When asked if she completed the speech evaluation dated 1/29/2016 for Individual #1, OSM # 3 stated yes. When asked about the missing signature on the speech evaluation, OSM # 3 stated, "I thought my typed name was my signature." OSM # 3 also acknowledged that there was no documentation that the typed name was an electronic signature. OSM # 3 further stated she would provide the written signature or the electronic signature on future assessments.

On 3/24/16 an attempt was made to conduct a phone interview with OSM # 5, physical therapist. OSM # 5 could not be reached.

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

References:

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W 114	Continued From page 13 (3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100 (4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001023.htm (5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html (6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html (7) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/epilepsy.html (8) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html 2. Individual # 2 was a 42 year old male, who was admitted to (Name of Group Home) on 1/14/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (3) [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	W 114		

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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.], cerebral palsy (9) [a group of disorders that affect a person's ability to move and to maintain balance and posture.], myopia (4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia (5) [a swallowing disorder.], osteoporosis(6) [makes your bones weak and more likely to break], seizures(10) [seizure disorder (symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain.], nephrolithiasis (11) [kidney stones result when urine becomes too concentrated and substances in the urine crystalize to form stones.] and scoliosis (12) [a sideways curve of your backbone, or spine.].

On 3/23/16 Individual # 2's Group Home residential clinical record was reviewed and revealed Individual # 2's speech therapy assessment dated 1/29/2016 and physical therapy assessment dated 10/28/2015. Further review of the speech therapy and physical therapy assessments failed to evidence written signatures or documentation that the typed name by the clinicians was an electronic signature.

On 3/24/16 at 8:40 a.m. a phone interview was conducted with OSM (other staff member) # 3, speech therapist. When asked if she completed the speech evaluation dated 1/29/2016 for Individual #2, OSM # 3 stated yes. When asked about the missing signature on the speech evaluation, OSM # 3 stated, "I thought my typed name was my signature." OSM # 3 also acknowledged that there was no documentation that the typed name was an electronic signature.

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W 114	Continued From page 15 OSM # 3 further stated she would provide the written signature or the electronic signature on future assessments. On 3/24/16 an attempt was made to conduct a phone interview with OSM # 5, physical therapist. OSM # 5 could not be reached. On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings. No further information was provided prior to exit. References: (3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100 (5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html (6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html (9) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html (10) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html (11) This information was obtained from the	W 114		

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W 114	Continued From page 16 website: https://www.nlm.nih.gov/medlineplus/ency/imagepages/17091.htm (12) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/scoliosis.html	W 114		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and staff interviews, and facility document review, it was determined that the facility staff failed to provide privacy during personal care for one of two individuals in the survey sample, Individual # 1. The facility staff failed to close the bedroom door when removing a brief from Individual #1 and failed to close the bathroom door while providing Individual #1, assistance with showering. The findings include: Individual # 1 was a 60 year old female, who was admitted to (Name of Group Home) on 1/12/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (3) [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	W 130	1) Corrective action taken: •Staff will close the bedroom door for individual #1 when a brief is being changed and close the bathroom door when providing for individual #1 with showering assistance. Assurance that other residents are protected from the possibility of this deficiency: •ICF Management will conduct random observation to ensure this deficiency is not in practice with all clients. Prevention of future occurrence: •QIDP and ICF management will monitor and document effectiveness of active treatment monthly and quarterly to ensure rights are implemented. Measures to maintain compliance: •At each staff meeting, client's Human Rights will be reviewed, discussed and it will be expected that each employee know these rights. Management will conduct random observations to ensure staff are ensuring and protecting the Human Rights of the residents. •Completion: 3/24/2016	

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result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness.], myopia (4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia (5) [a swallowing disorder.], osteoporosis (6) [makes your bones weak and more likely to break], epilepsy (7) [a brain disorder that causes people to have recurring seizures] and hypothyroidism (8) [not enough thyroid hormone to meet your body's needs].

On 3/23/16 at 6:10 a.m. through 6:25 a.m. an observation was conducted at (Name of Group Home). Individual # 1 was lying in bed asleep. LPN (licensed practical nurse) # 1 entered Individual # 1's bedroom to wake her. ASM (administrative staff member) # 3, assistant intermediate care facility manager, entered Individual # 1's room to assist. LPN # 1 and ASM # 3 assisted Individual # 1 to a sitting position on the edge of her bed. LPN # 1 then positioned the toilet/shower chair in front of Individual # 1. LPN # 1 and ASM # 3 then raised Individual # 1's night gown up to her to her hips, then they removed Individual # 1's brief. Further observation of Individual # 1's bedroom revealed that the bedroom door was left open while the staff removed the brief. LPN # 1 then proceeded to Individual # 1's closet and selected a set of clothes; pants, shirt socks and under garments for Individual # 1and placed them in a chair. LPN # 1 and ASM # 3 assisted Individual # 1 into a toileting/shower chair. LPN # 1 took Individual # 1 down the hall and into the bathroom. LPN # 1 then position Individual # 1 in the shower area of the bathroom and proceeded to remove her night gown and started the water running. ASM # 3 came into the bathroom carrying Individual # 1's

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clothes and placed them on a vanity and proceed toward Individual # 1 to assist with her shower. LPN # 1 then came to the bathroom door and closed it.

On 3/23/16 at 8:45 a.m. an interview was conducted with LPN # 1. When asked if privacy was provided when Individual # 1's brief was removed, LPN # 1 stated, "No. The bedroom door was open. We should have closed the door." When asked about providing privacy when Individual # 1 was taken into the bathroom for her shower, LPN # 1 stated, "The door should have been closed from the time she went into the bathroom."

On 3/23/16 at 9:15 a.m. an interview was conducted with ASM # 3. When asked if privacy was provided when Individual # 1's brief was removed, ASM # 3 stated, "We should have closed the door." When asked about providing privacy when Individual # 1 was taken into the bathroom for her shower, ASM # 3 agreed that the door was left open and stated, "The bathroom door should have been closed after we took (Individual # 1) into the bathroom."

The facility's policy "Section 2-1; Individual Rights and Assurances" documented, "a. Each individual will be treated with dignity and respect and not subjected to physical, verbal, sexual or psychological abuse or punishment."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

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W 130	Continued From page 19 References: (3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100 (4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001023.htm (5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html (6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html (7) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/epilepsy.html (8) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html	W 130		
W 159	483.430(a) QIDP 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 and day program record	W 159		

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reviews, staff interview and facility document review, it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate and monitor the individuals' active treatment programs and ensure the residential and day program records were complete and accurate for two of two individuals in the survey sample, Individual # 1 and # 2.

1a. The QIDP failed to ensure Individual # 1's speech therapy assessment, physical therapy assessment, consent for a behavioral support plan and a seizure protocol were in the day program clinical record.

1b. The QIDP failed to ensure Individual # 1's speech therapy assessment 1/29/2016 and physical therapy assessment dated 1/18/2016 were signed by the clinicians.

1c. Facility staff failed to ensure Individual # 1's seizure protocol was in the Group Home residential clinical record.

2a. The QIDP failed to ensure Individual # 2's speech therapy assessment; physical therapy assessment, oral hygiene guidelines and a seizure protocol were in the day program clinical record.

2b. The QIDP failed to ensure Individual # 2's speech therapy assessment dated 1/29/2016, physical therapy assessment dated 10/28/2015 were signed by the clinicians.

2c. Facility staff failed to ensure Individual # 2's seizure protocol was in the Group Home residential clinical record.

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1a) Corrective action taken:
•QIDP uploaded the speech therapy assessment, physical therapy assessment, consent for service (psychological/behavior support plan) and seizure protocol for Individual #1 in the day program clinical record (EHR).
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will review each of the ICF resident's EHR record for each service (episode) the resident receives to ensure the current documents are present.
Prevention of future occurrences:
•The EHR file of every resident will be reviewed quarterly and at the time of the annual support plan review to ensure that current documentation is present.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
Completion: 3/24/2016

1b) Corrective action taken:
•Individual #1's speech therapy assessment (dated 1/29/16) will be dated and signed by the speech and language pathologist who provided the assessment. Individual #1's physical therapy assessment (1/18/16) will be dated and signed by the physical therapist who provided the assessment.
Assurance that other residents are protected from the possibility of this deficiency:
•The review of all ICF resident clinical assessments will be completed by the QIDP. Signatures from the assessing clinician will be sought for any assessment found to be without signatures.
Prevention of future occurrences:
•All assessments will be reviewed by the QIDP to ensure there is a signature and date by the clinician prior to uploading in the electronic records.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
•Completion: 4/8/20216

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2d. For Individual #2 the QIDP failed to coordinate and monitor the daily progress notes and the active treatment plan to ensure this Individual's tooth brushing program was implemented.

The findings include:

1a. The QIDP failed to ensure Individual # 1's speech therapy assessment, physical therapy assessment, consent for a behavioral support plan and a seizure protocol were in the day program clinical record.

Individual # 1 was a 60 year old female, who was admitted to (Name of Group Home) on 1/12/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (3) [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.], myopia (4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia (5) [a swallowing disorder.], osteoporosis (6) [makes your bones weak and more likely to break], epilepsy (7) [a brain disorder that causes people to have recurring seizures] and hypothyroidism (8) [not enough thyroid hormone to meet your body's needs].

On 3/23/16 Individual # 1's day program clinical record was reviewed at (Name of Day Program). Individual # 1's day program clinical record failed to evidence Individual # 1's speech therapy

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1c) Corrective action taken:
•QIDP uploaded the seizure protocol for Individual #1 in the ICF residential clinical record (EHR).
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will review each the ICF resident's EHR record for each service (episode) the resident receives to ensure the current seizure documents are present.
Prevention of future occurrences:
•The EHR file of every resident will be reviewed by the QIDP quarterly and at the time of the annual support plan review to ensure that the ICF residential facility staff have current seizure documentation on record.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
•Completion: 3/24/2016

2a) Corrective action taken:
•QIDP uploaded the speech therapy assessment, physical therapy assessment, oral hygiene guidelines, and seizure protocol for Individual #2 in the day program clinical record (EHR).
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will review each the ICF resident's EHR record for each service (episode) the resident receives to ensure the current documents are present.
Prevention of future occurrences:
•The EHR file of every resident will be reviewed quarterly and at the time of the annual support plan review by the QIDP to ensure that current documentation is present.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
•Completion: 3/24/2016

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assessment dated 1/29/2016, physical therapy assessment dated 1/18/2016, consent for a behavioral support plan dated 2/12/2016 and a seizure protocol.

On 3/23/16 at 1:50 p.m. an interview was conducted with ASM (administrative staff member) # 6, the QIDP (Qualified Intellectual Disabilities Professional). When asked to described her responsibilities as the QIDP, ASM # 6 stated, "I'm responsibility to develop support plans, provide oversight of plans which includes monitoring the plan and ensuring it is implemented, reviewing data collection monthly at the day programs, reading progress notes, look at the data tracking, watch how the active treatment programs are being run at the day programs and in the residence. I review the residence and day program clinical records to ensure they are complete. ASM # 6 was asked about Individual # 1's current speech therapy assessment dated 1/29/2016, physical therapy assessment dated 1/18/2016, consent for a behavioral support plan dated 2/12/2016 and a seizure protocol not being available in Individual # 1 day program clinical record. ASM # 6 stated, "The assessments and the consent should have been uploaded to both the residential and day support computer programs."

The facility's policy "Section 1-4; Record Keeping" documented, "The records will contain and document the resident's relevant personal information, health care information, active treatment documentation, social information and protection of the individual's rights such as communications, correspondence, program plan (including outside service programs), progress summaries, activity plans and participation,

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2b) Corrective Action Taken:
•Individual #2's speech therapy assessment (dated 1/29/16) will be dated and signed by the speech and language pathologist who provided the assessment. Individual #2's physical therapy assessment (10/28/15) will be dated and signed by the physical therapist that provided the assessment.
Assurance that other residents are protected from the possibility of this deficiency:
•The review of all ICF resident clinical assessments will be completed by the QIDP. Signatures from the assessing clinician will be sought for any assessment found to be without signatures.
Prevention of future occurrences:
•All assessments will be reviewed by the QIDP to ensure there is a signature and date by the clinician prior to uploading in the electronic records.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
•Completion: 4/8/20216

2c) Corrective action taken:
•QIDP uploaded seizure protocol for Individual #2 in the ICF residential clinical record (EHR).
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will review each of the ICF resident's EHR record for each service (episode) the resident receives to ensure the current seizure documents are present.
Prevention of future occurrences:
•The EHR file of every resident will be reviewed by the QIDP quarterly and at the time of the annual support plan review to ensure that ICF residential facility staff have current documentation in the record.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
•Completion: 3/24/2016

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incidents consent forms, and all medical informations [sic]. This information will be accurate and functional. The Qualified Intellectual Disabilities Professional will be responsible for the maintenance of the resident's record books and electronic record."

The facility's policy "Section 4-2; Qualified Intellectual Disabilities Professional" documented, "f. Monitor and observe the individuals, their activities, the supports and services, progress notes and data. G. Acquires approval signatures on all plan and consents. h. Disseminates copies of approved plans to the individual, their family/Authorized Representative (AR) or Guardian, and all PST (Personal Support Team) members."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

References:

(3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100

(4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001023.htm

(5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdi

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2d) Corrective action taken:
•QIDP will coordinate and monitor the daily progress notes to ensure that the active treatment plan is being implemented for Individual #2 's tooth brushing outcome.
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will review each of the ICF residents data collection and progress notes in the EHR record for each service (episode) the resident receives to ensure the current active treatment outcomes are being addressed as written.
Prevention of future occurrences:
•The EHR file of every resident will be reviewed by the QIDP quarterly and at the time of the annual support plan review to ensure that ICF residential facility staff have current documentation in the record.
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
•Completion: 3/24/2016

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sorders.html

(6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html

(7) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/epilepsy.html

(8) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html

1b. The QIDP failed to ensure Individual # 1's speech therapy assessment 1/29/2016 and physical therapy assessment dated 1/18/2016 were signed by the clinicians.

On 3/23/16 Individual # 1's Group Home clinical record was reviewed and revealed Individual # 1's speech therapy assessment dated 1/29/2016 and physical therapy assessment dated 1/18/2016. Further review of the speech therapy and physical therapy assessments failed to evidence written signatures or documentation that the typed name by the clinicians was an electronic signature.

On 3/23/16 at 1:50 p.m. an interview was conducted with ASM # 6, the QIDP. ASM # 6 was asked about the speech therapy assessment dated 1/29/2016 and physical therapy assessment dated 1/18/2016 not being signed by the clinicians. ASM # 6 acknowledged that they

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should have been sign and had no further comment.

1c. Facility staff failed to ensure Individual # 1's seizure protocol was in the Group Home residential clinical record.

On 3/23/16 Individual # 1's Group Home residential clinical record was reviewed and failed to evidence Individual # 1's seizure protocol.

On 3/23/16 at 10:20 a.m. ASM (administrative staff member) # 2, intermediate care facility manager, provided this surveyor with a copy of Individual # 1's seizure protocol. When asked where she found Individual # 1's seizure protocol ASM # 2 stated, "It was in the filing cabinet in the office." When asked if the seizure protocol was part of Individual # 1's clinical record ASM # 2 stated, "Yes. It should have been in the books."

On 3/23/16 at 1:50 p.m. an interview was conducted with ASM # 6, the QIDP. ASM #6 was asked about Individual # 1's seizure protocol not being available in the Group Home residential clinical record. ASM # 6 acknowledged that it should have been available and had no further comment.

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

2a. The QIDP (Qualified Intellectual Disabilities Professional) failed to ensure Individual # 2's

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speech therapy assessment, physical therapy assessment; oral hygiene guidelines and a seizure protocol were in the day program clinical record.

Individual # 2 was a 42 year old male, who was admitted to (Name of Group Home) on 1/14/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (3) [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.], cerebral palsy(9) [a group of disorders that affect a person's ability to move and to maintain balance and posture.], myopia(4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia(5) [a swallowing disorder.], osteoporosis(6) [makes your bones weak and more likely to break], seizures(10) [seizure disorder (symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain.], nephrolithiasis (11) [kidney stones result when urine becomes too concentrated and substances in the urine crystalize to form stones.] and scoliosis (12) [a sideways curve of your backbone, or spine.].

On 3/23/16 Individual # 2's day program clinical record was review at (Name of Day Program). Individual # 2's day program clinical record failed to evidence Individual # 2's speech therapy assessment dated 1/29/2016, physical therapy assessment dated 10/28/2015, oral hygiene

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guidelines dated 2/12/2016 and a seizure protocol.

On 3/23/16 at 1:50 p.m. an interview was conducted with ASM (administrative staff member) # 6, the QIDP (Qualified Intellectual Disabilities Professional). When asked to described her responsibilities as the QIDP ASM # 6 stated, "I'm responsibility to develop support plans, provide oversight of plans which includes monitoring the plan and ensuring it is implemented, reviewing data collection monthly at the day programs, reading progress notes, look at the data tracking, watch how the active treatment programs are being run at the day programs and in the residence. I review the residence and day program clinical records to ensure they are complete. ASM # 6 was asked about Individual # 2's current speech therapy assessment dated 1/29/2016, physical therapy assessment dated 10/28/2015, oral hygiene guidelines and a seizure protocol not being available in Individual # 2's day program clinical record. ASM # 6 stated, "The assessments and the consent should have been uploaded to both the residential and day support computer programs."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

References:

(3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100

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(5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html
(6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html

(9) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html

(10) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html

(11) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/imagepages/17091.htm

(12) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/scoliosis.html

2b. The QIDP failed to ensure Individual # 2's speech therapy assessment dated 1/29/2016, physical therapy assessment dated 10/28/2015 were signed by the clinicians.

On 3/23/16 Individual # 2's Group Home residential clinical record was reviewed and revealed, Individual # 2's speech therapy

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assessment dated 1/29/2016 and physical therapy assessment dated 10/28/2015. Further review of the speech therapy and physical therapy assessments failed to evidence written signatures or documentation that the typed name by the clinicians was an electronic signature.

On 3/23/16 at 1:50 p.m. an interview was conducted with ASM # 6, the QIDP. When asked about the speech therapy assessment dated 1/29/2016 and physical therapy assessment dated 1/18/2016 not being signed by the clinicians, ASM # 6 acknowledged that they should have been sign and had no further comment.

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

2c. Facility staff failed to ensure Individual # 2's seizure protocol was in the Group Home residential clinical record.

On 3/23/16 Individual # 2's Group Home residential clinical record was reviewed and failed to evidence Individual # 2's seizure protocol.

On 3/23/16 at 10:20 a.m. ASM (administrative staff member) # 2, intermediate care facility manager, provided this surveyor with a copy of Individual # 2's seizure protocol. When asked where she found Individual # 2's seizure protocol ASM # 2 stated, "It was in the filing cabinet in the office." When asked if the seizure protocol was

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part of Individual # 2's clinical record ASM # 2 stated, "Yes. It should have been in the books."

On 3/23/16 at 1:50 p.m. an interview was conducted with ASM # 6, the QIDP. When asked about Individual # 2's seizure protocol not being available, ASM # 6 acknowledged that it should have been available and had no further comment.

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

2d. For Individual #2 the QIDP failed to coordinate and monitor the daily progress notes, data collection and the active treatment plan to ensure this Individual's tooth brushing program was implemented.

The ISP (Individual Service Plan) "Part V. Plan for Supports" dated 2/14/2016 through 2/13/2017 for Individual # 2 was reviewed. Under "Goal" it documented, "Teeth must be brushed after each meal and before bed. Follow Oral Hygiene Guidelines as per training. (Individual # 2) should be sitting upright in his wheelchair for tooth brushing." Under "Responsible Partner" it documented, "ICF (intermediate care facility) Residential and Day Support."

The (Name of Day Program) "Data Collection Sheet" dated "March 2016" for Individual # 2 was reviewed. Under "Outcome # 5" it documented "Tooth Brushing." Further review of the data collection sheet revealed dashes on 3/4/16, 3/7/16, 3/10/16 and 3/16/16.

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W 159	Continued From page 31 Review of the (Name of Day Program) "Comprehensive Progress Notes" dated 3/1/16 through 3/11/16 for Individual # 2 failed to evidence documentation regarding Individual # 2's tooth brushing program. On 3/22/16 at 12:30 p.m. an interview was conducted with OSM (other staff member) # 1, day support counselor. When asked what a dash indicated on the data collect sheet for Individual # 2, OSM # 1 stated, "It means it wasn't done." On 3/22/16 at 12:30 p.m. an interview was conducted with OSM (other staff member) # 2, day support counselor. When asked what a dash indicated on the data collect sheet for Individual # 2, OSM # 2 stated, "It would indicate it wasn't done." On 3/23/16 at 1:50 p.m. an interview was conducted with ASM # 6, the QIDP. When asked about the tooth brushing active treatment program for Individual # 2 not being implemented, ASM # 6 stated she was aware the active treatment programs were not being implemented. ASM # 6 further stated, "I need to use the right chain of communication to get the right results from the people who implement the plans." On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings. No further information was provided prior to exit.	W 159		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual	W 240		

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toward independence.

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 ISPs (Individual Service Plans) to support individual's move toward independence for two of two individuals in the survey sample, Individuals # 1 and # 2.

1. Facility staff failed to promote Individual # 1's progress toward independence.

2. Facility staff failed to promote Individual # 2's progress toward independence.

The findings include:

1. Individual # 1 was a 60 year old female, who was admitted to (Name of Group Home) on 1/12/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (3) [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.], myopia(4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia(5) [a swallowing disorder.], osteoporosis(6) [makes your bones weak and more likely to break], epilepsy(7) [a brain disorder that causes people to have recurring seizures] and hypothyroidism(8)

W 240

1) Corrective action taken:
•Individual #1's person centered plan outcomes will be revised by QIDP to include guidance for staff in how to assist her to function on a more independent level.
Assurance that other residents are protected from the possibility of this deficiency:
•All ICF resident plans will be reviewed by the QIDP and revised to provide assistance to the resident in functioning at a more independent level.
Prevention of future occurrences:
•Plans will be developed with the ICF resident and their support team with the emphasis on, "Is this plan assisting the individual in functioning on a more independent level?"
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
Completion by 4/13/2016
2)Corrective action taken:
•Individual #2's person centered plan outcomes will be revised by QIDP to include guidance for staff in how to assist him to function on a more independent level.
Assurance that other residents are protected from the possibility of this deficiency:
•All ICF resident plans will be reviewed by the QIDP and revised to provide assistance to the resident in functioning at a more independent level.
Prevention of future occurrences:
•Plans will be developed with the ICF resident and their support team with the emphasis on, "Is this plan assisting the individual in functioning on a more independent level?"
Measures to maintain compliance:
•The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
•Completion by 4/13/2016

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[not enough thyroid hormone to meet your body's needs].

On 3/23/16 and 3/24/16 Individual # 1's ISP (Individual Service Plan) dated 2/12/2016 through 2/11/2017 located in Individual # 1's Group Home residential clinical record was reviewed. Individual # 1's ISP documented, "Outcome # 1 Physical Support for Changing Positioning; Outcome # 2 Staff will provide assistance and support for exercise with walking, using wheelchair or standing; Outcome # 3 Provide support for shower and personal hygiene; Outcome # 4 Support, care and monitoring for urinary incontinence and bowel movements; Outcome # 5 Staffing support and supervision; Outcome # 6 Staff will assist with grooming and hygiene; Outcome # 7 Follow nutrition and eating plan." Further review of Individual # 1's ISP failed to evidence measurable goals for Individual # 1 to progress toward independence.

On 3/24/16 at 10:40 a.m. an interview was conducted with ASM (administrative staff member) # 2, intermediate care facility manager, ASM # 3 assistant intermediate care facility manager and ASM # 6, the QIDP (Qualified Intellectual Disabilities Professional). When asked how the ISP is developed ASM # 6 stated, "It's developed from the comprehensive functional assessments." When asked what the purpose of the ISP, ASM # 6 stated, "The purpose is to provide health, safety and personal growth." When asked about personal growth, ASM # 6 stated, "Personal growth takes in the individuals interests and moves toward independence." ASM # 2 and ASM # 6 were asked to review Individual # 1's current ISP dated 2/12/2016 through 2/11/2017. When asked if

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Individual # 1's outcome # 1 (one) through # 7 (seven) documented measurable goals to promote Individual # 1's progression toward independence, ASM # 2 and ASM # 6 stated, "No."

ASM # 6 stated, "We developed the ISPs from a 'Waver Home' stand point where the outcomes emphasis staff support."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

References:

(1) This information was obtained from the website:
http://www.ncbi.nlm.nih.gov/pubmed/16877067
(3) This information was obtained from the website:
https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100

(4) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/001023.htm

(5) This information was obtained from the website:
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(6) This information was obtained from the website:
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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
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(7) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/epilepsy.html

(8) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html

2. Facility staff failed to promote an Individual # 2's progress toward independence.

Individual # 2 was a 42 year old male, who was admitted to (Name of Group Home) on 1/14/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (3) [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.], cerebral palsy(9) [a group of disorders that affect a person's ability to move and to maintain balance and posture.], myopia(4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia(5) [a swallowing disorder.], osteoporosis(6) [makes your bones weak and more likely to break], seizures(10) [seizure disorder (symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain.], nephrolithiasis (11) [kidney stones result when urine becomes too concentrated and substances in the urine crystalize to form stones.] and

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scoliosis (12) [a sideways curve of your backbone, or spine.].

On 3/23/16 and 3/24/16 Individual # 2's ISP (Individual Service Plan) dated 2/14/2016 through 2/13/2017 located in Individual # 2's Group Home residential clinical record was reviewed. Individual # 2's ISP documented, "Outcome # 1 Physical Support for Changing Positioning; Outcome # 2 Staff will provide assistance and support for exercise with walking, using wheelchair or standing; Outcome # 4 Follow nutrition and eating; Outcome # 5 Staff assistance with medication administration; Outcome # 6 Support with scheduling, attending and follow-up for medical and clinical appointments; Outcome # 7 Provide support for shower and personal hygiene; Outcome # 11 Bed time routine."

On 3/24/16 at 10:40 a.m. an interview was conducted with ASM (administrative staff member) # 2, intermediate care facility manager, ASM # 3 assistant intermediate care facility manager and ASM # 6, the QIDP (Qualified Intellectual Disabilities Professional). When asked how the ISP is developed ASM # 6 stated, "It's developed from the comprehensive functional assessments." When asked what the purpose of the ISP, ASM # 6 stated, "The purpose is to provide health, safety and personal growth." When asked about personal growth, ASM # 6 stated, "Personal growth takes in the individuals interests and move toward independence." ASM # 2 and ASM # 6 were asked to review Individual # 2's current ISP dated 2/14/2016 through 2/13/2017. When asked if Individual # 2's outcomes # 1 (one), # 2 (two), # 4 (four), # 5 (five), # 7 (seven) and # 11

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W 240	Continued From page 37 documented measurable goals to promote Individual # 2's progression toward independence, ASM # 2 and ASM # 6 stated, "No." ASM # 6 stated, "We developed the ISPs from a 'Waver Home' stand point where the outcomes emphasis staff support." On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings. No further information was provided prior to exit.	W 240		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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 observations, staff interview and clinical record review, it was determined that the residential staff and the day program staff failed to ensure an Individual was receiving services consistent with the Individual Support Plan for two of two Individuals in the survey sample, Individuals # 1 and # 2. 1. Facility staff failed to implement Individual # 1's grooming/hygiene and communication	W 249	1) Corrective action taken: •Facility staff have implemented the active treatment in regards to individuals #1's grooming/hygiene and communication program as written in the current person centered plan. Assurance that other residents are protected from the possibility of this deficiency: •QIDP will provide monthly on site oversight/visits during active treatment service hours to ensure staff are implementing each ICF resident's outcomes as written in the current person centered plan. Prevention of future occurrences: •QIDP will ensure that all service locations have the information, understanding and /or equipment necessary to implement the Person Centered Plan as written. Measures to maintain compliance: •QIDP will provide monthly written summary to the ICF and day support service managers to summarize what supports are working well and what changes or revisions are required. •Completion: 4/5/2016	

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program.

2a. Facility staff failed to implement Individual # 2's communication program.

2b. Day program staff failed to implement Individual # 2's tooth brushing program.

The findings include:

1. Facility staff failed to implement Individual # 1's grooming/hygiene and communication program.

Individual # 1 was a 60 year old female, who was admitted to (Name of Group Home) on 1/12/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (3) [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.], myopia(4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia(5) [a swallowing disorder.], osteoporosis(6) [makes your bones weak and more likely to break], epilepsy(7) [a brain disorder that causes people to have recurring seizures] and hypothyroidism(8) [not enough thyroid hormone to meet your body's needs].

On 3/23/16 at 6:10 a.m. through 6:25 a.m. an observation was conducted. Individual # 1 was lying in bed asleep. LPN (licensed practical nurse) # 1 entered Individual # 1's bedroom to

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2a) Corrective action taken:
•Facility staff have implemented individuals #2's communication program as written in the current person centered plan.
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will provide monthly on site oversight visits during active treatment service hours to ensure staff are implementing each ICF resident's outcomes as written in the current person centered plan.
Prevention of future occurrences:
•QIDP will ensure that all service locations have the information, understanding and /or equipment necessary to implement the Person Centered Plan as written.
Measures to maintain compliance:
•QIDP will provide monthly written summary to the ICF and day support service managers to summarize what supports are working well, what changes or revisions are required.
Completion: 4/5/2016
2b) Corrective action taken:
•Day program staff have implemented the active treatment in regards to individuals #2's tooth brushing program as written in the current person centered plan.
Assurance that other residents are protected from the possibility of this deficiency:
•QIDP will provide monthly on site oversight /visits during active treatment service hours to ensure staff are implementing each ICF resident's outcomes as written in the current person centered plan.
Prevention of future occurrences:
•QIDP will ensure that all service locations have the information, understanding and /or equipment necessary to implement the Person Centered Plan as written.
Measures to maintain compliance:
•QIDP will provide monthly written summary to the ICF and day support service managers to summarize what supports are working well and what changes or revisions are required.
•Completion: 4/5/2016

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wake her. ASM (administrative staff member) # 3, assistant intermediate care facility manager, entered Individual # 1's room to assist. LPN # 1 then proceeded to Individual # 1's closet and selected a set of clothes, pants, shirt socks and under garments for Individual # 1and placed them in a chair. LPN # 1 and ASM # 3 assisted Individual # 1 into a toileting/shower chair. LPN # 1 took Individual # 1 down the hall and into the bathroom. ASM # 3 came into the bathroom carrying Individual # 1's clothes. Individual # 1 was then given a shower and dressed in the clothes brought into the bathroom by ASM # 3. Following Individual #1's care she was taken to the dining room for breakfast.

The ISP (Individual Service Plan) "Part V. Plan for Supports" dated 2/12/2016 through 2/11/2016 for Individual # 1 documented, "Outcome # 6 Staff will assist (Individual # 1) with grooming and hygiene." Under the heading "Describe how this will be provided based on individual preferences" documented, "Support staff will provide choices to (Individual # 1) by: Providing appropriate choices of what to wear for the day." Under "How often or by when?" it documented, "Daily." Under "Responsible Partner" it documented, "ICF (intermediate care facility) Residential." Under "Outcome # 11" it documented, "(Individual # 1) will be guided through her day by a visual daily schedule." Under the heading "Describe how this will be provided based on individual preferences" documented, "Divide the day into segments (morning/afternoon/evening); Be consistent with method; Use First/Then board for visual schedule. Use consistent PECS (Picture Exchange Communication System) [a unique augmentative/alternative communication intervention package for individuals with autism

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spectrum disorder and related developmental disabilities.](13) and same PECS when possible between locations; Fifteen minutes before the activities are about to change support staff will review the schedule with (Individual # 1)." Under "How often or by when?" it documented, "Daily. M-F (Monday through Friday) at day support. Every day at (Name of Group Home)." Under "Responsible Partner" it documented, "ICF (intermediate care facility) Residential and day support."

On 3/23/16 at 8:45 a.m. an interview was conducted with ASM # 3 regarding the implementation of Individual # 1's grooming/hygiene and communication programs. When asked if Individual # 1 ' s active treatment program for grooming/hygiene and communication was implemented during morning care ASM # 3 stated, "No. We didn't do it."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

References:

(3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100

(4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001023.htm

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W 249	Continued From page 41 (5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html (6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html (7) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/epilepsy.html (8) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html (13) This information was obtained from the website: http://www.pecsusa.com/pecs.php 2a. Facility staff failed to implement Individual # 2's communication program. Individual # 2 was a 42 year old male, who was admitted to (Name of Group Home) on 1/14/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (3) [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.],	W 249		

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cerebral palsy(9) [a group of disorders that affect a person's ability to move and to maintain balance and posture.], myopia(4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia(5) [a swallowing disorder.], osteoporosis(6) [makes your bones weak and more likely to break], seizures(10) [seizure disorder (symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain.], nephrolithiasis (11) [kidney stones result when urine becomes too concentrated and substances in the urine crystalize to form stones.] and scoliosis (12) [a sideways curve of your backbone, or spine.].

The ISP (Individual Service Plan) "Part V. Plan for Supports" dated 2/14/2016 through 2/13/2016 for Individual # 2 documented, "Outcome # 15 Provide support with choices thru communication methods." Under the heading "Describe how this will be provided based on individual preferences" documented, "This is a trial for communication method: (Individual # 2) will have a Yes/No board; Big Green square for yes; Big Red square for No; Support staff will use cueing at (Individual # 2's) elbow; Ask (Individual # 2) simple yes/no questions (starting with things that you know he likes for yes, and doesn't like/want for no); Using a tactile cue ...hand at elbow guide to yes As his response becomes more independent and reliable fade the tactile cue. Please track trial/data and note progress details in daily progress notes." Under "How often or by when?" it documented, "Daily." Under "Responsible Partner" it documented, "ICF (intermediate care facility) Residential and day staff." Under start it documented, "2/14/2016."

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Review of Individual # 2's residential clinical record failed to evidence documentation of Individual # 2's communication active treatment program.

On 3/23/16 at 7:10 a.m. an interview was conducted with ASM (administrative staff member) # 2, intermediate care facility manager. When asked about Individual # 2's communication program ASM # 2 stated, "We haven't started it yet."

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

References:

(3) This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100

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

(6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html

(9) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html

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(10) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html

(11) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/imagepages/17091.htm

(12) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/scoliosis.html

2b. Day program staff failed to implement Individual # 2's tooth brushing program.
The ISP (Individual Service Plan) "Part V. Plan for Supports" dated 2/14/2016 through 2/13/2017 for Individual # 2 was reviewed. Under "Goal" it documented, "Teeth must be brushed after each meal and before bed. Follow Oral Hygiene Guidelines as per training. (Individual # 2) should be sitting upright in his wheelchair for tooth brushing." Under "Responsible Partner" it documented, "ICF (intermediate care facility) Residential and Day Support."

The (Name of Day Program) "Data Collection Sheet" dated "March 2016" for Individual # 2 was reviewed. Under "Outcome # 5" it documented "Tooth Brushing." Further review of the data collection sheet revealed dashes on 3/4/16, 3/7/16, 3/10/16 and 3/16/16.

Review of the (Name of Day Program) "Comprehensive Progress Notes" dated 31/16 through 3/11/16 for Individual # 2 failed to

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W 249	Continued From page 45 evidence documentation regarding Individual # 2's tooth brushing program. On 3/22/16 at 12:30 p.m. an interview was conducted with OSM (other staff member) # 1, day support counselor. When asked what a dash indicated on the data collect sheet for Individual # 2, OSM # 1 stated, "It means it wasn't done." On 3/22/16 at 12:30 p.m. an interview was conducted with OSM (other staff member) # 2, day support counselor. When asked what a dash indicated on the data collect sheet for Individual # 2, OSM # 2 stated, "It would indicate it wasn't done." On 3/24/16 at 12:00 p.m. an interview was conducted with ASM (administrative staff member) # 2, intermediate care facility manager. When asked about Individual # 2's tooth brushing program ASM # 2 stated, "The active treatment program should have been done." On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings. No further information was provided prior to exit.	W 249		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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W 436	Continued From page 46 This STANDARD is not met as evidenced by: Based on observations, staff interview and clinical record review, it was determined that the residential staff failed to provide a communication system for one of two Individuals in the survey sample, Individuals # 2. Facility staff failed to provide Individual # 2's with a communication system. The findings include: Individual # 2 was a 42 year old male, who was admitted to (Name of Group Home) on 1/14/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (3) [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.], cerebral palsy(9) [a group of disorders that affect a person's ability to move and to maintain balance and posture.], myopia(4) [when light entering the eye is focused incorrectly, making distant objects appear blurred.], dysphagia(5) [a swallowing disorder.], osteoporosis(6) [makes your bones weak and more likely to break], seizures(10) [seizure disorder (symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain.], nephrolithiasis (11) [kidney stones result when urine becomes too concentrated and substances in the urine crystalize to form stones.] and scoliosis (12) [a sideways curve of your	W 436	1) Corrective Action Taken: •Facility staff has provided individual #2's communication device for daily use as required by their plan. Assurance that other residents are protected from the possibility of this deficiency. •Management will conduct observations and direction during active treatment to ensure staff are using the correct equipment and implementing each resident's outcomes as written in the current person centered plan. Prevention of future occurrences: •Management will ensure that staff have the information, understanding and / or equipment necessary to implement the Person Centered Plan as written. Measures to maintain compliance: •Management and QIDP will observe staff to ensure all equipment and devices are being used as stated in the individual's support plan. •Completion: 4/ 1/ 2016	

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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 436	Continued From page 47 backbone, or spine.]. The ISP (Individual Service Plan) "Part V. Plan for Supports" dated 2/14/2016 through 2/13/2016 for Individual # 2 documented, "Outcome # 15 Provide support with choices thru communication methods." Under the heading "Describe how this will be provided based on individual preferences" documented, "This is a trial for communication method: (Individual # 2) will have a Yes/No board; Big Green square for yes; Big Red square for No; Support staff will use cueing at (Individual # 2's) elbow; Ask (Individual # 2) simple yes/no questions (starting with things that you know he likes for yes, and doesn't like/want for no); Using a tactile cue ...hand at elbow guide to yes. As his response becomes more independent and reliable fade the tactile cue. Please track trial/data and note progress details in daily progress notes." Under "How often or by when?" it documented, "Daily." Under "Responsible Partner" it documented, "ICF (intermediate care facility) Residential and day staff." Under start it documented, "2/14/2016." Review of Individual # 2's residential clinical record failed to evidence documentation of Individual # 2's communication active treatment program. On 3/23/16 at 7:10 a.m. an interview was conducted with ASM (administrative staff member) # 2, intermediate care facility manager. When asked about Individual # 2's communication program ASM # 2 stated, "We haven't started it yet." When asked about the green and red squares for the communication system ASM # 2 stated, "We don't have it."	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VAICFID82	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE STREET ICF ID	815 WOLFE STREET FREDERICKSBURG, VA 22401

(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 436	Continued From page 48	W 436		

On 3/24/16 at 2:45 p.m. ASM (administrative staff member) # 2, intermediate care facility manager, was made aware of the findings.

No further information was provided prior to exit.

References:

(3) This information was obtained from the website:
https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100

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

(6) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/osteoporosis.html

(9) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html

(10) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/seizures.html

(11) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/imagepages/17091.htm

(12) This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VAICFID82	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE STREET ICF ID	815 WOLFE STREET FREDERICKSBURG, VA 22401

(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 436	Continued From page 49 https://www.nlm.nih.gov/medlineplus/scoliosis.html	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VAICFID82	A. BUILDING 01 - MAIN BLDG B. WING _____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE STREET ICF ID	815 WOLFE STREET FREDERICKSBURG, VA 22401

(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
K 000	INITIAL COMMENTS Surveyor: 29282 Description of structure: The facility is a 4,724 sq foot two story, on a basement, R5 with a construction type of 5B. The facility has an emergency generator, a fire alarm and is fully sprinklered with a 13D system. An announced initial (Construction) certification Life Safety Code survey was conducted between 5-14-2015 and 12-31-2015 in accordance with 42 Code of Federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Persons with Intellectual Disabilities(ICF/ID). The facility was surveyed for compliance using the 2000 Life Safety Code. The facility was in compliance with the Requirements for Participation Medicare and Medicaid.	K 000		

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

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.