PRINTED: 06/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF I	PROVIDER OR SUPPLIER		///	STREET ADDRESS, CITY, STATE, ZIP COD	
ROSS DI	RIVE			5604 ROSS DRIVE	
				FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
W 000	INITIAL COMMEN	rs	W 0	00	
W 156	Intermediate Care Intellectual Disabilit 5/23/16 through 5/2 compliance with 42 for Intermediate Ca Intellectually Disabl survey report will for The census in this time of the survey. of two current indiviand #2). 483.420(d)(4) STAIN The results of all into the administrator or to other officials within five working the This STANDARD is Based on staff intermediate with the standard stand	ed. The Life Safety Code	W 1	How corrective action vaccomplished for individual accomplished for individual accomplished for individual accomplished for investigation injuries of unknown original allegations of abuse will to the executive director working days of the inci	idual #2: ons for gins or be reported within 5 dent
	that the facility staff an abuse investigat within five working	failed to report the results of tion to the executive director days of the incident for one of e survey sample, Individual		Assurance that other reprotected from the post the deficiency: All results of investigations of the deficiency of the d	esidents are sibility of ons for
	Individual #2.on 4/2 concluded founded	n origin was observed on 8/17. The investigation (that physical abuse) was not ed to the executive director		injuries of unknown ori allegations of abuse will to the executive director working days of the inci occurring for all individ	be reported within 5 ident luals.
	The findings include	e.		Measures to be put into systemic changes to be	

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

Coordinator

(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.

ID Residential

	VIDER/SUPPLIER/CLIA	T _(VO) N ((OMB NO. 0938-0391
	VIDER/SUPPLIER/CLIA	L AVOLANTI			
	TIFICATION NUMBER:	A. BUILD		ISTRUCTION	(X3) DATE SURVEY COMPLETED
	49G065	B. WING			05/25/2017
NAME OF PROVIDER OR SUPPLIER		1	STREET	ADDRESS, CITY, STATE, ZIP COL	
			5604 R	OSS DRIVE	
ROSS DRIVE			FREDE	ERICKSBURG, VA 22407	
(X4) ID SUMMARY STATEMENT C PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTII	PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
Individual #2 was admitted thome) on 9/29/14. Individual included but were not limited intellectual disability, anxiety. An incident report dated 4/2 by the day support lead spe #2's day support program do a Detailed Description of the happened?) Attach addition When DSC (direct support of pulled (name of Individual # apply sunscreen, he noticed around (name of Individual # above his elbow. What Acti DSC (name) notified me and group home to see if anythin Pictures were taken. (Name not seem bothered by the brothinued with his daily sche Comments: After contacting [administrative staff member program manager), GH (Groand (name of ASM #6- group program manager), assistant manager, it was discovered Individual #2) required assist twice this morning because GH staff (name of DSP [diresaid those marks were not the was also reported by GH staff (name of Individual his normal self when he arrives supportProgram Director FID (Intellectual Disability) Retoreview camera footage at home) and report findings to	al #2's diagnoses of to: moderate of and autism. 8/17 and completed cialist from Individual ocumented, "Provide of Incident: (What had paper if necessary. Counselor) (name) 2's) sleeve up to of several small bruises #2's) left arm just cons Were Taken? of I contacted the had was documented. Of Individual #2) did ruises and he could be a considered of Individual #2 and ruises and he could be a considered of Individual #3 and the could be a considered of Individual #4 and the could be a cons	W 1	56	ensure that the deficience will not recur: Any staff appointed by director to investigate in injuries of unknown or allegations of abuse will responsible for ensuring results of the investigate reported to the executive within 5 working days. How the facility planse its performance to massolutions are sustained RACSB's Administrative oversee and ensure that any investigation of injunknown origin or allegabuse are reported to the director within 5 working Date of Completion: 6/8/17	the executive instances of rigin or l be g that the ion are we director to monitor ke sure that d: we team will tresults from uries of gations of the executive

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CENTER	S FOR MEDICARE	CENTERS FOR MEDICARE & MEDICAID SERVICES						
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
		49G065	B. WING		05/25/2017			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
ROSS DRIVE			5604 ROSS DRIVE FREDERICKSBURG, VA 22407					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION			
W 156	Continued From pa	ge 2	W 1	56				

A "Human Rights Investigation" with no signature or date documented, "Allegation of Human Rights Violation: Abuse- Complaint: While at Day Support on April 28, 2017, day support staff found several small bruises around (name of Individual #2's) left arm just above his elbow. Day support staff contacted the (sic) (name of Individual #2's) residential program to inquire about the bruises. The group home had not noted the bruising prior to (name of Individual #2) leaving for Day Support. An Incident Report form was completed and forwarded to Quality Assurance staff and the Deputy Executive Director. Immediately following, Executive Director (name) appointed (name of ASM #4), Quality Assurance Coordinator and (name). Utilization Review Specialist to initiate an investigation in compliance with the human rights regulations concerning allegations of 'Abuse, Neglect, and Exploitation' under the tents of abuse. (Name of ASM #4) and (name of Utilization Review Specialist) viewed video footage from (name of group home) for the morning of April 28, 2017. The video footage showed the following: Video footage showed (Individual #2) pacing, jumping up and down and moving items from place to place. The video showed that (Individual #2) went into the den area and was attempting to pick up another resident's shoes when he was redirected by (DSP #1). (Individual #2) then took another individual's books and (DSP #1) attempted to redirect (Individual #2). At that time, (Individual #2) attempted to hit (DSP #1). As (Individual #2) was swatting at (DSP #1), it appeared (DSP #1) held (Individual #2) by his arms, just above the elbow. As he was holding (Individual #2) by the arms the two of them moved toward the sofa. It appeared that

DEPARTMENT OF HEALTH AND HUMAN SERVICES					FORM APPROVED
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	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
ROSS D	RIVE			5604 ROSS DRIVE FREDERICKSBURG, VA 2240	7
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE	
W 156	Continued From pa	ge 3	W 1	56	
	with (DSP #1) still h stayed in that positi (Individual #2) stood (DSP #1) again, and #2) by the arms agas the entrance of the appeared to bump it door hitting the wall (Individual #2) begath hallwayIn consider and recorded hereing substantiate that classification obtained his physical result of inappropriation group home) staff. investigators considered this allegation founded" On 5/24/17 at 1:05 conducted with ASM member) #4 (the Quand person response)	er sat or fell onto the couch holding onto his arms. The two on for a few seconds and d up and attempted to hit d (DSP #1) held (Individual ain. The two men were near den and (Individual #2) into the door as evident by the . (DSP #1) let go and an walking down the eration of information collected in, the investigators are able to aim that (Individual #2) al injuries to his left arm as a ate intervention of (name of In conclusion, we the der the supporting evidence to an of physical abuse as			

incident report was received on 4/28/17. ASM #4 stated she also initiated the investigation on 4/28/17. ASM #4 stated she has ten business days to complete investigations per the human rights policy. ASM #4 stated she concluded the investigation and submitted the final report to the Executive Director on 5/11/17. ASM #4 was asked to provide documentation to evidence the date when the investigation was concluded and submitted to the Executive Director.

A form titled, "HUMAN RIGHTS ALLEGATION HARM, ABUSE, NEGLECT OR EXPLOITATION"

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<u>OLIVILI</u>	CO I OI (WEDIO) WE	T T T T T T T T T T T T T T T T T T T	<u> </u>			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		49G065	B. WING	i		05/25/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE. ZIP CO 5604 ROSS DRIVE FREDERICKSBURG, VA 22407	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD E	BE COMPLETION
W 156	makes report to Ex within ten (10) work On 5/24/17 at 4:50 staff member) #1 (t #2 (the assistant re (the Qualified Intelle Professional) and Amanager) were maconcern. The facility human "CHAPTER 115 RL	217- Agency investigative team ecutive Director or designee king days" p.m., ASM (administrative he program manager), ASM sidential coordinator), ASM #5	W	156		
	RECEIVING SERV LICENSED, FUNDI DEPARTMENT OF RETARDATION AN SERVICESPart V The investigating ar report of the results or neglect to the dir advocate within 10	ICES FROM PROVIDERS ED, OR OPERATED BY THE MENTAL HEALTH, MENTAL ID SUBSTANCE ABUSE III Reporting Requirements3. uthority shall provide a written of the investigation of abuse ector and human rights working days from the date gan unless an exemption has				
W 159	483.430(a) QIDP Each client's active integrated, coordina qualified intellectua This STANDARD is Based on staff integrand residential receithat the QIDP (Qua	treatment program must be ated and monitored by a disability professional. In some that as evidenced by: rview, facility document review and review, it was determined lified Intellectual Disabilities to coordinate and monitor	W 1	59		

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING _		05/25/2017
NAME OF F	ROVIDER OR SUPPLIER	1	'	STREET ADDRESS, CITY, STATE, ZIP CO	
BOSS DI	on/E			5604 ROSS DRIVE	
KU33 DI	ROSS DRIVE			FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
				W159 .	6/30/17
W 159	Continued From pa	ige 5	W 15	⁹ 1a.	
	active treatment for two of two individuals in the survey sample, Individuals #1 and #2.			How corrective action	will be
				accomplished for indi	
	1 a The OIDP fail	ed to ensure objectives on the		The QIDP will revise the	
		port Plan) for Individual # 1		for individual #1 to ens	11 1
	were developed in			are documented in mea	C
				Assurance that other i	esidents are
		ed to ensure the data		protected from the po	
	# 1 were in measur	outcomes/goals for Individual able terms		deficiency:	
	" I Word III III dadar.	abio torrito.		The QIDP will review a	and revise
		ed to ensure Individual #1's		support plans for each	
		ogram for laundry was		ensure that goals are do	
	implemented.			measurable terms.	
	1. d. The QIDP faile	ed to ensure Individual #1's		Measures to be put int	o place or
		ogram for water activity was		systemic changes to be	
	implemented.			ensure that the deficie	
	1 a The OIDD faile	ed to develop training		will not recur:	
		ed to develop training rea of eating in Individual #1's		The QIDP will extract of	outcomes from
		comprehensive functional		the Comprehensive Fu	
	assessment.	•		Clinical Assessments to	establish skill
	0 - The OIDD felle			building outcomes that	can be
	ISP for Individual #2	ed to ensure objectives on the		documented in measur	
	measurable terms.	were developed in		How the facility plans	to monitor its
				performance to make	
		ed to ensure the data		solutions are sustained	<u>-</u>
		outcomes/goals for Individual		The annual ISP for each	
	#2 was in measurat	ne terms.		reviewed by the ICF su	
	2. c. The QIDP faile	ed to ensure Individual #2's		to submission deadline	
		ogram for laundry was		that goals are documen	ited in

The findings include:

1. a. The QIDP failed to ensure objectives on the

implemented.

measurable terms. **Date of Completion:**

6/30/17

Facility ID: VAICFMR63

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		49G065	B. WING	;		05/2	5/2017
NAME OF F	PROVIDER OR SUPPLIER		***************************************	STR	REET ADDRESS, CITY, STATE, ZIP CODE		Market and Salah S
ROSS DE	ROSS DRIVE			1	4 ROSS DRIVE EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 159	Individual #1 was a 11/28/14. Individual were not limited to: glaucoma and skin Individual #1's curre through 12/28/17 de "Goal 1. Important (Individual #1) will hetween some of his satisfied and involve lead to increased perurther review of go documentation of q indicators of perform "Goal 2. It is Import (Individual #1) will his visit with, and be involved in the satisfied and involved indicators of performance in the satisfied	dmitted to the group home on all #1's diagnoses included but severe intellectual disability, rashes. ent ISP dated 12/29/16 occumented: To and For Choices. Have structured choices is activities. He will be more end in activities and eventually ositive independence" oal #1 failed to evidence uantitative measurable mance. ant To and For Socialization. Have opportunities to talk to, volved in activities with family, at home and in the community. For choices, the end opportunities to help a successful experience" oal #2 failed to evidence uantitative measurable mance.	W	159	W159 1b. How corrective action will accomplished for individue The QIDP will revise the descollection sheet for individue ensure that goal data is colled documented in measurable Assurance that other reside protected from the possible deficiency: The QIDP will review and recollection sheets for each recensure that goal data is colled documented in measurable Measures to be put into pleasystemic changes to be mandle ensure that the deficient protection and the Comprehensive Function Clinical Assessments to established by the Comprehensive Function Clinical Assessments to established ensure that the documented measurable terms. How the facility plans to measurable terms. How the facility plans to measurable terms are sustained: The data collection sheets for each reconstruction of the put into plant	atal #1: ata ual #1 to ected and eterms. lents are ility of the revise data esident to ected and eterms. ace or de to ractice will omes from onal and ablish skill be in nonitor its ethat	6/30/17
	(Individual #1) will a he can communicat	To Communication. nnunciate his words so that e his wants and needs view of goal #3b failed to ation of quantitative			client will be reviewed by the supervisor prior to initiation that goal data can be collected documented in measurable	ne ICF on to ensure ted and	

measurable indicators of performance.

"Goal 5. Important For Health and

6/30/17

Date of Completion:

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM APPROVE	ΞĽ
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-			OMB NO. 0938-039	91
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G065	B. WING			05/25/2017	
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP (ODE	***********
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11000 51				FRE	DERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO	iN
W 159	Continued From pa	ide 7	W ²	150	W159	6/30/17	7
		eth and medical appointments.	**	100	1c.		
	ICF (Intermediate Care Facility) Nurse will assess				How corrective action	n will be	
		y and quarterly to assist in			accomplished for Inc	dividual #1:	
	• •	lual #1's) health status and			The QIDP will monit	or facility staff to	
	making referrals. (Individual #1) will have annual dental appointments and will also be supported in				ensure they are imple	•	
		at least twice daily" Further			active treatment outc	ome for laundry	
review of goal #5 failed to evidence				with Individual #1.			
		uantitative measurable			Assurance that other		
	indicators of perforr	mance.			protected from the p	ossibility of the	
	"Goal 7. It is Import	ant FOR Medication			deficiency:	on facility staff to	
	Management. (Indi	ividual #1) will receive his			The QIDP will monit ensure they are imple		
		duled and as ordered"			outcomes in the activ	•	
		oal #7 failed to evidence uantitative measurable			for each resident.	e treatment plan	
	indicators of perforr				Measures to be put in	nto place or	
					systemic changes to	<u>-</u>	
		ant FOR (Individual #1) to			ensure that the defic	ient practice will	
		Support Staff will assist sic) personal care and			not recur:		
		Further review of goal #9 failed			The QIDP will review		
		entation of quantitative			outcome implementa		
	measurable indicate	ors of performance.			recorded accurately b	•	
	"Goal 11 It is Impor	rtant To (Individual #1) to build			How the facility plan		
		ence in the area of laundry.			performance to mak		
		ic) participate at least once			solutions are sustain		
		dry, and/or fold his laundry"			The ICF Supervisor a manager will review a		
		pal #11 failed to evidence uantitative measurable			at a minimum of mor		
	indicators of perform				that implementation		
					man map remientation		

"Goal 12. It is Important To and For (Individual #1)

quantitative measurable indicators of

Date of Completion:

6/30/17

accurately.

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		NSTRUCTION	(X3) DATE SU COMPLE		
		49G065	B. WING	***************************************	DARANDON DE PRINTENDE CONTROL DE	05/25/	2017	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<u></u>	STRE	ET ADDRESS, CITY, STATE, ZIP C		Minimum management and a second a second and a second and a second and a second and a second an	
ROSS DI	RIVE				ROSS DRIVE DERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO	(X5) DMPLETION DATE	
W 159	Continued From pa	ge 8	W	159	W159 1d.		6/30/17	
	performance.				How corrective action	on will be		
	On 5/25/17 at 8:52 conducted with ASM member) #1 (the pr (the assistant reside (the current QIDP), program manager) manager). ASM #5 responsible for devivith the interdiscipli stated the ISP is de comprehensive fundassessments from therapy, speech the and psychology. In reviewed with ASM the above areas of measurable terms to ASM #1, ASM #2, ASM #2, ASM #1, ASM #2, ASM #2, ASM #1, ASM #1	te Individual #1's ISP was no the group home. a.m., an interview was M (administrative staff rogram manager), ASM #2 ential coordinator), ASM #5 ASM #6 (the assistant and ASM #7 (the nurse stated the QIDP was eloping the ISP and worked mary team to do so. ASM #5 eveloped based on the ctional assessment and physical therapy, occupational erapy, the nutrition specialist dividual #1's ISP was #5. ASM #5 confirmed all of the ISP were not written in out could be. At this time, as M #5, ASM #6 and ASM #7 of the above concern.			accomplished for In The QIDP will monit to ensure they are im active treatment outce activity for Individua Assurance that other protected from the p the deficiency: The QIDP will monit to ensure they are im outcomes in the active plan for each residen Measures to be put i systemic changes to ensure that the defice will not recur: The QIDP will review outcome implementa recorded accurately by	tor facility staff plementing the come for water l #1. r residents are possibility of tor facility staff plementing all the treatment tt. nto place or be made to cient practice w data to ensure attion is being		
	4-2: Qualified Intelled Professional" documenthe QIDP: a. Facilitate the indirect (PCP) (also known Support Team (PST twice a year, with do by the QIDP. b. Ensure that all Peters	led, "Facility Staffing. Section ectual Disabilities mented, "3. Responsibilities of vidual's Person Centered plan as the ISP) and Personal () for development and review ocumented quarterly reviews erson Centered Plans for the lually developed and tailored.			How the facility plan its performance to n solutions are sustain. The ICF Supervisor a manager will review a collection at a minim to ensure that implembeing recorded accurdate of Completion: 6/30/17	nake sure that ned: and assistant all data aum of monthly mentation is rately.		

analysis, data collection, etc.

c. Ensure that the PCP is reflective of the criteria for Active Treatment, plans, interventions, task

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391
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		49G065	B. WING	è		05/25/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSS DE	SIVE			1	5604 ROSS DRIVE	
KO33 DI	(IVL				FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
W 159	Continued From pa	ge 9	W ²	159	9 W159	6/30/17
		PCP is revised and updated			1e.	3,33,2,
	as needed.	·			How corrective action will	he
		dents to ensure that the			accomplished for individua	
	experiences and pr	the individual's actual			The QIDP will coordinate a	
		rve the individuals, their	*		the support plan for individ	
		orts and services, progress			develop active treatment pro	
	notes, and data"				the area of eating in accorda	•
	No fembor informati	ion was presented prior to exit			the information gathered in	
	No turtner informati	on was presented prior to exit.	Comprehensive Functional			
	1. b. The QIDP fail	ed to ensure the data			Assessment.	
	collection of the ISF	outcomes/goals for Individual			Assurance that other residence	ents are
	# 1 were in measur	able terms.			protected from the possibi	
	Individual #41a ourre	ent ISP dated 12/29/16			deficiency:	ity of the
	through 12/28/17 do				The QIDP will coordinate a	nd revise
	an oagir izizor i a				the support plans for all ind	
		To and For Choices.			to develop active treatment	
		nave structured choices			in accordance with the infor	
		is activities. He will be more ed in activities and eventually			gathered in the Comprehen	
		ositive independence			Functional Assessment.	
					Measures to be put into pla	ace or
		ant To and For Socialization.			systemic changes to be made	
		have opportunities to talk to, volved in activities with family,			ensure that the deficient pr	
		at home and in the community.			will not recur:	<u></u>
	Support staff will off				The QIDP will extract infor	mation
	parameters/guidand	ce and opportunities to help			from the Comprehensive Fu	
	(Individual #1) have	a successful experience			Assessments to develop acti	
					1	

Goal 3b. Important To Communication.

Goal 5. Important For Health and Safety-Brushing teeth and medical appointments. ICF

Event ID: H8OZ11

treatment outcomes for each

for their ISP or as changes or

revisions are needed based on

individualized needs.

individual at a minimum of annually

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				ON	<mark>ИВ N</mark> O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		49G065	B. WING			05/25/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, (CITY, STATE, ZIP CODE	
ROSS DRIVE				5604 ROSS DRIVE FREDERICKSBU	RG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 159	(Intermediate Care monitor monthly an maintaining (Individual)	ge 10 Facility) Nurse will assess and d quarterly to assist in lual #1's) health status and lndividual #1) will have annual	W 1	perform solution The ann	e facility plans to monance to make sure the sare sustained:	t will be

Goal 7. It is Important FOR Medication Management. (Individual #1) will receive his medication as scheduled and as ordered...

brushing his teeth at least twice daily...

Goal 9. It is important FOR (Individual #1) to have good hygiene. Support Staff will assist (Individual #1) will (sic) personal care and hygiene needs...

dental appointments and will also be supported in

Goal 11. It is Important To (Individual #1) to build upon his independence in the area of laundry. (Individual #1) rill (sic) participate at least once per week to wash, dry, and/or fold his laundry...

Goal 12. It is Important To and For (Individual #1) to engage in water activity. (Individual #1) would benefit from water exercise as instructed by the ICF Physical Therapist..."

Further review of the above goals failed to evidence documentation of quantitative measurable indicators of performance.

The ISP "Checklists" (data collection forms) and progress notes for Individual #1 dated 4/1/17 through 5/20/17 were reviewed. The checklists and progress notes failed to evidence documentation of the data collection of Individual #1's ISP outcomes/goals in measurable terms.

On 5/25/17 at 8:52 a.m., an interview was conducted with ASM (administrative staff member) #1 (the program manager), ASM #2 reviewed by the ICF supervisor prior to submission deadlines to ensure that active treatment programs in accordance with the Comprehensive Functional Assessment for each resident are documented in the ISP.

Date of Completion:

6/30/17

W159

6/30/17

2a.

How corrective action will be accomplished for individual #2:

The QIDP will revise the support plan for individual #2 to ensure that goals are documented in measurable

Assurance that other residents are protected from the possibility of the deficiency:

The QIDP will review and revise support plans for each resident to ensure that goals are documented in measurable terms.

Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:

The QIDP will extract outcomes from the Comprehensive Functional

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CENTERS FOR MEDICA	ARE & MEDICAID SERVICES		***************************************	0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CON	ISTRUCTION	(X3) DATE SURVEY COMPLETED
	49G065	B. WING			05/25/2017
NAME OF PROVIDER OR SUPPL	JER .	······	STREET	ADDRESS, CITY, STATE, ZIP CODE	
D000 DD11/E			5604 R	OSS DRIVE	
ROSS DRIVE			FREDE	ERICKSBURG, VA 22407	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
W 159 Continued From	n page 11	W ²	159	Clinical Assessments to esta	
	esidential coordinator), ASM #5			skill building outcomes that documented in measurable	
	M #6 (the assistant program				
	ASM #7 (the nurse manager).			How the facility plans to m its performance to make su	
	the QIDP was responsible for			solutions are sustained:	ire mat
	ISP and worked with the team to do so. ASM #5 stated			The annual ISP for each clie	net will
	oped based on the			be reviewed by the ICF supe	
	functional assessment and	_		prior to submission deadling	
	om physical therapy, occupationa			ensure that goals are docum	
therapy, speech therapy, the nutrition specialist and psychology. Individual #1's ISP and ISP				measurable terms.	icited iii
, , ,	oril and May 2017 was reviewed			Date of Completion:	
	SM #5 confirmed all of the above			6/30/17	
	were not written in measurable			0,00,1,	
	ata checklists were based on the he data collection was not			W159	6/30/17
	well. At this time, ASM #1, ASM			$\frac{\sqrt{135}}{2b}$	0/30/1/
	SM #6 and ASM #7 were made			How corrective action will	he
aware of the ab	ove concern.			accomplished for individu	
No further inform	mation was presented prior to exit			The QIDP will revise the da	
ivo tuttilei illion	fiation was presented prior to exit	••		collection sheet for individu	
1. c. The QIDP	failed to ensure Individual #1's			ensure that goal data is colle	
	t program for laundry was			documented in measurable	
implemented.				Assurance that other resid	
Individual #1's c	current ISP dated 12/29/16			protected from the possibi	
through 12/28/1				the deficiency:	
_				The QIDP will review and r	evise data
	nportant To (Individual #1) to build			collection sheets for each re	
	endence in the area of laundry. ill (sic) participate at least once			ensure that goal data is colle	ected and
	sh, dry, and/or fold his laundry.			documented in measurable	
Describe how th	nis will be Provided based on			Measures to be put into pla	ace or
	rences (support instructions) and			systemic changes to be made	
location where F SKILL BUILDIN	Program strategy can be found:			ensure that the deficient p	
	eems to enjoy watching the			will not recur:	
,					

laundry cycle in the washing machine. (Individual

		AND HUMAN SERVICES			FORM APPROVE
		& MEDICAID SERVICES	T		OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O	ODE
ROSS D	DIVE			5604 ROSS DRIVE	
NO33 D	NIV L			FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTION
W 159	Continued From pa	ige 12	W 1	59 The QIDP will extr	act outcomes
,,,,,,		d in the past with his laundry	VV 1.	from the Comprehe	
		capabilities in improving his		Functional and Clin	
		1) will be encouraged to		Assessments to esta	blish skill
		ng, drying, and/or folding is		building outcomes	that can be
		nooses at least once per week.) to put his dirty clothing into		collected and docur	
		ne. Remind him to close the		measurable terms.	
	washing machine.			How the facility pl	ans to monitor
	O :	offer (Individual #1) to pour the		its performance to	make sure that
	pointing at it.	ne proper receptacle while		solutions are susta	ined:
		al #1) to close the soap		The data collection	sheets for each
	receptacle.			client will be review	red by the ICF
		ns on the washing machine to		supervisor prior to	
	begin the wash cycl	e in order for (Individual #1) to		ensure that goal da	
		know when the wash cycle is		collected and docur	nented in
	finished and let him	know that his clothes are		measurable terms.	
	ready to be put into			Date of Completio	<u>n:</u>
		dual #1) to take out his asher and put into the dryer.		6/30/17	
	Ü	is on the dryer to model one at			
	a time in order for (Individual #1) to begin the dry		14450	C 10 0 11 1
	cycle.	the second as Alexander second at the		W159	6/30/17
	,	know when the dry cycle is im to fold his laundry. Allow		2c.	د ما السرو مي
		ld his laundry to the best of his		How corrective acti	
	ability and model or	use hand over hand to fold		accomplished for In QIDP will monitor	
		d to be straightened out in		ensure they are imp	•
	order to prevent wri	nkles. ual #1's) progress toward		active treatment ou	C
		ig his laundry process in your		laundry for Individ	
	support logs"	J , , , , , , , , , , , , , , , , , , ,		Assurance that oth	
	.	L // 41 L 10 D . L		protected from the	
		I #1's ISP checklist (data April 2017 revealed a section		the deficiency:	possibility of
		This For Love and a section		the delicities.	

of documentation regarding the weekly laundry

outcome/goal. The key at the bottom of the form

documented, "initials = (equals) support provided;

Facility ID: VAICFMR63

The QIDP will monitor facility staff

to ensure they are implementing all

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONS		(X3) DATE SURVEY COMPLETED
		49G065	B. WING			05/25/2017
NAME OF I	PROVIDER OR SUPPLIER			5604 ROS	ADDRESS, CITY, STATE, ZIP CODE SS DRIVE RICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
W 159	participation." The - A minus sign was through 4/5/17, 4/8/ and 4/24/17 through - A plus sign was do and 4/23/17 A plus sign and m for 4/7/17 and 4/9/1 Review of Individua notes failed to revearegarding the individual on the properties of the properties of the properties of the part when asked why the each day when the supposed to be impostated the checklist ASM #5 stated the properties of the properties	us sign) = participation/no following was documented: documented for 4/1/17 17; 4/10/17 through 4/21/17 in 4/30/17. Documented for 4/6/17, 4/22/17 inus sign were documented 7. I #1's April 2017 progress al any documentation dual's laundry outcome/goal. a.m., an interview was M (administrative staff ogram manager), ASM #2 ential coordinator), ASM #5 is (the assistant program #7 (the nurse manager). 5 were asked to explain the the ISP checklist and uce that the weekly laundry mplemented for Individual #1.	W 1	59	outcomes in the active treat plan for each resident. Measures to be put into posystemic changes to be made ensure that the deficient possible will not recur: The QIDP will review data outcome implementation is recorded accurately by state that the facility plans to performance to make sure solutions are sustained: The program Supervisor at assistant manager will reviculection at a minimum of to ensure that implementate being recorded accurately. Date of Completion: 6/30/17	lace or ade to oractice to ensure s being ff. monitor its e that and ew all data f monthly

in the progress notes then there was no proof the

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO. 0938-03</u>	<u> 191</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G065	B. WING	}		05/25/2017	
NAME OF F	PROVIDER OR SUPPLIER			-	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSS DE	RIVE			I	604 ROSS DRIVE REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	ON
W 159	Continued From pa	ige 14	W ·	159			
	ASM #1, ASM #2, A	implemented. At this time, ASM #5, ASM #5 and ASM #7 of the above concern.					
	No further informat						
	1. d. The QIDP failed to ensure Individual #1's active treatment program for water activity was implemented.						
	Individual #1's curre through 12/28/17 d	ent ISP dated 12/29/16 ocumented:					
	"Goal 12. It is Important To and For (Individual #1) to engage in water activity. (Individual #1) would benefit from water exercise as instructed by the ICF Physical Therapist. Describe how this will be Provided based on individual preferences (support instructions) and location where Program strategy can be found: The Physical Therapist will assess (Individual #1) in the pool and train staff to safely help him into and out of the water as well as how to work with (Individual #1) in certain exercises that would promote muscle tone and range of motion. Staff will support (Individual #1) in the pool in accordance with the Physical Therapy assessment once the assessment in (sic) complete. This outcome will not go into effect until assessment in water and staff training is complete"						
	collection form) for of documentation re activity outcome/go the form document provided; + (plus signal)	Il #1's ISP checklist (data April 2017 revealed a section egarding the monthly water al. The key at the bottom of ed, "initials = (equals) support gn)/ - (minus sign) = ticipation." The following was					

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A SUMMARY STATEMENT OF DEFICIENCIES AND PROVIDER OR SUPPLIER ROSS DRIVE CALL ADDRESS CALL			TAND TOWAR SERVICES					JRM APPROVEL
NAME OF PROVIDER OR SUPPLIER ROSS DRIVE SUMMARY STATEMENT OF DEFICIENCIES 10				Т	••••			
NAME OF PROVIDER OR SUPPLIER ROSS DRIVE (XA) ID SUMMARY STATEMENT OF DEFICIENCIES FREDERICKSBURG, VA 22407								
NAME OF PROVIDER OR SUPPLIER ROSS DRIVE (XA) ID SUMMARY STATEMENT OF DEFICIENCIES FREDERICKSBURG, VA 22407			49G065	B. WING	•			05/25/2017
ROSS DRIVE SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL PREPIX PROVIDER'S PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECEDED BY FULL PREPIX PREPIX PROVIDER'S PLAN OF CORRECTION CACH DEFICIENCY PREPIX PREPIX PROVIDER'S PLAN OF CORRECTION CACH DEFICIENCY	NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	<u></u>		ET ADDRESS, CITY, STATE, ZIP CO		USIZSIZUTI
IX.3) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 159 Continued From page 15 documented: - A minus sign was documented for each day of April 2017. Review of Individual #1's April 2017 progress notes failed to reveal any documentation regarding the individual's water activity outcome/goal. On 5/25/17 at 8:52 a.m., an interview was conducted with ASM (administrative staff member) #1 (the program manager), ASM #2 (the assistant residential coordinator), ASM #5 (the QIDP), ASM #6 (the sasistant program manager) and ASM #7 (the nurse manager). ASM #1 and ASM #5 were asked to explain the documentation on the ISP checklist and demonstrate evidence that the monthly water activity outcome/goal was ompleted. ASM #5 stated a minus sign either meant the outcome/goal was ont achieved for that day. ASM #5 stated that according to the ISP checklist key a minus sign meant the individual didn't participate in the outcome/goal. When asked why there was documentation for each day when the water activity outcome/goal was supposed to be implemented monthly, ASM #5 stated that according to the ISP checklist was filled out incorrectly.				1			DL	
SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE	ROSS DE	RIVE						
documented: - A minus sign was documented for each day of April 2017. Review of Individual #1's April 2017 progress notes failed to reveal any documentation regarding the individual's water activity outcome/goal. On 5/25/17 at 8:52 a.m., an interview was conducted with ASM (administrative staff member) #1 (the program manager), ASM #2 (the assistant residential coordinator), ASM #5 (the QIDP), ASM #6 (the assistant program manager) and ASM #7 (the nurse manager). ASM #1 and ASM #5 were asked to explain the documentation on the ISP checklist and demonstrate evidence that the monthly water activity outcome/goal was implemented for Individual #1. ASM #1 stated signatures meant the outcome/goal was completed. ASM #5 stated a minus sign either meant the outcome/goal didn't happen or the outcome/goal was not achieved for that day. ASM #5 stated that according to the ISP checklist key a minus sign meant the individual din't participate in the outcome/goal. When asked why there was documentation for each day when the water activity outcome/goal was supposed to be implemented monthly, ASM #5 stated the checklist was filled out incorrectly.	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	SHOULD BE	COMPLETION
notes failed to reveal any documentation regarding the individual's water activity outcome/goal. On 5/25/17 at 8:52 a.m., an interview was conducted with ASM (administrative staff member) #1 (the program manager), ASM #2 (the assistant residential coordinator), ASM #5 (the QIDP), ASM #6 (the assistant program manager) and ASM #7 (the nurse manager). ASM #1 and ASM #5 were asked to explain the documentation on the ISP checklist and demonstrate evidence that the monthly water activity outcome/goal was implemented for Individual #1. ASM #1 stated signatures meant the outcome/goal was completed. ASM #5 stated a minus sign either meant the outcome/goal didn't happen or the outcome/goal was not achieved for that day. ASM #5 stated that according to the ISP checklist key a minus sign meant the individual didn't participate in the outcome/goal. When asked why there was documentation for each day when the water activity outcome/goal was supposed to be implemented monthly, ASM #5 stated the checklist was filled out incorrectly.	W 159	documented: - A minus sign was		W 1	59			
conducted with ASM (administrative staff member) #1 (the program manager), ASM #2 (the assistant residential coordinator), ASM #5 (the QIDP), ASM #6 (the assistant program manager) and ASM #7 (the nurse manager). ASM #1 and ASM #5 were asked to explain the documentation on the ISP checklist and demonstrate evidence that the monthly water activity outcome/goal was implemented for Individual #1. ASM #1 stated signatures meant the outcome/goal was completed. ASM #5 stated a minus sign either meant the outcome/goal didn't happen or the outcome/goal was not achieved for that day. ASM #5 stated that according to the ISP checklist key a minus sign meant the individual didn't participate in the outcome/goal. When asked why there was documentation for each day when the water activity outcome/goal was supposed to be implemented monthly, ASM #5 stated the checklist was filled out incorrectly.		notes failed to rever regarding the individ	eal any documentation					
document whether the water activity outcome/goal was implemented and if there was no documentation in the progress notes then		conducted with ASM member) #1 (the property (the assistant reside (the QIDP), ASM #6 manager) and ASM #4 documentation on the demonstrate evider activity outcome/goal was a minus sign either happen or the outcome/goal was a individual didn't part When asked why the each day when the was supposed to be #5 stated the check ASM #5 stated the property document whether to outcome/goal was in	M (administrative staff rogram manager), ASM #2 ential coordinator), ASM #5 6 (the assistant program M #7 (the nurse manager). #5 were asked to explain the the ISP checklist and noce that the monthly water hal was implemented for M #1 stated signatures meant was completed. ASM #5 stated meant the outcome/goal didn't ome/goal was not achieved for stated that according to the minus sign meant the ticipate in the outcome/goal. Here was documentation for water activity outcome/goal e implemented monthly, ASM colist was filled out incorrectly. Progress notes should the water activity implemented and if there was					

implemented. ASM #1 stated the program manager, assistant program manager and QIDP were responsible for ensuring active treatment was implemented. At this time, ASM #1, ASM #2,

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>	<mark>ИВ N</mark> O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSS DI	RIVE			5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 159	Continued From pa	ge 16	W 1	59	
	·	nd ASM #7 were made aware	** .		
	of the above conce				
	No further informati	on was presented prior to exit.			
	outcomes for the ar	ed to develop training rea of eating in Individual #1's comprehensive functional			
	Individual # 1 reveal Behavior Assessment (zero): Task Resistic cooperate or become Dependent - staff of the task; 2 (two): Moreompletes 75% of the task is tance is used in may initially guide the tand-over-hand assessistance - staff of the task is tance - staff of task is task is tance - staff of task is task	dated November 2016 for led a page entitled "Adaptive ent Keys." The "Adaptive ent Keys" documented, "0 ve - consumer does not ne combative; 1 (one): ompletes 100% (percent) of aximum Assistance - staff ask. Hand-over-hand to complete the process. Staff ne consumer then release esistance; 3 (three): Moderate ompletes 50% of task. Partial sistance is required. Staff may			

initially guide the consumer then release hand-over-hand; 4 (four): Minimal Assistance staff completes 25% of task. Intermittent hand-over-hand assistance is required. Staff provides hand-over-hand assistance as needed to complete the task; 5 (five): Touch Prompt - a quick touch is given to get consumer to begin the task; 6 (six): Verbal direction - a verbal statement is given to the hearing consumer; 7 (seven): Manual Sign - a manual sign is given to a hearing impaired consumer, instead of or in addition to a verbal direction; 8 (eight): Verbal Cue - a cue or hint about completing the task; 9 (nine) Gestural Cue - a visual cue such as pointing; 10 Set-up, supervision, contact guard - the environment is

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) I IDENTIFICATION NUMBER: A. BL		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
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ROSS DRIVE				5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
1 1 (100)	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
set u		age 17 consumer to complete the or the consumer is supervised	W	159	

during the independent completion of the task for safety purposes; 11 Modified Independence - the consumer uses some type of adaptive equipment to complete a task without prompting or supervision; 12 Complete Independence - the consumer completes the task without prompts or cues, in a timely and safe manner. If the consumer were left alone, he/she would complete the task by his or her self; 13 N/A (non applicable) - Only to be used for gender or disability specific questions such as menstrual care, bra use, wheelchair use."

Further review of the CFA revealed that in the area of "Eating" Individual #1 scored a "10 Set-up, supervision, contact guard- the environment is set up to cause the consumer to complete the task independently or the consumer is supervised during the independent completion of the task for safety purposes" for the tasks of:

- -Grasping the cup or glass properly
- -Bringing the cup or glass to mouth
- -Tipping the cup to mouth at appropriate angle
- -Opening a twist-top lid on pitcher
- -Eating independently with fingers
- -Holding a spoon with food on it
- -Scooping food with a spoon
- -Bringing the filled spoon to mouth
- -Stirring with the spoon
- -Removing all food from the spoon
- -Holding the fork after food has been speared
- -Scooping food from the fork
- -Spearing soft food with the fork
- -Spearing hard food with the fork
- -Bringing the filled fork to mouth
- -Using the napkin to wipe mouth

Event ID: H8OZ11

		I AND HUMAN SERVICES E & MEDICAID SERVICES		Of	FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	F
ROSS DR	UVE			5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 159	Continued From pa	_	W 1	59	
		al #1's ISP dated 12/29/16 ailed to evidence training rea of eating.			
	conducted with ASM member) #5 the QII developing the Indix Comprehensive Fur asked to describe the "The team, which in assistant manager, therapy, speech the psychologist and the comprehensive functional transfer includes the areas of sensorimotor, life saleisure, social, previous from the major areas of the sensorimotor.	afety/health, domestic skills, vocational cognitive and Subcategories are selected as for the individual to work on the ISP based on the scoring assistance to ten,			
•	On 5/25/17 at 8:52	a.m., an interview was			

conducted with ASM #1 (the program manager), ASM #2 (the assistant residential coordinator), ASM #5, ASM #6 (the assistant program manager) and ASM #7 (the nurse manager). ASM #5 confirmed if an individual has an area on the comprehensive functional assessment where the individual is not fully dependent or fully independent (as evidenced by a score from two to ten) then the area should be addressed in the ISP and a goal should be created for the individual to develop a skill and work toward independence. ASM #5 stated an eating goal should have been developed for Individual #1's ISP. At this time, ASM #1, ASM #2, ASM #5,

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T _{(X2) MUL}	 ! TIF	PIEC	CONSTRUCTION		<u>O. 0938-0391</u> ATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI					DMPLETED
	!	49G065	B. WING	ì				= !0= !0047
NAME OF I	PROVIDER OR SUPPLIER		10		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	5/25/2017
ROSS DE	DIVE			l		4 ROSS DRIVE		
KU33 DI	KIVE			i _'	FRE	EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 159	Continued From pa	aae 19	W 1	15(a			
	·	#7 were made aware of the	•• .	0.	,			
	No further informati	ion was presented prior to exit.						
	2. a. The QIDP faile ISP for Individual #2 measurable terms.							
	9/29/14. Individual :	dmitted to the group home on #2's diagnoses included but moderate intellectual nd autism.						
	Individual #2's curre through 10/28/17 do	ent ISP dated 10/29/16 ocumented:						
	make choices; Com	To and For (Individual #2) to munication" Further review evidence documentation of rable indicators of						
	assistance accompli Health and Safety'	For (Individual #2) to have lishing his personal care; "Further review of goal #5 ocumentation of quantitative ors of performance.						
	Outings. (Individual successful participat least once per week (Individual #2) will be in Richmond, VA"	To and For Community I #2) will be supported in Attion in community activities at C. At least once per month, The supported to visit ARC park Further review of goal 7 Cocumentation of quantitative Tors of performance.						

"Goal 8. Swimming- Important To (Individual #2)

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CENTERS FOR MEDICARE & MEDICAID SERVICES						M APPROVED	
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STATEMENT AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION		ATE SURVEY DMPLETED
		49G065	B. WING			0,	5/25/2017
NAME OF I	PROVIDER OR SUPPLIER	4	1	STR	REET ADDRESS, CITY, STATE, ZIP CODE		J/m-V-1
n					4 ROSS DRIVE		
ROSS DE	RIVE				EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
W 159	Continued From page	age 20	W 1:	59			
100	will go swimming or review of goal #8 fa	nce per month" Further ailed to evidence quantitative measurable					
	Important For (Indiv chores at home in o Further review of go	the trash-Skill building- vidual #2) will participate in order to gain independence" oal #9 failed to evidence juantitative measurable mance.					
	will put his dirty cloth participate in washir						
	The QIDP who wrote longer employed at	te Individual #2's ISP was no the group home.					
	conducted with ASM member) #1 (the pro (the assistant reside (the current QIDP), a program manager) a manager). ASM #5 responsible for deve with the interdisciplin stated the ISP is dev comprehensive func assessments from p therapy, speech ther	a.m., an interview was M (administrative staff rogram manager), ASM #2 ential coordinator), ASM #5 ASM #6 (the assistant and ASM #7 (the nurse stated the QIDP was eloping the ISP and worked nary team to do so. ASM #5 veloped based on the ctional assessment and physical therapy, occupational grapy, the nutrition specialist dividual #2's ISP was					

reviewed with ASM #5. ASM #5 confirmed all of the above areas of the ISP were not written in measurable terms but could be. At this time,

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		- AND HUMAN SERVICES					M APPROVED
		E & MEDICAID SERVICES	T				<u>0. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		E CONSTRUCTION		ATE SURVEY OMPLETED
		49G065	B. WING	***************************************		0!	5/25/2017
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP COD		// =
ROSS DE	DIVE			56	604 ROSS DRIVE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 159	Continued From pa	~~~ O1	10/ 4				
VV 100	•	•	W 1	59			
	ASM #1, ASM #2, ASM #5, ASM #6 and ASM #7 were made aware of the above concern.						
2 c # ! t	No further information						
	2. b. The QIDP faile collection of the ISP #2 was in measurable						
	Individual #2's curre through 10/28/17 do	ent ISP dated 10/29/16 ocumented:					
	"Goal 2. Important T make choices; Com	To and For (Individual #2) to nmunication					
		For (Individual #2) to have dishing his personal care;					
	Outings. (Individual successful participal least once per week	To and For Community all #2) will be supported in ation in community activities at k. At least once per month, be supported to visit ARC park					
	"Goal 8. Swimming- will go swimming on	- Important To (Individual #2) nce per month					
	Important For (Indivi	the trash-Skill building- vidual #2) will participate in order to gain independence					
		Important For (Individual #2) hes in his hamper and will					

week..."

participate in washing his laundry once per

Further review of the above goals failed to

		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G065	B. WING_		05/25/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 159	evidence document measurable indicated. The ISP "Checklists progress notes for I through 5/20/17 we and progress notes documentation of the #2's ISP outcomes/s. On 5/25/17 at 8:52 acconducted with ASM member) #1 (the professional treside (the QIDP), ASM #6 manager) and ASM ASM #5 stated the Geveloping the ISP interdisciplinary tear the ISP is developed comprehensive fund.	ation of quantitative ors of performance. "(data collection forms) and ndividual #2 dated 4/1/17 re reviewed. The checklists failed to evidence the data collection of Individual goals in measurable terms. "A.m., an interview was and (administrative staff ogram manager), ASM #2 ential coordinator), ASM #5 of (the assistant program #7 (the nurse manager). QIDP was responsible for and worked with the m to do so. ASM #5 stated	W 15	59	

No further information was presented prior to exit.

therapy, speech therapy, the nutrition specialist and psychology. Individual #2's ISP and ISP checklists for April and May 2017 was reviewed with ASM #5. ASM #5 confirmed all of the above areas of the ISP were not written in measurable terms and the data checklists were based on the

2. c. The QIDP failed to ensure Individual #2's active treatment program for laundry was implemented.

ISP; therefore the data collection was not measurable as well. At this time, ASM #1, ASM #2, ASM #5, ASM #6 and ASM #7 were made

aware of the above concern.

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING	è		05/25/2017
NAME OF F	PROVIDER OR SUPPLIER		1	5604	REET ADDRESS, CITY, STATE, ZIP CODE 4 ROSS DRIVE	
			***************************************	<u> </u>	EDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	D BE COMPLETION
W 159	Continued From pa	age 23	W	159		
	·	ent ISP dated 10/29/16				
	will put his dirty clot participate in washi Describe how this vindividual preference location where Prog (Individual #2) has a clothing in the trash bathroom. Staff sh for this and discourtion (Individual #2) will his dirty clothes into rather than the trashing on his laundry day (Individual #2) will thamper and put it in Staff will use mode and/or verbal encourant independent of needed in that more	I be verbally reminded to throw to the hamper in the bathroom th can. By at least once per week, take his clothing from his into the washing machine. Iteling, hand over hand support, uragement, starting with the option, depending on what is ment"				
	collection form) for revealed a section of	al #2's ISP checklist (data April 2017 and May 2017 of documentation regarding outcome/goal. The key at the documented:				
	Initials = (equal) superior circled initials = superior continuous control con	pport provided/notation in log articipate				

- (a minus sign) = Not Offered

A minus sign was documented each day from

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. (038-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE	
		49G065	B. WING		05/2	5/2017
NAME OF	PROVIDER OR SUPPLIER		ľ	STREET ADDRESS, CITY, STATE, ZIP COD	······	
ROSS D	RIVE			5604 ROSS DRIVE		
	·			FREDERICKSBURG, VA 22407	***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 159	Continued From pa	ge 24	W 1	59		
	4/23/17 through 5/7	7/17.				
	4/23/17 through 5/7	Il #2's progress notes from //17 failed to reveal any arding the individual's laundry				
	conducted with ASM member) #1 (the pr (the assistant reside (the QIDP), ASM #6 manager) and ASM # documentation on the demonstrate evident outcome/goal was in ASM #5 stated the routcome/goal was in the program managemanager and QIDP active treatment was ASM #1, ASM #2, A	a.m., an interview was M (administrative staff ogram manager), ASM #2 ential coordinator), ASM #5 of (the assistant program #7 (the nurse manager). So were asked to explain the he ISP checklist and ace that the weekly laundry implemented for Individual #2. In minus sign indicated the not offered. ASM #1 stated in er, assistant program were responsible for ensuring is implemented. At this time, ask #5, ASM #5 and ASM #7 of the above concern.				
W 227		on was presented prior to exit. IDUAL PROGRAM PLAN	W 22	27 W227		6/30/17
	objectives necessar as identified by the o	am plan states the specific y to meet the client's needs, comprehensive assessment ph (c)(3) of this section.		How corrective action of accomplished for indiversity of the QIDP will coordinate the support plan for independent develop active treatments.	idual #1: ate and revise ividual #1 to t programs in	1
	Based on staff inter	not met as evidenced by: view, facility document review of review, it was determined		the area of eating in according the information gathere Comprehensive Function	d in the	

Assessment.

		AND HUMAN SERVICES				FORM APPROVE
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	·			<u> MB NO. 0938-039</u>
	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING	j	unmannannannakannakannakanni sini sini sini sini sini sini sini	05/25/2017
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
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KO33 Di	IXIV L			FRE	EDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
W 227	Continued From pa	ge 25	۱۸/ ٬	227	Assurance that other reside	ents are
V V ZZ1		failed to develop an ISP	VV 2	221	protected from the possibil	lity of the
		plan) based on the CFA			deficiency:	
		nctional assessment) for one			The QIDP will coordinate a	nd revise
		the survey sample, Individual			the support plans for all ind	ividuals
	#1.				to develop active treatment	programs
	The facility staff fail	ed to develop training			in accordance with the infor	rmation
		ea of eating in Individual #1's			gathered in the Comprehen	sive
		comprehensive functional			Functional Assessment.	
	assessment				Measures to be put into pla	ace or
	The findings include	· ·			systemic changes to be mad	<u>de to</u>
	The findings include	3 .			ensure that the deficient pr	ractice
	Individual #1 was a	dmitted to the home on			will not recur:	
		l #1's diagnoses included but			The QIDP will extract infor	mation
		severe intellectual disability,			from the Comprehensive Fu	ınctional
	glaucoma and skin	rasnes.			Assessments to develop acti	ve
	Review of the CFA	dated November 2016 for			treatment outcomes for each	h
	Individual # 1 revea	led a page entitled "Adaptive			individual at a minimum of	annually
	Behavior Assessme	ent Keys." The "Adaptive			for their ISP or as changes o	
		ent Keys" documented, "0			revisions are needed based of	on
		ve - consumer does not ne combative; 1 (one):			individualized needs.	
		ompletes 100% (percent) of			How the facility plans to m	onitor its
	the task; 2 (two): Ma	aximum Assistance - staff			performance to make sure	<u>that</u>
	•	ask. Hand-over-hand			solutions are sustained:	
		to complete the process. Staff			The annual ISP for each clie	ent will be
		ne consumer then release sistance; 3 (three): Moderate			reviewed by the ICF supervi	isor prior
		ompletes 50% of task. Partial			to submission deadlines to e	ensure
		sistance is required. Staff may			that active treatment progra	ıms in
		nsumer then release			accordance with the Compr	ehensive
	hand-over-hand; 4 (four): Minimal Assistance -			Functional Assassment for	

staff completes 25% of task. Intermittent

hand-over-hand assistance is required. Staff

provides hand-over-hand assistance as needed

to complete the task; 5 (five): Touch Prompt - a quick touch is given to get consumer to begin the 6/30/17

Functional Assessment for each

Date of Completion:

resident are documented in the ISP.

DEPAR [®]	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 06/01/201
		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
ROSS D	RIVE			5604 ROSS DRIVE FREDERICKSBURG, VA 22407	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE COMPLETION E APPROPRIATE DATE
W 227	is given to the heari Manual Sign - a maimpaired consumer verbal direction; 8 (whint about completing Cue - a visual cue is supervision, contact set up to cause the task independently during the independently during the independent safety purposes; 11 consumer uses some to complete a task with supervision; 12 Conconsumer complete cues, in a timely and consumer were left the task by his or herounder of the task by his or herounder to be used for questions such as now the left area of "Eating" Indicest-up, supervision, environment is set up to consumer to the task by his or herounder to be used for questions such as now the left area of "Eating" Indicest-up, supervision, environment is set up to the task by his or herounder the task	direction - a verbal statement ing consumer; 7 (seven): inual sign is given to a hearing, instead of or in addition to a eight): Verbal Cue - a cue or ing the task; 9 (nine) Gestural such as pointing; 10 Set-up, it guard - the environment is consumer to complete the or the consumer is supervised dent completion of the task for Modified Independence - the ine type of adaptive equipment without prompting or inplete Independence - the is the task without prompts or disafe manner. If the alone, he/she would complete er self; 13 N/A (non applicable) in gender or disability specific menstrual care, bra use,	W 2	27	

complete the task independently or the consumer is supervised during the independent completion of the task for safety purposes" for the tasks of:

- -Grasping the cup or glass properly
- -Bringing the cup or glass to mouth
- -Tipping the cup to mouth at appropriate angle
- -Opening a twist-top lid on pitcher
- -Eating independently with fingers
- -Holding a spoon with food on it
- -Scooping food with a spoon
- -Bringing the filled spoon to mouth
- -Stirring with the spoon

Event ID: H8OZ11

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30 EOD MEDIOADE	* 0 MEDIONID OFFINIOFO			FORM APPROVED
	. & MEDICAID SERVICES			MB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED
	49G065	B. WING		05/25/2017
PROVIDER OR SUPPLIER	No.		STREET ADDRESS, CITY, STATE, ZIP CODE	***************************************
⊅I//E			5604 ROSS DRIVE	
			FREDERICKSBURG, VA 22407	
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIOI X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
Continued From pa	iae 27	W 2	27	
-Removing all food -Holding the fork aft -Scooping food from -Spearing soft food -Spearing hard food -Bringing the filled fo -Using the napkin to Review of Individual through 12/28/17 fa outcomes for the arc On 5/24/17 at 2:00 p conducted with ASM member) #5 the QID Disabilities Profession developing the Indiv Comprehensive Fur asked to describe th "The team, which in assistant manager,	from the spoon feer food has been speared in the fork with the fork d with the fork fork to mouth o wipe mouth al #1's ISP dated 12/29/16 alled to evidence training rea of eating. p.m. an interview was M (administrative staff DP (Qualified Intellectual ional) regarding the process of vidual Support Plan from the inctional Assessment. When the process ASM #5 stated, includes the supervisor, physical therapy, occupational			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa -Removing all food -Holding the fork aff -Scooping food from -Spearing soft food -Spearing hard food -Bringing the filled fr -Using the napkin to Review of Individua through 12/28/17 fa outcomes for the ar On 5/24/17 at 2:00 p conducted with ASM member) #5 the QII Disabilities Professi developing the Indiv Comprehensive Fur asked to describe th "The team, which in assistant manager, therapy, speech the	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 -Removing all food from the spoon -Holding the fork after food has been speared -Scooping food from the fork -Spearing soft food with the fork -Spearing hard food with the fork -Bringing the filled fork to mouth -Using the napkin to wipe mouth Review of Individual #1's ISP dated 12/29/16 through 12/28/17 failed to evidence training outcomes for the area of eating. On 5/24/17 at 2:00 p.m. an interview was conducted with ASM (administrative staff member) #5 the QIDP (Qualified Intellectual Disabilities Professional) regarding the process of developing the Individual Support Plan from the Comprehensive Functional Assessment. When asked to describe the process ASM #5 stated, "The team, which includes the supervisor, assistant manager, physical therapy, occupational therapy, speech therapy, the nutritionist, the	A BUILDI B WING B WING CONTINUE Continued From page 27 Removing all food from the spoon -Holding the fork after food has been speared -Scooping food from the fork -Spearing soft food with the fork -Spearing hard food with the fork -Bringing the filled fork to mouth -Using the napkin to wipe mouth Review of Individual #1's ISP dated 12/29/16 through 12/28/17 failed to evidence training outcomes for the area of eating. On 5/24/17 at 2:00 p.m. an interview was conducted with ASM (administrative staff member) #5 the QIDP (Qualified Intellectual Disabilities Professional) regarding the process of developing the Individual Support Plan from the Comprehensive Functional Assessment. When asked to describe the process ASM #5 stated, "The team, which includes the supervisor, assistant manager, physical therapy, occupational	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER SUPPLIER LIDENTIFICATION NUMBER 49G065 B. WING STREET ADDRESS, CITY. STATE. ZIP CODE 5604 ROSS DRIVE FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 Removing all food from the spoon Holding the fork after food has been speared -Scooping food from the fork -Spearing soft food with the fork -Bringing the filled fork to mouth -Using the napkin to wipe mouth Review of Individual #1's ISP dated 12/29/16 through 12/28/17 failed to evidence training outcomes for the area of eating. On 5/24/17 at 2:00 p.m. an interview was conducted with ASM (administrative staff member) #5 the QIDP (Qualified Intellectual Disabilities Professional) regarding the process of developing the Individual Support Plan from the Comprehensive Functional Assessment. When asked to describe the process ASM #5 stated, "The team, which includes the supervisor, assistant manager, physical therapy, occupational therapy, speech therapy, the nutritionist, the

On 5/25/17 at 8:52 a.m., an interview was conducted with ASM #1 (the program manager), ASM #2 (the assistant residential coordinator), ASM #5, ASM #6 (the assistant program manager) and ASM #7 (the nurse manager).

ASM #5 confirmed if an individual has an area on

comprehensive functional assessment which includes the areas of self-care, eating,

sensorimotor, life safety/health, domestic skills, leisure, social, pre-vocational cognitive and community living. Subcategories are selected from the major areas for the individual to work on and it is added in the ISP based on the scoring

from two, maximum assistance to ten, set-up/supervision/contact guard."

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CENTER	49 FOR MEDICARE	A MEDICAID SERVICES			OIVID INO. 0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CO IX (EACH CORRECTIVE ACTION	PRRECTION (X5) N SHOULD BE COMPLETION
W 227	the comprehensive the individual is not independent (as ev to ten) then the are ISP and a goal sho individual to develo independence. AS should have been of ISP. At this time, A ASM #6 and ASM #6 above concern. The facility policy tit Facility) Service: Ac Person Centered P policy of (name of han Individualized Pre Plan) (also known a reviewed every 90 oneededObjectives necessary to meet identified by the CF	functional assessment where fully dependent or fully idenced by a score from two a should be addressed in the uld be created for the p a skill and work toward M #5 stated an eating goal developed for Individual #1's SM #1, ASM #2, ASM #5, #7 were made aware of the titled, "ICF (Intermediate Care cive Treatment; Section 5-8: lan" documented, "It is the nome) that every resident have rogram Plan (Person Centered as an ISP) which will be days and revised as swill be specific and the recipient's needs as A (needs observed to most dividual's ability to functions in	W 2	227	
W 231	483.440(c)(4)(iii) IN The objectives of the must be expressed	on was presented prior to exit. DIVIDUAL PROGRAM PLAN ne individual program plan in behavioral terms that e indices of performance.	W 2	<u>1.</u> How corrective action accomplished for in	dividual #1:
	This STANDARD is Based on staff inte and residential reco	s not met as evidenced by: rview, facility document review ord review, it was determined failed to develop objectives in for two of two individuals in the		The QIDP will revise plan for individual # outcomes/goals in m in the areas of #1 Ch Socialization, #3b Co #5 Health and Safety Management, #9 Hy	1 to define the neasurable terms oices, #2 ommunication, r, #7 Medication

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	49G065	B. WING		05/25/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSS DRIVE			5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		BE COMPLETION

W 231 Continued From page 29 survey sample, Individuals #1 and #2.

- 1. The facility staff failed to define the following ISP (individual support plan) outcomes/goals in measurable terms for Individual #1: Outcomes: #1 Choices; #2 Socialization; #3b Communication; #5 Health and Safety; #7 Medication Management; #9 Hygiene; #11 Laundry; #12 Water Activity.
- 2. The facility staff failed to define the following ISP outcomes/goals in measurable terms for Individual #2: Outcomes: #2 Choices/Communication: #5 Personal Care/Health and Safety; #7 Community Outings; #8 Swimming; #9 Taking out the Trash; #10 Laundry.

The findings include:

1. The facility staff failed to define the following ISP (individual support plan) outcomes/goals in measurable terms for Individual # 1: "Outcomes: # 1 Choices: #2 Socialization: #3b Communication; #5 Health and Safety; #7 Medication Management; #9 Hygiene; #11 Laundry; #12 Water Activity.

Individual #1 was admitted to the group home on 11/28/14. Individual #1's diagnoses included but were not limited to: severe intellectual disability, glaucoma and skin rashes.

Individual #1's current ISP dated 12/29/16 through 12/28/17 documented:

"Goal 1. Important To and For Choices. (Individual #1) will have structured choices between some of his activities. He will be more

Laundry, and #12 Water Activity. W 231 Assurance that other residents are

protected from the possibility of the deficiency:

The QIDP will review and revise support plans for each resident to ensure that the objectives of the individual program plans are expressed in behavioral terms that provide measurable indices of performance.

Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:

The OIDP will review all annual documentation for each resident at the annual support plan as it is completed to ensure that the objectives of the individual program plan are expressed in behavioral terms that provide measurable indices of performance.

How the facility plans to monitor its performance to make sure that solutions are sustained:

The annual ISP for each client will be reviewed by the ICF supervisor prior to submission deadlines to ensure that the objectives of the individual program plan are expressed in behavioral terms that provide measurable indices of

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				OMB NO. 0938-039
STATEMENT	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING	;		05/25/2017
NAME OF F	PROVIDER OR SUPPLIER	<u></u>		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2011
ROSS DE	RIVE				ROSS DRIVE EDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 231	Continued From pa	age 30	W 2	231	performance.	
		ed in activities and eventually			Date of Completion:	
	Further review of go documentation of q	ositive independence" oal #1 failed to evidence juantitative measurable			6/30/17	
	indicators of perforr	nance.			<u>W231</u>	6/30/17
	"Goal 2. It is Import	tant To and For Socialization.			<u>2.</u>	0/30/1/
	(Individual #1) will h	nave opportunities to talk to,			How corrective action wi	
		volved in activities with family,			accomplished for individ	lual #2:
	Support staff will off	at home and in the community.			The QIDP will revise the	support
		ce and opportunities to help			plan for individual #2 to c	lefine the
		e a successful experience"			outcomes/goals in measur	rable terms
	Further review of go	oal #2 failed to evidence			in the areas of #2 Choices	
		uantitative measurable			Communication, #5 Perso	onal Care/
	indicators of perforn	nance.			Health and Safety, #7 Cor	nmunity
	"Goal 3h Important	t To Communication.			Outings, #8 Swimming, #	•
		annunciate his words so that			out the trash, #10 Laundr	•
	he can communicat	te his wants and needs			Assurance that other res	•
		eview of goal #3b failed to			protected from the possi	
	evidence document	•			deficiency:	
	measurable indicato	ors or performance.			The QIDP will review and	ł revise
	"Goal 5. Important F	For Health and			support plans for each res	
	Safety-Brushing tee	eth and medical appointments.			ensure that the objectives	
		Care Facility) Nurse will assess			individual program plans	
	-	y and quarterly to assist in			expressed in behavioral te	
		ual #1's) health status and ndividual #1) will have annual			provide measurable indice	
		s and will also be supported in			performance.	
		it least twice daily" Further			Measures to be put into	olace or
	review of goal #5 fai	iled to evidence			systemic changes to be m	
		uantitative measurable			ensure that the deficient	
	indicators of perform	nance.			will not recur:	practice
	"Goal 7. It is Importa	ant FOR Medication			The QIDP will review all:	annual

"Goal 7. It is Important FOR Medication Management. (Individual #1) will receive his

medication as scheduled and as ordered..."

documentation for each resident at

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CENTER	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
ROSS DI	RIVE			5604 ROSS DRIVE	
	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~			FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
W 231	Continued From pa	age 31	W 2	the annual support pla	n as it is
	•	oal #7 failed to evidence	V V 2	completed to ensure th	
		quantitative measurable		objectives of the indivi	
	indicators of perform			plan are expressed in b	1 0
				terms that provide mea	
		tant FOR (Individual #1) to  . Support Staff will assist		indices of performance	
		(sic) personal care and		How the facility plans	
		Further review of goal #9 failed		performance to make	
		entation of quantitative		solutions are sustaine	<u>d:</u>
	measurable indicate	tors of performance.		The annual ISP for each	h client will be
	"Goal 11 It is Impo	ortant To (Individual #1) to build		reviewed by the ICF su	
		ence in the area of laundry.		to submission deadline	-
		sic) participate at least once		that the objectives of the	ne individual
		dry, and/or fold his laundry"		program plan are expr	
		oal #11 failed to evidence		behavioral terms that p	
	indicators of perforr	quantitative measurable		measurable indices of	
	indicators of periori	nance.		Date of Completion:	•
	to engage in water abenefit from water of	ortant To and For (Individual #1) activity. (Individual #1) would exercise as instructed by the		6/30/17	
	-	pist" Further review of goal note documentation of			
	quantitative measur				
	performance.				
	Professional) who v	d Intellectual Disabilities wrote Individual #1's ISP was			
	no longer employed	d at the group home.			
	conducted with ASN member) #1 (the pr (the assistant reside	a.m., an interview was M (administrative staff rogram manager), ASM #2 ential coordinator), ASM #5 ASM #6 (the assistant			
	program manager)	and ASM #7 (the nurse 5 stated the QIDP was			

responsible for developing the ISP and worked

		AND HUMAN SERVICES			FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	T		OMB NO. 0938-0391
	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSS D	DIVE			5604 ROSS DRIVE	
KO33 D	NIV L			FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODES OF THE APPRODES O	JLD BE COMPLETION
W 231	Continued From pa	ge 32	W 2	31	
	•	nary team to do so. ASM #5			
		veloped based on the			
	•	ctional assessment and			
		physical therapy, occupational			
		erapy, the nutrition specialist dividual #1's ISP was			
		#5. ASM #5 confirmed all of			
	the above areas of	the ISP were not written in			
		out could be. At this time,			
		ASM #5, ASM #6 and ASM #7 of the above concern.			
	were made aware c	if the above concern.			
	Treatment. Section documented, "c. Obnecessary to meet tidentified by the CF assessment) (needsimpact the individual	led, "ICF Service: Active 5-8: Person Centered Plan" bjectives will be specific and the recipient's needs as A (comprehensive functional is observed to most likely l's ability to function in daily objectives expressed in			
	behavioral terms the of performance (the accurately in quantit	at provide measurable indices objective can be measured fiable data each time the e, intervention, or interaction			
	No further information	on was presented prior to exit.			
	ISP outcomes/goals Individual #2: Outco Choices/Communic Care/Health and Sa				

Individual #2 was admitted to the group home on 9/29/14. Individual #2's diagnoses included but were not limited to: moderate intellectual

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		& MEDICAID SERVICES					NO 0038 0304
			T (VO) MILI	TIDLE	CONCEDUCTION		NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		DATE SURVEY COMPLETED
		49G065	B. WING				05/25/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP COD		00/20/2011
DOCC D	D11/E			560	04 ROSS DRIVE		
ROSS D	RIVE			FR	REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 231	Continued From pa	ge 33	W 2	:31			
	disability, anxiety ar	nd autism.					
	Individual #2's curre through 10/28/17 de	ent ISP dated 10/29/16 ocumented:					
	make choices; Com of goal #2 failed to quantitative measur performance.						
	assistance accomp Health and Safety	For (Individual #2) to have lishing his personal care; "Further review of goal #5 ocumentation of quantitative ors of performance.					
	Outings. (Individua successful participa least once per week (Individual #2) will b in Richmond, VA"	To and For Community I #2) will be supported in Ition in community activities at X. At least once per month, e supported to visit ARC park Further review of goal 7 ocumentation of quantitative ors of performance.					
	will go swimming or review of goal #8 fa	uantitative measurable					
	Important For (Indiv chores at home in o Further review of go	the trash-Skill building- idual #2) will participate in rder to gain independence" ral #9 failed to evidence uantitative measurable					

indicators of performance.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		49G065	B. WING		05/2	25/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5604 ROSS DRIVE FREDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE	
W 231	"Goal 10. Laundry-will put his dirty clot participate in washi week" Further re evidence document measurable indicate.  The QIDP (qualified professional) who was no longer employed.  On 5/25/17 at 8:52 conducted with ASM member) #1 (the professional) the professional of the current QIDP), program manager). ASM #5 responsible for devivith the interdisciplistated the ISP is decomprehensive fundassessments from the professional of the profess	Important For (Individual #2) thes in his hamper and will ng his laundry once per view of goal #10 failed to tation of quantitative ors of performance.  If intellectual disabilities wrote Individual #2's ISP was if at the group home.  a.m., an interview was if (administrative staff rogram manager), ASM #2 tential coordinator), ASM #5 ASM #6 (the assistant and ASM #7 (the nurse is stated the QIDP was teloping the ISP and worked inary team to do so. ASM #5 teloped based on the ctional assessment and physical therapy, occupational terapy, the nutrition specialist dividual #2's ISP was #5. ASM #5 confirmed all of the ISP were not written in out could be. At this time, ASM #5, ASM #6 and ASM #7 of the above concern.	W	231			
W 249		on was presented prior to exit. GRAM IMPLEMENTATION	W 2	$\frac{\mathbf{W249}}{\mathbf{1a.}}$		6/8/17	
	formulated a client's each client must red	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed		How corrective action accomplished for indifferent Facility staff have impleactive treatment programmer.	vidual #1: emented the	2	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´			E SURVEY IPLETED
		49G065	B. WING	i	05/	25/2017
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
ROSS DI	RIVE			l	4 ROSS DRIVE EDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	and frequency to sure objectives identified plan.  This STANDARD is Based on staff interested and residential record that the facility staff treatment for two of sample, Individuals  1. a. The facility staff Individual #1's week April 2017.  1. b. The facility staff Individual #1's montoutcome/goal in April 2017.  The facility staff f	ervices in sufficient number apport the achievement of the I in the individual program  a not met as evidenced by: rview, facility document review ord review, it was determined failed to implement active two individuals in the survey #1 and #2.  If failed to implement kly laundry outcome/goal in failed to implement thly water activity ril 2017.  ailed to implement Individual outcome/goal from 4/23/17  a:  If failed to implement Individual outcome/goal from 4/23/17	W :	249	laundry for individual #1.  Assurance that other residents are protected from the possibility of the deficiency: Facility staff will implement active treatment program for all ISP outcomes for each resident as written in their current support plans.  Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:  QIDP will monitor and document effectiveness of active treatment programs monthly and quarterly to ensure outcomes are implemented.  How the facility plans to monitor is performance to make sure that solutions are sustained:  The ICF Supervisor and QIDP will ensure that facility staff are implementing active treatment programs through conducting observations.  Date of Completion: 6/8/17	n
	April 2017. Individual #1 was ac 11/28/14. Individual	dmitted to the group home on #1's diagnoses included but severe intellectual disability, rashes.			W249 1b. How corrective action will be accomplished for individual #1: Facility staff will implement the activ	6/30/17 re

Individual #1's current ISP (Individual Support Plan) dated 12/29/16 through 12/28/17

treatment program for water activity

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM / OMB NO.	APPROVEI
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CON	ISTRUCTION	(X3) DATE	E SURVEY PLETED
		49G065	B. WING		***************************************	05/2	25/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CO	ODE	
ROSS DI	RIVE			5604 ROSS DRIVE			
NOCO D.	(I V L			FREDE	ERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	Continued From pa	age 36	W 2	49	for individual #1.		
	documented:	.5		. •	Assurance that other	residents are	
					protected from the p	ossibility of th	1e
		rtant To (Individual #1) to build			deficiency:	•	
		ence in the area of laundry.			Facility staff will impl	ement active	
		sic) participate at least once dry, and/or fold his laundry.			treatment program fo	r all ISP	
		vill be Provided based on			outcomes for each res	sident as writte	n
	individual preferences (support instructions) and				in their current suppo	ort plans.	
	-	gram strategy can be found:			Measures to be put in	nto place or	
	SKILL BUILDING:	ns to enjoy watching the			systemic changes to l	oe made to	
		washing machine. (Individual			ensure that the defici	ient practice	
		d in the past with his laundry			will not recur:		
		capabilities in improving his			QIDP will monitor an	nd document	
		1) will be encouraged to			effectiveness of active	treatment	
		ng, drying, and/or folding is looses at least once per week.			programs monthly an	d quarterly to	
		) to put his dirty clothing into			ensure outcomes are i	implemented.	
	the washing machin	ne. Remind him to close the			How the facility plan	s to monitor i	<u>ts</u>
	washing machine.	effect (local) data at 440 to more the			performance to make	e sure that	
		offer (Individual #1) to pour the ne proper receptacle while			solutions are sustain	ed:	
	pointing at it.	le proper receptacie willie			The ICF supervisor as	nd QIDP will	
		il #1) to close the soap			ensure that facility sta	ıff are	
	receptacle.				implementing active t	reatment	
		ns on the washing machine to			programs through con	nducting	
	begin the wash cyc	e in order for (Individual #1) to			observations.		
		know when the wash cycle is			<b>Date of Completion:</b>		
		know that his clothes are			6/30/17		
	ready to be put into	•					
		dual #1) to take out his					
		asher and put into the dryer.  is on the dryer to model one at			<u>W249</u>		6/8/17
		Individual #1) to begin the dry			<u>2.</u>		
					II and a sum a stirus a stir		

How corrective action will be accomplished for individual #2:

Facility staff have implemented the

- Let (Individual #1) know when the dry cycle is complete and ask him to fold his laundry. Allow

(Individual #1) to fold his laundry to the best of his

# DEDARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES			FORM APPROVED
		& MEDICAID SERVICES	T		MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE	
BOSS DI	DIV/E		560	04 ROSS DRIVE	
ROSS DI	XIVE		FR	REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
W 249	Continued From pa	ige 37	W 249	active treatment program	for
VV 240	•	-	VV 249	laundry for individual #2.	
		r use hand over hand to fold ed to be straightened out in		Assurance that other res	
	order to prevent wri				
	- Document (Individ	lual #1's) progress toward		are protected from the p	<u>ossibility</u>
		ng his laundry process in your		of the deficiency:	
	support logs"			Facility staff will impleme	
	Review of Individua	ıl #1's ISP checklist (data		treatment program for all	
		April 2017 revealed a section		outcomes for each resider	
		egarding the weekly laundry		written in their current su	ıpport
		key at the bottom of the form		plans.	
		ls = (equals) support provided; us sign) = participation/no		Measures to be put into j	
		following was documented:		systemic changes to be m	nade to
		documented for 4/1/17		ensure that the deficient	practice
		17, 4/10/17 through 4/21/17		will not recur:	
	and 4/24/17 through			QIDP will monitor and d	ocument
	- A plus sign was do and 4/23/17.	ocumented for 4/6/17, 4/22/17		effectiveness of active trea	atment
		inus sign were documented		programs monthly and qu	uarterly
	for 4/7/17 and 4/9/1			to ensure outcomes are	·
				implemented.	
		I #1's April 2017 progress		How the facility plans to	monitor
		al any documentation dual's laundry outcome/goal.		its performance to make	
	regarding the marke	radi s ladilary odtoome/godi.		that solutions are sustain	
	On 5/25/17 at 8:52	a.m., an interview was		The ICF Supervisor and C	
		M (administrative staff		ensure that facility staff ar	
		ogram manager), ASM #2		•	
		ential coordinator), ASM #5 intellectual disabilities		implementing active treat	
		#6 (the assistant program		programs through conductions	cung
		#7 (the nurse manager).		observations.	
		5 were asked to explain the		<b>Date of Completion:</b>	
	documentation on th	ne ISP checklist and		6/8/17	

demonstrate evidence that the weekly laundry outcome/goal was implemented for Individual #1.

outcome/goal was completed. ASM #5 stated a

ASM #1 stated signatures meant the

		HAND HUMAN SERVICES				FORI	M APPROVED
	RS FOR MEDICARE FOR DEFICIENCIES	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	LTIPLE	CONSTRUCTION		<u>O. 0938-0391</u> ATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	JING		cc	OMPLETED
		49G065	B. WING	<i>i</i>		0:	5/25/2017
NAME OF F	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE		
ROSS DF	RIVE			1	04 ROSS DRIVE EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	Continued From pa	age 38	W 2	249			
	minus sign either m	meant the outcome/goal didn't					
	happen or the outco	come/goal was not achieved for					
		stated that according to the					
		a minus sign meant the rticipate in the outcome/goal.					
		here was documentation for					
	each day when the	laundry outcome/goal was					
	supposed to be imp	plemented weekly, ASM #5					
		t was filled out incorrectly.					
		progress notes should the laundry outcome/goal was					
		f there was no documentation					
	in the progress note	es then there was no proof the					
	outcome/goal was i	implemented. At this time,					
		ASM #5, ASM #5 and ASM #7					
		of the above concern.					
		itled, "ICF Service: Active					
		n 5-9: Implementation and					
		ocumented, "4. Program ach individual must receive a					
		reatment program consisting					
		tions and services in sufficient					
	intensity and freque						
		CP (Person Centered Plan)					
	(also known as the working with the inc	: ISP) objectives by all staff dividual"					
	No further informati	tion was presented prior to exit.					
	1. b. The facility sta	aff failed to implement					
	Individual #1's mon	nthly water activity					
	outcome/goal in Ap	ıril 2017.					
		ent ISP (Individual Support 16 through 12/28/17					
	i latty dated 12/20/1	70 till dagit 12/20/17					

"Goal 12. It is Important To and For (Individual #1)

documented:

		E & MEDICAID SERVICES					M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING			ATE SURVEY DMPLETED
		49G065	B. WING			0:	5/25/2017
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP COD		
ROSS DE	RIVE				04 ROSS DRIVE EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 249	Continued From pa	age 39	W 2	49			
	benefit from water of ICF Physical Thera Provided based on (support instruction Program strategy of The Physical Thera in the pool and train and out of the wate (Individual #1) in compromote muscle for will support (Individual accordance with the assessment once to complete. This out	apist will assess (Individual #1) In staff to safely help him into er as well as how to work with ertain exercises that would ne and range of motion. Staff lual #1) in the pool in					
	collection form) for of documentation re activity outcome/go the form document provided; + (plus signarticipation/no pardocumented:	al #1's ISP checklist (data April 2017 revealed a section egarding the monthly water bal. The key at the bottom of ed, "initials = (equals) support gn)/ - (minus sign) = "ticipation." The following was documented for each day of					
	notes failed to reve	al #1's April 2017 progress al any documentation dual's water activity					
	On 5/25/17 at 8:52	a.m., an interview was					

conducted with ASM (administrative staff member) #1 (the program manager), ASM #2 (the assistant residential coordinator), ASM #5 (the QIDP [qualified intellectual disabilities

		AND HUMAN SERVICES  & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391			
STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		49G065	B. WING	i	05/25/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5604 ROSS DRIVE		
KUSS DI	RIVE			FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE COMPLETION	
W 249	Continued From pa	ge 40	W 2	249		
	manager) and ASM ASM #1 and ASM # documentation on the demonstrate evider activity outcome/goal Individual #1. ASM the outcome/goal was a minus sign either happen or the outcome/goal was individual didn't part When asked why the each day when the was supposed to be #5 stated the check ASM #5 stated the producement whether to outcome/goal was in no documentation in there was no proof to implemented. ASM manager, assistant were responsible for was implemented. ASM #5, ASM #5 ar of the above concernion.	mplemented and if there was in the progress notes then the outcome/goal was if #1 stated the program program manager and QIDP or ensuring active treatment At this time, ASM #1, ASM #2, and ASM #7 were made aware				

disability, anxiety and autism.

through 5/7/17.

Individual #2 was admitted to the group home on 9/29/14. Individual #2's diagnoses included but were not limited to: moderate intellectual

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		E & MEDICAID SERVICES	OMB NO. 0938-039					
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED		
		49G065	B. WING_		0	5/25/2017		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		N. C.		
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KU33 Dr	TIVE			FREDERICKSBURG, VA 22407				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE	(X5) COMPLETION DATE		
W 249	Continued From pa	age 41	W 24	49				
		ent ISP (individual support 16 through 10/28/17						
	will put his dirty clot participate in washi Describe how this windividual preference location where Prog (Individual #2) has a clothing in the trash bathroom. Staff she for this and discourted (Individual #2) will his dirty clothes into rather than the trasher	I be verbally reminded to throw of the hamper in the bathroom of the hamper in the bathroom of the can.  If y at least once per week, take his clothing from his not the washing machine. It leling, hand over hand support, the uragement, starting with the option, depending on what is ment"						
	collection form) for a revealed a section of	al #2's ISP checklist (data April 2017 and May 2017 of documentation regarding outcome/goal. The key at the documented:						
	Initials = (equal) sup Circled initials = sup C = chose not to pa	pport provided/notation in log						

I = Incident O = Other

A = individual not present

- (a minus sign) = Not Offered

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

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			<u> </u>	<u> MB NO. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED
	!	49G065	B. WING	***************************************		05/25/2017
NAME OF F	PROVIDER OR SUPPLIER	<u>L</u>		STREET ADDRESS, CIT	Y, STATE, ZIP CODE	00/20/20
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	ATO VONAMA			FREDERICKSBURG		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORR	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD I ENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 249	Continued From pa	ge 42	W 2	49		
	A minus sign was d 4/23/17 through 5/7	locumented each day from 7/17.				
	4/23/17 through 5/7	al #2's progress notes from 7/17 failed to reveal any arding the individual's laundry				
	conducted with ASM member) #1 (the professional), ASM manager) and ASM ASM #1 and ASM # documentation on the demonstrate eviden outcome/goal was in ASM #5 stated the routcome/goal was in the program manager and QIDP active treatment was ASM #1, ASM #2, A	a.m., an interview was M (administrative staff rogram manager), ASM #2 ential coordinator), ASM #5 d intellectual disabilities M #6 (the assistant program #7 (the nurse manager). #5 were asked to explain the he ISP checklist and note that the weekly laundry mplemented for Individual #2. minus sign indicated the not offered. ASM #1 stated per, assistant program were responsible for ensuring as implemented. At this time, ASM #5, ASM #5 and ASM #7 of the above concern.				
W 252	483.440(e)(1) PROC Data relative to acco specified in client ind	on was presented prior to exit. GRAM DOCUMENTATION  omplishment of the criteria dividual program plan documented in measurable	W 25	1. How corn accompli Facility st revised da	rective action will be shed for individual taff will document of ata collection sheet fall #1 to ensure that g	1 #1: on for

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	49G065	B. WING		05/25/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSS DRIVE			5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETION
				. 1.

### W 252 Continued From page 43

This STANDARD is not met as evidenced by: Based on staff interview, facility document review and residential record review, it was determined that the facility staff failed to collect data of objectives in measurable terms for two of two individuals in the survey sample, Individuals #1 and #2.

- 1. The facility staff failed to collect data in measurable terms for the following outcomes/goals on the ISP (Individual Support Plan) for Individual #1: # 1 Choices; #2 Socialization; #3b Communication; #5 Health and Safety; #7 Medication Management; #9 Hygiene; #11 Laundry; #12 Water Activity.
- 2. The facility staff failed to collect data in measurable terms for the following outcomes/goals on the ISP for Individual #2: #2 Choices/Communication; #5 Personal Care/Health and Safety; #7 Community Outings; #8 Swimming; #9 Taking out the Trash; #10 Laundry.

The findings include:

1. The facility staff failed to collect data in measurable terms for the following outcomes/goals on the ISP (Individual Support Plan) for Individual #1: # 1 Choices; #2 Socialization; #3b Communication; #5 Health and Safety; #7 Medication Management; #9 Hygiene; #11 Laundry; #12 Water Activity.

Individual #1 was admitted to the home on 11/28/14. Individual #1's diagnoses included but were not limited to: severe intellectual disability, glaucoma and skin rashes.

W 252 data is collected and documented in measurable terms.

# Assurance that other residents are protected from the possibility of the deficiency:

Facility staff will document on data collection sheet for each resident to ensure that goal data is collected and documented in measurable terms.

Measures to be put into place or

# Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:

The QIDP will monitor and review data collection sheets monthly and quarterly to ensure outcomes are being documented in measurable terms.

# How the facility plans to monitor its performance to make sure that solutions are sustained:

The data collection sheets for each client will be reviewed by the ICF supervisor prior to initiation to ensure that goal data can be collected and documented in measurable terms.

## **Date of Completion:**

6/30/17

W252

6/30/17

<u>2.</u>

How corrective action will be accomplished for individual #2:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			0	MB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KUSS D.	(IVE	<u></u>		ſ	FREDERICKSBURG, VA 22407	
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					Facility staff will document of	on
W 252	Continued From pa	_	W 2	252	revised data collection sheet	
		ent ISP dated 12/29/16			individual #2 to ensure that	
	through 12/28/17 do	ocumented:			data is collected and docume	C
	"C==14 Important	To and Ear Chairma			measurable terms.	Jitted III
		: To and For Choices. have structured choices			Assurance that other reside	ente are
		nis activities. He will be more			protected from the possibil	
	satisfied and involve	ed in activities and eventually			the deficiency:	<u>Ity 01</u>
		ositive independence			Facility staff will document of	andata
	O LO DE LES Engagements				collection sheet for each resi	
		ant To and For Socialization.				
		nave opportunities to talk to, volved in activities with family,			ensure that goal data is colle	
		at home and in the community.			documented in measurable t	
	Support staff will off	fer choices,			Measures to be put into pla	
	parameters/guidance	ce and opportunities to help			systemic changes to be mad	
	(Individual #1) have	e a successful experience			ensure that the deficient pr	<u>actice</u>
	Goal 3b. Important	To Communication			will not recur:	-
		annunciate his words so that			The QIDP will monitor and	
		te his wants and needs			data collection sheets month	•
	better				quarterly to ensure outcome	
					being documented in measu	rable
		For Health and Safety-Brushing			terms.	
	teeth and medical a	appointments. ICF Facility) Nurse will assess and			How the facility plans to me	
		d quarterly to assist in			its performance to make su	re that
		lual #1's) health status and			solutions are sustained:	
		Individual #1) will have annual			The data collection sheets fo	
		s and will also be supported in			client will be reviewed by the	e ICF
	brushing his teeth at	t least twice daily			supervisor prior to initiation	ı to
	Goal 7. It is Importa	ent FOR Medication			ensure that goal data can be	
		ividual #1) will receive his			collected and documented in	
		duled and as ordered			measurable terms.	
					Date of Completion:	
	Goal 9. It is importar	int FOR (Individual #1) to have			6/20/17	

good hygiene. Support Staff will assist (Individual #1) will (sic) personal care and hygiene needs...

6/30/17

		HAND HUMAN SERVICES  E & MEDICAID SERVICES			C		APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		49G065	B. WING	3		05	/25/2017
NAME OF	PROVIDER OR SUPPLIER			560	REET ADDRESS, CITY, STATE, ZIP CODE		/AUIAU L.
		TELETINE OF OFFICIENCE			REDERICKSBURG, VA 22407		
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W 252	Continued From pa	age 45	W 2	252			
		rtant To (Individual #1) to build	• •	-02			
	upon his independe	ence in the area of laundry.					
	(Individual #1) riii (s per week to wash,	sic) participate at least once dry, and/or fold his laundry					
		·					
		rtant To and For (Individual #1)					
		activity. (Individual #1) would exercise as instructed by the					
	ICF Physical Therap						
	Further review of th	ne above goals failed to					
		tation of quantitative					
	measurable indicate						
	The ISP "Checklists	s" (data collection forms) and					
	progress notes for In	Individual #1 dated 4/1/17					
	through 5/20/17 wer	ere reviewed. The checklists					
	and progress notes						
		he data collection of Individual /goals in measurable terms.					
		a.m., an interview was					
		M (administrative staff					
		ogram manager), ASM #2 ential coordinator), ASM #5					
		f intellectual disabilities					
	professional]), ASM	1 #6 (the assistant program					
	manager) and ASM	#7 (the nurse manager).					
	ASM #5 stated the C	QIDP was responsible for					
	developing the ISP a						
	interdisciplinary tean the ISP is developed	m to do so. ASM #5 stated					
		d based on the ctional assessment and					
	001p. 00	Mondi accoccinent and					

assessments from physical therapy, occupational therapy, speech therapy, the nutrition specialist and psychology. Individual #1's ISP and ISP checklists for April and May 2017 was reviewed with ASM #5. ASM #5 confirmed all of the above areas of the ISP were not written in measurable

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	FORM AI				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		49G065	B. WING	~	05/25/2017		
NAME OF	PROVIDER OR SUPPLIER		56	REET ADDRESS, CITY, STATE, ZIP 04 ROSS DRIVE REDERICKSBURG, VA 22407	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE COMPLETION E APPROPRIATE DATE		
	ISP; therefore the d measurable as well. #2, ASM #5, ASM # aware of the above  The facility policy titl Treatment. Section documented, "c. Ob necessary to meet t identified by the CFA assessment) (needs impact the individualife) and includeiv. behavioral terms that of performance (the accurately in quantificatment, procedure occurs)"  The facility titled, "ICS ection 5-9: Implemedocumented, "6. Production Accurate, systematic about the individual's meeting the criterias Centered Plan) (also objectives serves as change and revision  No further information  2. The facility staff fameasurable terms for outcomes/goals on the Choices/Communicate Care/Health and Safe	checklists were based on the ata collection was not. At this time, ASM #1, ASM 6 and ASM #7 were made concern.  ed, "ICF Service: Active 5-8: Person Centered Plan" jectives will be specific and the recipient's needs as A (comprehensive functional sobserved to most likely I's ability to function in daily objectives expressed in at provide measurable indices objective can be measured table data each time the eq., intervention, or interaction  F Service: Active Treatment. Entation and Documentation: gram Documentation: gram Documentation: c, behaviorally stated data as performance toward stated in PCP (Person known as the ISP) the basis for necessary to the program"  In was presented prior to exit. illed to collect data in the following the ISP for Individual #2: #2	W 252				

Laundry.

### PRINTED: 06/01/2017 EPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 49G065 B. WING 05/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5604 ROSS DRIVE **ROSS DRIVE** FREDERICKSBURG, VA 22407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 252 Continued From page 47 W 252 Individual #2 was admitted to the group home on 9/29/14. Individual #2's diagnoses included but were not limited to: moderate intellectual disability, anxiety and autism. Individual #2's current ISP dated 10/29/16 through 10/28/17 documented: "Goal 2. Important To and For (Individual #2) to make choices; Communication... "Goal 5. Important For (Individual #2) to have assistance accomplishing his personal care: Health and Safety... "Goal 7. Important To and For Community Outings. (Individual #2) will be supported in successful participation in community activities at least once per week. At least once per month, (Individual #2) will be supported to visit ARC park in Richmond, VA... "Goal 8. Swimming- Important To (Individual #2) will go swimming once per month... "Goal 9. Taking out the trash-Skill building-Important For (Individual #2) will participate in chores at home in order to gain independence... "Goal 10. Laundry- Important For (Individual #2) will put his dirty clothes in his hamper and will participate in washing his laundry once per

Further review of the above goals failed to evidence documentation of quantitative measurable indicators of performance.

week..."

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

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STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/25/2017
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSS DRIVE				5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE COMPLETION

### W 252 Continued From page 48

The ISP "Checklists" (data collection forms) and progress notes for Individual #2 dated 4/1/17 through 5/20/17 were reviewed. The checklists and progress notes failed to evidence documentation of the data collection of Individual #2's ISP outcomes/goals in measurable terms.

On 5/25/17 at 8:52 a.m., an interview was conducted with ASM (administrative staff member) #1 (the program manager), ASM #2 (the assistant residential coordinator), ASM #5 (the QIDP [qualified intellectual disabilities professional]), ASM #6 (the assistant program manager) and ASM #7 (the nurse manager). ASM #5 stated the QIDP was responsible for developing the ISP and worked with the interdisciplinary team to do so. ASM #5 stated the ISP is developed based on the comprehensive functional assessment and assessments from physical therapy, occupational therapy, speech therapy, the nutrition specialist and psychology. Individual #2's ISP and ISP checklists for April and May 2017 was reviewed with ASM #5. ASM #5 confirmed all of the above areas of the ISP were not written in measurable terms and the data checklists were based on the ISP; therefore the data collection was not measurable as well. At this time, ASM #1, ASM #2, ASM #5, ASM #6 and ASM #7 were made aware of the above concern.

No further information was presented prior to exit.

W 252