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	49G065	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An unannounced annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted 5/24/16 through 5/26/16. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. The Life Safety Code survey report will follow. The census in this four bed facility was four at the time of the survey. The survey sample consisted of three current individual reviews, (Individuals #1 through #3).	W 000	RECEIVED JUN 27 2016 VDH/OLC	
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, staff interview, residential record review and facility document review, it was determined that the facility staff failed to teach an individual to manage their own finances for one of three individuals in the survey sample, Individual #1. The facility staff failed to teach Individual #1 financial management and/or provide evidence the individual was not capable of learning to manage his financial affairs. The findings include: Individual #1 was admitted to (name of group	W 126	**W126** **How corrective action will be accomplished for Individual #1:** Facility staff will assess Individual #1's interest and ability in managing his personal financial affairs. If assessment indicates capability and interest, QIDP will develop a support plan outcome to provide training for Individual #1 to assume responsibility of his financial affairs to the best of his abilities. If assessment indicates a lack of capability to learn or a lack of interest in managing his financial affairs, evidences will be included in Individual #1's support plan. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will assess each resident's interest and ability in managing their personal financial affairs. If assessment indicates capability and interest, QIDP will develop a support plan outcome to provide training for each resident to assume	6/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ID Residential Coordinator	6/23/16

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

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W 126	Continued From page 1 home) on 11/28/14 with diagnoses that included but were not limited to: severe intellectual disability, glaucoma and osteoarthritis. Review of Resident #1's comprehensive functional assessment dated 11/17/15 documented, "Community Living: Money Management- 1. Uses coins/currency for purchasing: N (No). 2. Carries/handles money responsibly: N. 3. Performs simple conputations (sic): N. 4. Deposits money in bank: N. 5. Withdraws money from bank: N. 6. Cashes a check: N. 7. Writes a check: N..." An intermediate care facility level of functioning survey summary sheet dated 12/1/15 documented, COMMUNITY LIVING SKILLS- With what type of assistance would this person currently be able to...c) Add coins of various denominations up to one dollar: 5 (Total Care)..." Further review of Individual #1's residential record failed to reveal documentation of whether the individual could participate in any financial management or a plan to teach Individual #1 financial management. Review of section five (plan for supports) of Individual #1's ISP (individual service plan) with a start date of 12/29/15 failed to document information regarding financial management. On 5/24/16 from 5:30 p.m. to 6:30 p.m., observations of Individual #1 were conducted. During this time period, Individual #1 was observed holding a utensil and feeding himself with staff supervision. On 5/25/16 at 6:00 p.m., an interview was conducted with ASM (administrative staff	W 126	responsibility of their financial affairs to the best of their abilities. If assessment indicates a lack of capability to learn or a lack of interest in managing their financial affairs, evidence will be included in each resident's support plan. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** Facility staff will complete an annual money management assessment for each resident to address the level of skill and interest in participating in managing their financial affairs to the best of their ability. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained. **Date of Completion:** 6/30/16 RECEIVED JUN 27 2016 VDH/OLC	

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member) #1 (the ICF [intermediate care facility] supervisor) and ASM #2 (the QIDP [qualified intellectual disabilities professional]). ASM #2 was asked how she determines what financial management goals are developed for each individual. ASM #2 stated the goals depend on the level of function, level of inventory and what the individual can hold onto. ASM #2 stated each individual has a capacity evaluation that talks about whether the individual can manage their money, and staff talks about focuses during annual meetings. ASM #2 was asked if Individual #1 could hold onto objects. ASM #2 stated the individual could hold objects but throws them. At this time, ASM #2 was asked to provide Individual #1's capacity evaluation and any further documentation to evidence the individual was not capable of participating in financial management.

On 5/26/16 at 8:10 a.m., ASM #2 stated she tried to find Individual #1's capacity evaluation but the individual came to the facility in 2012 and all of his historical data was scanned into one continuous file and she couldn't find the evaluation. ASM #2 stated she could not find any documentation to evidence Individual #1 was not capable of participating in financial management.

The facility policy titled, "Client Protections. Section 2-1: Individual Rights and Assurances" documented in part, "Each individual will have the right to choices in regards (sic) managing financial affairs, community involvement to include social, religious, and community group activities, and daily household routines. Staff will assist individuals with skill building, exploration of options and assistance with accessing activities and services written in their plan..."

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W 126	Continued From page 3 No further information was presented prior to exit.	W 126		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interview, residential record review and facility document review, it was determined that the facility staff failed to implement policies prohibiting mistreatment for one of three individuals in the survey sample, Individual #3. The facility staff failed to immediately report allegations regarding staff calling Individual #3 "Nosferatu (a vampire character in a movie (1))," holding doors to prevent the individual from exiting the room, and forcing the individual to go take a shower or go to the bedroom before he was ready. The findings include: Individual #3 was admitted to (name of group home) on 2/24/16 with diagnoses that included but were not limited to: moderate intellectual disability, seizures and allergies. An "Allegation of Human Rights Violation: Abuse" report (no date) documented, "An Incident Report written on March 20, 2016 by (name of facility) staff stated: I, (name of ASM [administrative staff member] #1 [intermediate care facility supervisor), received a text message at 8:01 am from (name of DSP [direct support staff] #7) that	W 149	**W149** **How corrective action will be accomplished for individual #3:** Facility staff have been re-trained on policies prohibiting mistreatment for Individual #3 to ensure he is referred to by his preferred name, to ensure doors are not held to prevent him from exiting the room, and he is not forced to go take a shower or go to his bedroom before he is ready. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff have retaken the Human Rights training which specifies the right of all residents to be called by their first name or preferred name, to ensure staff do not hold doors to prevent any residents from exiting any rooms, and do not force any residents to go take a shower or go to their bedrooms before they are ready. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** QIDP and ICF Management will monitor facility staff adherence to Human Rights policies to ensure compliance in the facility. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Resident's Human Rights will be reviewed at mandatory staff meetings at least annually. ICF Management will monitor and document various shift checks to ensure that individuals' Human Rights are being protected. **Date of Completion:** 6/6/16	6/6/16

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said, 'Noferatu (sic) is the name (DSP #9) calls (Individual #3) and this morning he has called him fat ass. This is the type of worker you want around here? He clearly does not like (Individual #3).' (Name of ASM #4 [assistant residential coordinator]) also received the same message. He notified (name of residential coordinator) and I of the message he had received from her and I confirmed that I had received the same thing. (Name of residential coordinator) called me and gave me direction to go ask (DSP #9) about it and to send him home until further notice..."

Further review of the allegation report revealed the allegation that DSP #9 called Individual #3 a fat ass was unfounded but revealed the following additional allegations that were reported by direct support staff during the investigation but not reported prior to the investigation:

-An interview conducted by ASM #1 with DSP #7 on 3/20/16 revealed that DSP #7 allegedly heard DSP #9 call Individual #3 "Nosferatu" in the past but "looked past it."

-An interview conducted by ASM #1 with DSP #6 on 3/20/16 revealed that he allegedly heard DSP #9 call Individual #3 "Nosferatu" but didn't think much of it.

-An interview conducted by ASM #3 (quality assurance coordinator) with DSP #7 on 3/21/16 revealed that DSP #7 allegedly heard DSP #9 call Individual #3 "Nosferatu" on several occasions. DSP #7 also alleged DSP #9 had prevented Individual #3 from exiting the activity room by holding the door in the past. DSP #7 reported she feared reporting these allegations because DSP #9 had mentioned that he worked for one of

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the company's board members.

-An interview conducted by ASM #3 with DSP #6 on 3/21/16 revealed that DSP #6 alleged on one occasion he witnessed DSP #9 holding the activity room door to prevent Individual #3 from exiting the room. DSP #6 stated he did not report this because he originally thought DSP #9 and Individual #3 were "playing and after the situation lasted for a while he was not sure of what was really going on."

-An interview conducted by ASM #3 with DSP #5 on 3/21/16 revealed DSP #5 alleged on one occasion, she witnessed DSP #9 send Individual #3 to his room and in the past she heard DSP #9 and DSP #10 call Individual #3 "Nosferatu." DSP #5 stated she did not believe DSP #9 or DSP #10 meant the name "Nosferatu" in a derogatory manner.

-An interview conducted by ASM #3 with DSP #10 (no longer employed at the facility) on 3/21/16 revealed DSP #10 admitted to calling Individual #3 "Nosferatu." DSP #10 stated he did not mean harm by the name and Individual #3's body language resembled "Nosferatu" when he went into "attack mode." DSP #10 reported ASM #1 overheard him calling Individual #3 "Nosferatu" and informed him that was not a proper name and may be considered derogatory. DSP #10 stated he stopped calling Individual #3 "Nosferatu." During this interview, DSP #10 also reported on one occasion he witnessed DSP #9 give Individual #3 a "time out" by putting the individual in his room and telling him to sit on his bed.

-An interview conducted by ASM #3 with DSP #3

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on 3/21/16 revealed that DSP #3 allegedly heard DSP #9 and DSP #10 call Individual #3 "Nosferatu" but felt they were not trying to be demeaning.

-An interview conducted by ASM #3 with DSP #2 on 3/21/16 revealed DSP #2 allegedly witnessed DSP #9 "pushing Individual #3 along to take showers" before the individual was ready and had also allegedly seen DSP #8 and DSP #9 escort Individual #3 to go to bed before he was ready.

-An interview conducted by ASM #3 with DSP #9 on 3/21/16 revealed DSP #9 admitted to calling Individual #3 "Nosferatu" but stated he didn't mean the name in a derogatory way. DSP #9 also stated that he escorted Individual #3 to his room and sat with the individual when he was really aggressive. DSP #9 denied calling Individual #3 a fat ass.

On 5/25/16 at 9:05 a.m., an interview was conducted with DSP #2. DSP #2 stated DSP #10 began calling Individual #3 "Nosferatu" when he began employment (approximately six months ago). DSP #2 stated he didn't know what "Nosferatu" meant. DSP #2 stated DSP #9 and DSP #10 became close and DSP #9 began calling Individual #3 "Nosferatu." DSP #2 stated DSP #9 called Individual #3 "Nosferatu" on a regular basis and stated the name in an irritating tone when the individual would not complete a task. DSP #2 stated he reported the name calling to ASM #1 after he realized it was becoming a pattern. When asked if he had any other concerns regarding DSP #9's treatment of Individual #3, DSP #2 stated DSP #8 (no longer employed at the facility) and DSP #9 would have Individual #3 go to the bedroom or bathroom at

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their preferred time versus the individual's preferred time. When asked what he meant, DSP #2 stated Individual #3 gets stuck (in completing a task) and will display grunts and moves. DSP #2 stated DSP #8 and DSP #9 would try to turn the individual around and guide him to his room. DSP #2 stated during these times, the individual was not endangering himself or others. DSP #2 stated Individual #3 could be sitting and listening to music and DSP #8 and DSP #9 would make the individual go to the bedroom or bathroom instead of allowing him to initiate the task.

On 5/25/16 at 10:30 a.m., an interview was conducted with DSP #7. DSP #7 stated she reports allegations of abuse, neglect or mistreatment to her supervisor right after the incidents occur. DSP #7 stated she heard DSP #9 call Individual #3 "Nosferatu" for about a month but didn't know what the name meant until she looked it up at home.

On 5/25/16 at 11:00 a.m., an interview was conducted with DSP #6. DSP #6 stated allegations of abuse, neglect or mistreatment should be immediately reported to the supervisor. DSP #6 stated he heard about all of the above allegations during the investigation but had never witnessed any of the allegations because he works during the night.

On 5/25/16 at 12:35 p.m., an interview was conducted with ASM #1, [intermediate care facility supervisor]. ASM #1 stated staff must report allegations of abuse, neglect or mistreatment to her or another member of management within 24 hours. ASM #1 stated prior to the investigation on 3/20/16, someone mentioned DSP #10 called

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Individual #3 "Nosferatu" so she addressed this with DSP #10 who stopped. ASM #1 stated the name was not appropriate and individuals were supposed to be called by their first name or preferred name. ASM #1 stated "Nosferatu" was not Individual #3's preferred name. ASM #1 stated she was not aware that DSP #9 was calling the individual "Nosferatu" until the investigation on 3/20/16.

On 5/25/16 at 1:00 p.m., ASM #1 and ASM #4 were made aware of the above findings.

On 5/25/16 at 3:45 p.m., an interview was conducted with ASM #3, (quality assurance coordinator). ASM #3 stated during her investigation, she could substantiate some staff was calling Individual #3 "Nosferatu" but could not substantiate it was meant in a derogatory manner. ASM #3 stated DSP #9 said everyone has nicknames. At this time, ASM #3 confirmed staff were aware of allegations of potential abuse or mistreatment and didn't immediately report those concerns to management.

Further review of facility documents revealed that after the investigation on 3/20/15, DSP #9 and #10 were transferred to another facility and DSP #2, #3, #5, #6 and #7 were given counseling memorandums for failing to report acts of misconduct by other staff.

The facility policy titled, "Client Protection. Section 2-3: Abuse and Neglect" documented in part, "It is the policy of (name of facility) to ensure that all individuals are free from physical, verbal, sexual or psychological abuse, punishment, neglect or mistreatment...8. Any employee who witnesses any behavior prohibited by (name of

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W 149	Continued From page 9 company's) Human Rights Plan is required to complete an incident report and immediately inform the supervisor and (name of company's) Human Rights Advocate in accordance with (name of company's) Code of Ethics and Corporate Compliance Plan. Failure to do so violates (name of company's) Human Rights Plan and Corporate Responsibility Resolution..." The Human Rights Plan documented in part, "Each individual has the right to: 1. Use his preferred or legal name. The use of an individual's preferred name may be limited when a licensed professional makes the determination that the use of the name will result in demonstrable harm or have significant negative impact on the program itself or the individual's treatment, progress, and recovery...2. Be protected from harm including abuse, neglect, and exploitation...Providers shall recognize, respect, support and protect the dignity rights of each individual at all times..." No further information was presented prior to exit. (1) This information was obtained from the website: http://nosferatumovie.com/	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	W 153	**W153** **How corrective action will be accomplished for Individual #3:** Facility staff involved have received corrective action and counseling for their failure to report allegations of mistreatment and abuse of Individual #3. Staff meetings have been utilized to educate facility staff concerning this deficiency. All staff have been re-trained on Human Rights policies and will review the mandated reporter policy to ensure that facility staff will immediately report allegations of mistreatment for Individual #3 to ensure he is referred to by his preferred name, to ensure doors are not held to prevent him from exiting the room, and he is not forced to go take a shower or go to his bedroom before he is ready.	6/30/16

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W 153	Continued From page 10 Based on staff interview, residential record review and facility document review, it was determined that the facility staff failed to report allegations of abuse and/or mistreatment for one of three individuals in the survey sample, Individual #3. The facility staff failed to immediately report allegations regarding staff calling Individual #3 "Nosferatu (a vampire character in a movie) (1)," holding doors to prevent the individual from exiting the room, and forcing the individual to go take a shower or go to the bedroom before he was ready. The findings include: Individual #3 was admitted to (name of group home) on 2/24/16 with diagnoses that included but were not limited to: moderate intellectual disability, seizures and allergies. An "Allegation of Human Rights Violation: Abuse" report (no date) documented, "An Incident Report written on March 20, 2016 by (name of facility) staff stated: I, (name of ASM [administrative staff member] #1 [intermediate care facility supervisor), received a text message at 8:01 am from (name of DSP [direct support staff] #7) that said, 'Noferatu (sic) is the name (DSP #9) calls (Individual #3) and this morning he has called him fat ass. This is the type of worker you want around here? He clearly does not like (Individual #3).' (Name of ASM #4 [assistant residential coordinator]) also received the same message. He notified (name of residential coordinator) and I of the message he had received from her and I confirmed that I had received the same thing. (Name of residential coordinator) called me and	W 153	**Assurance that other residents are protected from the possibility of the deficiency:** Staff meetings have been utilized to educate facility staff concerning this deficiency. Facility staff have been re-trained on Human Rights policies and will review the mandated reporter policy to ensure that allegations of mistreatment will be immediately reported for all residents to ensure they are referred to by their preferred name, to ensure doors are not held to prevent them from exiting any rooms, and they are not forced to go take a shower or go to their bedrooms before they are ready. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** QIDP and ICF Management will monitor facility staff adherence to Human Rights policies and Mandated Reporter requirements to ensure compliance in the facility. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Resident's Human Rights and Mandated Reporter reqirements will be reviewed at mandatory staff meetings at least annually. ICF Management will conduct monthly 1:1 supervision meetings with each staff to ensure that there are no unreported allegations or concerns. **Date of Completion:** 6/30/16	

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gave me direction to go ask (DSP #9) about it and to send him home until further notice..."

Further review of the allegation report revealed the allegation that DSP #9 called Individual #3 a fat ass was unfounded but revealed the following additional allegations that were reported by direct support staff during the investigation but not reported prior to the investigation:

-An interview conducted by ASM #1 with DSP #7 on 3/20/16 revealed that DSP #7 allegedly heard DSP #9 call Individual #3 "Nosferatu" in the past but "looked past it."

-An interview conducted by ASM #1 with DSP #6 on 3/20/16 revealed that he allegedly heard DSP #9 call Individual #3 "Nosferatu" but didn't think much of it.

-An interview conducted by ASM #3 (quality assurance coordinator) with DSP #7 on 3/21/16 revealed that DSP #7 allegedly heard DSP #9 call Individual #3 "Nosferatu" on several occasions. DSP #7 also alleged DSP #9 had prevented Individual #3 from exiting the activity room by holding the door in the past. DSP #7 reported she feared reporting these allegations because DSP #9 had mentioned that he worked for one of the company's board members.

-An interview conducted by ASM #3 with DSP #6 on 3/21/16 revealed that DSP #6 alleged on one occasion he witnessed DSP #9 holding the activity room door to prevent Individual #3 from exiting the room. DSP #6 stated he did not report this because he originally thought DSP #9 and Individual #3 were "playing and after the situation lasted for a while he was not sure of what was

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really going on."

-An interview conducted by ASM #3 with DSP #5 on 3/21/16 revealed DSP #5 alleged on one occasion, she witnessed DSP #9 send Individual #3 to his room and in the past she heard DSP #9 and DSP #10 call Individual #3 "Nosferatu." DSP #5 stated she did not believe DSP #9 or DSP #10 meant the name "Nosferatu" in a derogatory manner.

-An interview conducted by ASM #3 with DSP #10 (no longer employed at the facility) on 3/21/16 revealed DSP #10 admitted to calling Individual #3 "Nosferatu." DSP #10 stated he did not mean harm by the name and Individual #3's body language resembled "Nosferatu" when he went into "attack mode." DSP #10 reported ASM #1 overheard him calling Individual #3 "Nosferatu" and informed him that was not a proper name and may be considered derogatory. DSP #10 stated he stopped calling Individual #3 "Nosferatu." During this interview, DSP #10 also reported on one occasion he witnessed DSP #9 give Individual #3 a "time out" by putting the individual in his room and telling him to sit on his bed.

-An interview conducted by ASM #3 with DSP #3 on 3/21/16 revealed that DSP #3 allegedly heard DSP #9 and DSP #10 call Individual #3 "Nosferatu" but felt they were not trying to be demeaning.

-An interview conducted by ASM #3 with DSP #2 on 3/21/16 revealed DSP #2 allegedly witnessed DSP #9 "pushing Individual #3 along to take showers" before the individual was ready and had also allegedly seen DSP #8 and DSP #9 escort

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Individual #3 to go to bed before he was ready.

-An interview conducted by ASM #3 with DSP #9 on 3/21/16 revealed DSP #9 admitted to calling Individual #3 "Nosferatu" but stated he didn't mean the name in a derogatory way. DSP #9 also stated that he escorted Individual #3 to his room and sat with the individual when he was really aggressive. DSP #9 denied calling Individual #3 a fat ass.

On 5/25/16 at 9:05 a.m., an interview was conducted with DSP #2. DSP #2 stated DSP #10 began calling Individual #3 "Nosferatu" when he began employment (approximately six months ago). DSP #2 stated he didn't know what "Nosferatu" meant. DSP #2 stated DSP #9 and DSP #10 became close and DSP #9 began calling Individual #3 "Nosferatu." DSP #2 stated DSP #9 called Individual #3 "Nosferatu" on a regular basis and stated the name in an irritating tone when the individual would not complete a task. DSP #2 stated he reported the name calling to ASM #1 after he realized it was becoming a pattern. When asked if he had any other concerns regarding DSP #9's treatment of Individual #3, DSP #2 stated DSP #8 (no longer employed at the facility) and DSP #9 would have Individual #3 go to the bedroom or bathroom at their preferred time versus the individual's preferred time. When asked what he meant, DSP #2 stated Individual #3 gets stuck (in completing a task) and will display grunts and moves. DSP #2 stated DSP #8 and DSP #9 would try to turn the individual around and guide him to his room. DSP #2 stated during these times, the individual was not endangering himself or others. DSP #2 stated Individual #3 could be sitting and listening to music and DSP #8 and

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DSP #9 would make the individual go to the bedroom or bathroom instead of allowing him to initiate the task.

On 5/25/16 at 10:30 a.m., an interview was conducted with DSP #7. DSP #7 stated she reports allegations of abuse, neglect or mistreatment to her supervisor right after the incidents occur. DSP #7 stated she heard DSP #9 call Individual #3 "Nosferatu" for about a month but didn't know what the name meant until she looked it up at home.

On 5/25/16 at 11:00 a.m., an interview was conducted with DSP #6. DSP #6 stated allegations of abuse, neglect or mistreatment should be immediately reported to the supervisor. DSP #6 stated he heard about all of the above allegations during the investigation but had never witnessed any of the allegations because he works during the night.

On 5/25/16 at 12:35 p.m., an interview was conducted with ASM #1, [intermediate care facility supervisor]. ASM #1 stated staff must report allegations of abuse, neglect or mistreatment to her or another member of management within 24 hours. ASM #1 stated prior to the investigation on 3/20/16, someone mentioned DSP #10 called Individual #3 "Nosferatu" so she addressed this with DSP #10 who stopped. ASM #1 stated the name was not appropriate and individuals were supposed to be called by their first name or preferred name. ASM #1 stated "Nosferatu" was not Individual #3's preferred name. ASM #1 stated she was not aware that DSP #9 was calling the individual "Nosferatu" until the investigation on 3/20/16.

On 5/25/16 at 1:00 p.m., ASM #1 and ASM #4

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were made aware of the above findings.

On 5/25/16 at 3:45 p.m., an interview was conducted with ASM #3, (quality assurance coordinator). ASM #3 stated during her investigation, she could substantiate some staff was calling Individual #3 "Nosferatu" but could not substantiate it was meant in a derogatory manner. ASM #3 stated DSP #9 said everyone has nicknames. At this time, ASM #3 confirmed staff were aware of allegations of potential abuse or mistreatment and didn't immediately report those concerns to management.

Further review of facility documents revealed that after the investigation on 3/20/15, DSP #9 and #10 were transferred to another facility and DSP #2, #3, #5, #6 and #7 were given counseling memorandums for failing to report acts of misconduct by other staff.

The facility policy titled, "Client Protection. Section 2-3: Abuse and Neglect" documented in part, "It is the policy of (name of facility) to ensure that all individuals are free from physical, verbal, sexual or psychological abuse, punishment, neglect or mistreatment...8. Any employee who witnesses any behavior prohibited by (name of company's) Human Rights Plan is required to complete an incident report and immediately inform the supervisor and (name of company's) Human Rights Advocate in accordance with (name of company's) Code of Ethics and Corporate Compliance Plan. Failure to do so violates (name of company's) Human Rights Plan and Corporate Responsibility Resolution..."

The Human Rights Plan documented in part,

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W 153	Continued From page 16 "Each individual has the right to: 1. Use his preferred or legal name. The use of an individual's preferred name may be limited when a licensed professional makes the determination that the use of the name will result in demonstrable harm or have significant negative impact on the program itself or the individual's treatment, progress, and recovery...2. Be protected from harm including abuse, neglect, and exploitation...Providers shall recognize, respect, support and protect the dignity rights of each individual at all times..." No further information was presented prior to exit. (1) This information was obtained from the website: http://nosferatumovie.com/	W 153		
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, residential record review and facility document review, it was determined that QIDP (qualified intellectual disabilities professional) failed to coordinate and monitor active treatment for two of three individuals in the survey sample, Individuals #1 and #2. 1. The QIDP failed to develop an ISP (individual service plan) to promote Individual # 1's progress toward independence. 2.a. The QIDP failed to develop an ISP to promote Individual # 2's progress toward independence.	W 159	W159 1. **How corrective action will be accomplished for Individual #1:** The QIDP will revise the support plan for Individual #1 to reflect outcomes to encourage progress toward independence. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will review and revise support plans as necessary for each resident to ensure there are outcomes that encourage progress towards independence. RECEIVED JUN 27 2016 VDH/OLC	6/30/16

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W 159	Continued From page 17 2.b. The QIDP failed to ensure staff implemented PECS (picture exchange communication system) per Individual #2's ISP (individual service plan). The findings include: 1. The QIDP failed to develop an ISP to promote Individual #1's progress toward independence. Individual #1 was admitted to (name of group home) on 11/28/14 with diagnoses that included but were not limited to: severe intellectual disability, glaucoma and osteoarthritis. On 5/26/16 Individual #1's ISP (individual service plan) dated 12/29/15 through 12/28/16 was reviewed. Individual # 1's ISP documented, "Goal 2- Important To be connected to family and friends/peers." Further review of goal two in Individual # 1's ISP failed to evidence clear measurable goals for Individual # 1 to progress toward independence. On 5/26/16 at 8:10 a.m., an interview was conducted with ASM (administrative staff member) #1 (the intermediate care facility supervisor) and ASM #2 (the QIDP [qualified intellectual disabilities professional]). ASM #2 stated the purpose of an ISP is to promote independence and personal choices. ASM #2 was shown goal two in Individual #1's ISP and asked what the individual was learning and how the goal was promoting independence. ASM #2 stated the goal was more about helping the individual maintain connections. The facility policy titled, "ICF (intermediate care facility) Service: Active Treatment. Section 5-10:	W 159	**Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The facility staff will review the skills of each resident during the annual support plan meeting. The Comprehensive Functional and Clinical Assessments will be used to establish skill building outcomes aimed at increasing independence. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained. **Date of Completion:** 6/30/16	

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W 159	Continued From page 18 Goals and Objectives" documented in part, "It is the policy of (name of facility) that residents will have a Person Centered Plan (PCP) (ISP) that includes individualized goals based on assessed needs, and specific objectives and methods of intervention or support to be implemented by the program to work towards progress and achievement of identified goals/needs with each individual...2. Objectives will be developed to address one specific learning result or behavioral outcome for the individual and a projected completion date..." No further information was presented prior to exit. 2.a. The QIDP failed to develop an ISP to promote Individual # 2's progress toward independence. Individual #2 was admitted to (name of group home) on 9/29/14 with diagnoses that included but were not limited to: moderate intellectual disability, autism and anxiety. On 5/25/16 Individual # 2's ISP (Individual Service Plan) dated 10/29/15 through 10/28/16 was reviewed. Individual # 2's ISP documented, "Goal 6- Important For (name of Individual #2) to have assistance accomplishing his personal care." Further review of goal six in Individual # 2's ISP failed to evidence clear measurable goals for Individual # 2 to progress toward independence. On 5/26/16 at 8:10 a.m., an interview was conducted with ASM (administrative staff member) #1 (the intermediate care facility supervisor) and ASM #2 (the QIDP [qualified intellectual disabilities professional]). ASM #2 stated the purpose of an ISP is to promote	W 159	2a. **How corrective action will be accomplished for individual #2:** The QIDP will revise the support plan for Individual #2 to reflect outcomes to encourage progress toward independence. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will review and revise support plans as necessary for each resident to ensure there are outcomes that encourage progress towards independence. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The facility staff will review the skills of each resident during the annual support plan meeting. The Comprehensive Functional and Clinical Assessments will be used to establish skill building outcomes aimed at increasing independence.	6/30/16

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W 159	Continued From page 19 independence and personal choices. ASM #2 was shown Individual #1's ISP. ASM #2 agreed goal six in the ISP didn't clearly document what the individual was learning and only documented the individual participated. No further information was presented prior to exit. 2.b. The QIDP failed to ensure staff implemented PECS (picture exchange communication system) per Individual #2's ISP (individual service plan). Individual #2 was admitted to (name of group home) on 9/29/14 with diagnoses that included but were not limited to: moderate intellectual disability, autism and anxiety. A speech and language report conducted by a speech and language pathologist on 10/18/15 documented, "While (name of Individual #2) is non-verbal, he has a great deal of means to communicate his wants and needs when in a controlled and familiar setting. These communication methods include grabbing his attendant or communicative partner by the hand and leading them to where he wants to go or seeking the location on his own, in which his attendant will follow. He also demonstrated an ability to choose between items by using an open handed tap to make his choices. (Name of individual #2) is able to demonstrate refusal by pushing away the item he does not want. Finally, (name of individual #2) exhibited loud vocalizations (mainly screams or squeals) several times. The purpose of these vocalizations appeared to be in frustration, but there were times in which they appeared to have no obvious function as well. No words or word approximations were heard during the evaluation... Recommendations: Based on this	W 159	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained. **Date of Completion:** 6/30/16 **2b.** **How corrective action will be accomplished for Individual #2:** The QIDP will monitor facility staff to ensure they are implementing the picture exchange communication system with Individual #2. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will monitor facility staff to ensure they are implementing the active treatment plan for each resident. **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 observe active treatment/implementation of outcomes for each resident. If a revision or clarification is necessary, the QIDP will revise the support plan and ensure all staff are trained on the changes.	6/30/16

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W 159	Continued From page 20 evaluation, the following recommendations are being made to assist (name of Individual #2) with his independence and functioning in his communication skills: 2. Learn more about his communication in the past and prior alternative communication methods (PECS, board maker pictures, high tech options) to determine if he would benefit from a low communication system to request or express his needs or if his current communication method is suffice..." Section five (plan for supports) of Individual #2's ISP (individual service plan) with a start date of 10/29/15 documented, "Goal 5- Important To and For (name of Individual #2) to keep a routinized schedule to help increase his ability to anticipate his activities. Goals: (Name of Individual #2) will have a daily routine to support him in reducing anxiety and staying regulated. Objective: Each setting (day support and residential) should choose one method that works for (name of Individual #2) and stick with it. 'First/Then' picture choices. Use PEC's and a transportable schedule/list. i.e. two PECS to represent, First Eat Breakfast, Then Brush Teeth. Each time adding the Then activity PEC's picture. Four items in a sequence- use four PEC's and a transportable schedule/list. Set up no more than four of the next activities. i.e. 1st- Eat Breakfast. 2nd- Brush Teeth. 3rd- Gather back pack with lunch 4th- Sit and wait. Items that contribute to success: verbal guidance through his daily schedule/routine to keep him moving; use the timed timer for activities and activities like waiting: show him the timer with the set time, provide verbal prompts to wait, point/focus on the time leaving the timer..." Observations of Individual #2 were conducted at	W 159	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained. **Date of Completion:** 6/30/16	

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the individual's day program on 5/24/16 from 2:30 p.m. until 3:35 p.m. and at the individual's home on 5/24/16 from 5:30 p.m. until 6:30 p.m. During these observations, staff failed to use picture choices and/or a timed timer to assist Individual #2 with communicating his schedule.

On 5/25/16 at 9:30 a.m., an interview was conducted with DSP (direct support staff) #3 regarding Individual #2's communication methods. DSP #3 stated staff verbally communicates to Individual #2 and he comprehends what is spoken to him very well. DSP #3 stated the individual communicates by pulling and pushing; the individual pulls an object that he wants and pushes an object that he does not want. When asked if any communication books, pictures or a PECS system was used with Individual #2, DSP stated those tools were not used because the individual gets irritated if "stuff" is in his space.

On 5/25/16 at 6:00 p.m., an interview was conducted with ASM (administrative staff member) #1 (the ICF [intermediate care facility] supervisor) and ASM #2 (the QIDP [qualified intellectual disabilities professional]). ASM #2 was shown Individual #2's ISP and asked to explain goal number five (as documented above). ASM #2 stated the speech language pathologist recommended using the "first then" picture tiles to help Individual #2 make choices about what he wants to do first and then what task he would like to complete next. ASM #1 and ASM #2 were made aware of the above findings.

The facility policy titled, "ICF Service: Active Treatment. Section 5-9: Implementation and Documentation" documented in part, " 1. The

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W 159	Continued From page 22 QIDP is responsible for making sure all staff is familiar with every resident's Person Centered Plan (PCP) (individual service plan). Staff will be trained, observed, and retrained as necessary in order to provide the supports and services as written in the PCP...4. Program Implementation: Each individual must receive a continuous active treatment program consisting of needed interventions and services in sufficient intensity and frequency to support the achievement of PCP objectives by all staff working with the individual..." No further information was presented prior to exit.	W 159		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on staff interview, residential record review and facility document review it was determined that the facility staff failed to develop ISPs (Individual Service Plans) to support individuals' move toward independence for two of three individuals in the survey sample, Individuals #1 and #2. 1. The facility staff failed to develop an ISP with interventions and measurable goals to support Individual # 1's progress toward independence. 2. The facility staff failed to develop an ISP with interventions and measurable goals to support Individual # 2's progress toward independence.	W 240	**W240** 1. **How corrective action will be accomplished for Individual #1:** The QIDP will revise the support plan for Individual #1 to reflect outcomes to encourage progress toward independence. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will review and revise support plans as necessary for each resident to ensure there are outcomes that encourage progress towards independence. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The facility staff will review the skills of each resident during the annual support plan meeting. The Comprehensive Functional and Clinical Assessments will be used to establish skill building outcomes aimed at increasing independence.	6/30/16

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The findings include:

1. The facility staff failed to develop an ISP with interventions and measurable goals to support Individual # 1's progress toward independence.

Individual #1 was admitted to (name of group home) on 11/28/14 with diagnoses that included but were not limited to: severe intellectual disability, glaucoma and osteoarthritis.

On 5/26/16 Individual #1's ISP (individual service plan) dated 12/29/15 through 12/28/16 was reviewed. Individual # 1's ISP documented, "Goal 2- Important To be connected to family and friends/peers." Further review of goal two in Individual # 1's ISP failed to evidence clear measurable goals for Individual # 1 to progress toward independence.

On 5/26/16 at 8:10 a.m., an interview was conducted with ASM (administrative staff member) #1 (the intermediate care facility supervisor) and ASM #2 (the QIDP [qualified intellectual disabilities professional]). ASM #2 stated the purpose of an ISP is to promote independence and personal choices. ASM #2 was shown goal two in Individual #1's ISP and asked what the individual was learning and how the goal was promoting independence. ASM #2 stated the goal was more about helping the individual maintain connections.

The facility policy titled, "ICF (intermediate care facility) Service: Active Treatment. Section 5-10: Goals and Objectives" documented in part, "It is the policy of (name of facility) that residents will have a Person Centered Plan (PCP) (ISP) that includes individualized goals based on assessed

How the facility plans to monitor its performance to make sure that solutions are sustained:
The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained.
Date of Completion:
6/30/16

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W 240	Continued From page 24 needs, and specific objectives and methods of intervention or support to be implemented by the program to work towards progress and achievement of identified goals/needs with each individual...2. Objectives will be developed to address one specific learning result or behavioral outcome for the individual and a projected completion date..." No further information was presented prior to exit. 2. The facility staff failed to develop an ISP with interventions and measurable goals to support Individual # 2's progress toward independence. Individual #2 was admitted to (name of group home) on 9/29/14 with diagnoses that included but were not limited to: moderate intellectual disability, autism and anxiety. On 5/25/16 Individual # 2's ISP (Individual Service Plan) dated 10/29/15 through 10/28/16 was reviewed. Individual # 2's ISP documented, "Goal 6- Important For (name of Individual #2) to have assistance accomplishing his personal care." Further review of goal six in Individual # 2's ISP failed to evidence clear measurable goals for Individual # 2 to progress toward independence. On 5/26/16 at 8:10 a.m., an interview was conducted with ASM (administrative staff member) #1 (the intermediate care facility supervisor) and ASM #2 (the QIDP [qualified intellectual disabilities professional]). ASM #2 stated the purpose of an ISP is to promote independence and personal choices. ASM #2 was shown Individual #1's ISP. ASM #2 agreed goal six in the ISP didn't clearly document what	W 240	2. **How corrective action will be accomplished for Individual #2:** The QIDP will revise the support plan for Individual #2 to reflect outcomes to encourage progress toward independence. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will review and revise support plans as necessary for each resident to ensure there are outcomes that encourage progress towards independence. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The facility staff will review the skills of each resident during the annual support plan meeting. The Comprehensive Functional and Clinical Assessments will be used to establish skill building outcomes aimed at increasing independence.	

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W 240	Continued From page 25 the individual was learning and only documented the individual participated. No further information was presented prior to exit.	W 240	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The RACSB Quality Assurance Department and/or program administration will conduct audits of individual records to ensure compliance is maintained. **Date of Completion:** 6/30/16	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, residential record review and facility document review, it was determined that the facility staff failed to implement active treatment for one of three individuals in the survey sample, Individual #2. The facility staff failed to implement PECS (picture exchange communication system) per Individual #2's ISP (individual service plan). The findings include: Individual #2 was admitted to (name of group home) on 9/29/14 with diagnoses that included but were not limited to: moderate intellectual disability, autism and anxiety. A speech and language report conducted by a speech and language pathologist on 10/18/15 documented, "While (name of Individual #2) is	W 249	**W249** **How corrective action will be accomplished for individual #2:** Facility staff have implemented active treatment for Individual #2's PECS communication system as written in the current support plan. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will implement active treatment 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 monthly and quarterly to ensure outcomes are implemented.	6/6/16

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W 249	Continued From page 26 non-verbal, he has a great deal of means to communicate his wants and needs when in a controlled and familiar setting. These communication methods include grabbing his attendant or communicative partner by the hand and leading them to where he wants to go or seeking the location on his own, in which his attendant will follow. He also demonstrated an ability to choose between items by using an open handed tap to make his choices. (Name of individual #2) is able to demonstrate refusal by pushing away the item he does not want. Finally, (name of individual #2) exhibited loud vocalizations (mainly screams or squeals) several times. The purpose of these vocalizations appeared to be in frustration, but there were times in which they appeared to have no obvious function as well. No words or word approximations were heard during the evaluation... Recommendations: Based on this evaluation, the following recommendations are being made to assist (name of Individual #2) with his independence and functioning in his communication skills: 2. Learn more about his communication in the past and prior alternative communication methods (PECS, board maker pictures, high tech options) to determine if he would benefit from a low communication system to request or express his needs or if his current communication method is suffice..." Section five (plan for supports) of Individual #2's ISP (individual service plan) with a start date of 10/29/15 documented, "Goal 5- Important To and For (name of Individual #2) to keep a routinized schedule to help increase his ability to anticipate his activities. Goals: (Name of Individual #2) will have a daily routine to support him in reducing anxiety and staying regulated. Objective: Each	W 249	**How the facility plans to monitor its performance to make sure that solutions are sustained:** ICF Management and QIDP will ensure that facility staff are implementing active treatment as written in each resident's current support plans through reviewing data collection and conducting observations. **Date of Completion:** 6/6/16	

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setting (day support and residential) should choose one method that works for (name of Individual #2) and stick with it. 'First/Then' picture choices. Use PEC's and a transportable schedule/list. i.e. two PECS to represent, First Eat Breakfast, Then Brush Teeth. Each time adding the Then activity PEC's picture. Four items in a sequence- use four PEC's and a transportable schedule/list. Set up no more than four of the next activities. i.e. 1st- Eat Breakfast. 2nd- Brush Teeth. 3rd- Gather back pack with lunch 4th- Sit and wait. Items that contribute to success: verbal guidance through his daily schedule/routine to keep him moving; use the timed timer for activities and activities like waiting: show him the timer with the set time, provide verbal prompts to wait, point/focus on the time leaving the timer..."

Observations of Individual #2 were conducted at the individual's day program on 5/24/16 from 2:30 p.m. until 3:35 p.m. and at the individual's home on 5/24/16 from 5:30 p.m. until 6:30 p.m. During these observations, staff failed to use picture choices and/or a timed timer to assist Individual #2 with communicating his schedule.

On 5/25/16 at 9:30 a.m., an interview was conducted with DSP (direct support staff) #3 regarding Individual #2's communication methods. DSP #3 stated staff verbally communicates to Individual #2 and he comprehends what is spoken to him very well. DSP #3 stated the individual communicates by pulling and pushing; the individual pulls an object that he wants and pushes an object that he does not want. When asked if any communication books, pictures or a PECS system was used with Individual #2, DSP stated those tools were not

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W 249	Continued From page 28 used because the individual gets irritated if "stuff" is in his space. On 5/25/16 at 6:00 p.m., an interview was conducted with ASM (administrative staff member) #1 (the ICF [intermediate care facility] supervisor) and ASM #2 (the QIDP [qualified intellectual disabilities professional]). ASM #2 was shown Individual #2's ISP and asked to explain goal number five (as documented above). ASM #2 stated the speech language pathologist recommended using the "first then" picture tiles to help Individual #2 make choices about what he wants to do first and then what task he would like to complete next. ASM #1 and ASM #2 were made aware of the above findings. The facility policy titled, "ICF Service: Active Treatment. Section 5-9: Implementation and Documentation" documented in part, "4. Program Implementation: Each individual must receive a continuous active treatment program consisting of needed interventions and services in sufficient intensity and frequency to support the achievement of PCP (person centered plan [individual service plan]) objectives by all staff working with the individual..." No further information was presented prior to exit.	W 249		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by:	W 288	**W288** **How corrective action will be accomplished for individual #3:** Facility staff have been retrained on the active treatment steps from Individual #3's positive behavioral support plan.	6/30/16

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W 288	Continued From page 29 Based on staff interview, residential record review and facility document review, it was determined that the facility staff failed to ensure behavior management was not used as a substitute for active treatment for one of three individuals in the survey sample, Individual #3. The facility staff locked Individual #3 outside of the home while the individual was displaying aggressive behavior toward other individuals. The findings include: Individual #3 was admitted to (name of group home) on 2/24/16 with diagnoses that included but were not limited to: moderate intellectual disability, seizures and allergies. Individual #3's behavior support plan dated 3/19/14 and 3/16/16 documented, "Previously Identified Problem Behaviors: Aggression toward others- pulling hair, pinching Property destruction- pulling apart notebooks Grabbing sharp objects, such a (sic) scissors or knives..." The "Procedures" documented to use social reinforcement when his behavior was appropriate and to withhold social reinforcement when his behavior was not appropriate. The plan failed to document any procedure such as locking Individual #3 outside of the home. Individual #3's ISP (individual service plan) with a start date of 3/25/16 through 3/24/17 failed to document any intervention related to locking the individual outside of the home. A facility "Fact Finding Report" (no date) documented, "On March 11, while reviewing March 9, 2016 video footage at (name of facility),	W 288	**Assurance that other residents are protected from the possibility of the deficiency:** Facility staff have been retrained on the active treatment steps from each resident's positive behavioral support plan. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** QIDP and ICF Management will monitor facility staff adherence to active treatment steps from each resident's behavioral support plan to ensure compliance in the facility. **How the facility plans to monitor its performance to make sure that solutions are sustained:** ICF Management will review each resident's behavioral support plan and active treatment at mandatory staff meetings at least annually. **Date of Completion:** 6/30/16	

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I noted that on two occasions (name of Individual #3) was escorted and appeared to be locked out of the front entrance of the ICF (intermediate care facility). The first occasion involved staff (DSP [direct support staff] #8) and the second involved staff person, (DSP #9)...

Prior to leaving the facility on March 11, I shared what I had observed on the video with the site supervisor (ASM [administrative staff member] #1)...She also stated that the incident involving (Individual #3) was bizarre. I informed her that I would be sharing my findings with the Deputy Executive Director, (name).

After being briefed on what I observed on the video, (name of Deputy Executive Director) sent an email to (name of ASM #4 [residential assistant coordinator]) and name of residential coordinator) asking them to review the video and provide a report on their findings.

Email was received from (ASM #4) at 3:50 stating the following: 'In talking to both staff, their stories were the same. (Individual #3) was having a difficult evening; they were attempting to redirect (Individual #3's) ongoing behaviors. (DSP #9) immediately saw our concern, and took the matter extremely serious. I'm not sure (DSP #8) completely understood our concern with the video, and this worries me. I have sent them both home on administrative leave; I believe we need to investigate this further. (ASM #1) is working on coverage. Please keep me posted as to next steps and however I can help. Thanks, (ASM #4).'

Face to Face interviews were held with (DSP #8) and (DSP #9) on March 14, 2016.

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Face to face interview with (DSP #9) March 14, 2016
(DSP #9) stated that on March 9, 2016, he was assigned to administer medication to the individuals at (name of facility). When asked about the situation involving (Individual #3), he stated that (Individual #3) was having a rough day. He reported that (Individual #3) attempted to hit several of his peers and had bitten one of the residents. There was an incident report submitted for (name of another individual) date of incident was March 9, 2016. The report stated (Individual #3) bit (name of other individual) on the left hand. (DSP #9) and I reviewed several clips of video to determine (Individual #3's) behaviors that evening.

Based on video footage of various angles of the house:

At approximately 4:34 PM (Individual #3) was put outside for the first time. When staff opened the door, staff continued to block (Individual #3's) entrance into the home. The second incident occurred shortly after the first. At one point during this situation (Individual #3) did go toward (name of another individual) as if he was going to hit him on the head. At this point (name of other individual) and (Individual #3) were lead outside. It appeared that they were going to the mail box. (Individual #3) headed back to the house and once he saw (name of another individual) he quickly went back down the drive way toward (name of other individual).
At approximately 4:38 PM (Individual #3) was in the kitchen with staff and (Individual #3) was observed running toward the living room area. Video of the living room area showed that

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(Individual #3) was headed toward (name of another individual). Staff, (DSP #9), intervened and redirected (Individual #3).
At approximately 4:49 PM (name of another individual) entered the back entrance of the ICF from the courtyard. The video from the courtyard showed staff close behind (name of other individual) as (name of other individual) was proceeding in a fast pace to the back door. (Individual #3) approached (other individual) and put (other individual's) hand in his mouth. Staff quickly intervened. Staff, (DSP #3), redirected (Individual #3) and staff member (DSP #2) attended to (other individual).

When asked if there was another staff person outside while (Individual #3) was placed outside, I was told that (DSP #2) was outside with (name of other individual); however (DSP #9) nor (DSP #8) informed (DSP #2) that they were making (Individual #3) stay outside. In addition, it should be noted that (DSP #2) was not in the immediate area of the front of the home as he and (name of other individual) were taking a walk to enjoy the weather.

There was much discussion regarding (DSP #9's) interaction with (Individual #3). He appeared to realize that there are better ways to handle situations when an individual is having a challenging day...

Face to face interview with (DSP #8) March 14th, 2016
(DSP #8) stated that he and (Individual #3) had gone on a walk with (DSP #2) and (other individual). (Individual #3) had become aggressive toward (other individual) thus (DSP #8) stated that he brought (Individual #3) back to

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the ICF so that (other individual) could finish enjoying his walk. (DSP #8) stated that he locked (Individual #3) out of the home to try and calm him down and so that he would not go after the other residents. When asked if he had informed (DSP #2) that he was leaving (Individual #3) outside, he reported no that he had not. He continued to state that even though (Individual #3) was outside he was keeping an eye on him through the peep hole. When asked about why he would leave (Individual #3) outside if the reason he had decided to bring him home was that he was aggressive toward (other individual) and (other individual) was still outside. (DSP #8) just repeated that he was watching him through the peep hole. (DSP #8) stated that his intent was not to violate (Individual #3's) rights he just wanted him to calm down and not be aggressive toward his housemates. (DSP #8) appeared to be having a challenging time understanding the concerns of leaving (Individual #3) outside...

Face to face interview with (ASM #1) March 14, 2016
(ASM #1) and I again discussed my findings. She stated that the behaviors of (DSP #9) and (DSP #8) were not acceptable. She stated that (DSP #9) is a good staff and that she thinks that (DSP #8) doesn't understand the concerns and that it may possibly (sic) due to his culture/native language..."

Further review of the above fact finding report, employee records and staff training records revealed DSP #8 was given a standard of conduct violation and transferred to another facility; DSP #9 was given a standard of conduct violation; Individual #3's behavior plan was reviewed and revised; staff were educated on

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Individual #3's behavior plan and monthly staff meetings were conducted.

On 5/25/16 at 1:00 p.m., an interview was conducted with ASM #4 regarding the above matter. ASM #4 stated Individual #3 was trying to "go after people" so staff put him on the front porch and was watching him through the peep hole. ASM #4 stated staff was supposed to follow Individual #3's behavior plan; to redirect and not isolate the individual. ASM #4 stated he remembered a staff member saying another staff member was outside walking another individual but the facility was Individual #3's home and staff couldn't just put him on the porch. ASM #4 stated DSP #9 was given a formal write up. ASM #4 stated DSP #8 was transferred to another facility. ASM #4 stated he got the impression that due to cultural reasons, DSP #8 didn't understand the seriousness of the situation until (ASM #4) really explained the situation to him. ASM #4 stated staff receives human rights training upon hire and yearly but the training doesn't give specific examples.

On 5/25/16 at 3:45 p.m. an interview was conducted with ASM #3 (the quality assurance coordinator who documented the fact finding report). ASM #3 stated she was watching video footage while investigating another incident and noticed Individual #3 was outside the door while DSP #8 and DSP #9 locked the door and appeared to be looking through the peep hole. ASM #3 stated she questioned why staff would do that and who else was outside. ASM #3 stated at one point (in the video), Individual #3 came inside, was escorted back outside and the door was shut. ASM #3 stated she conducted interviews with staff who told her DSP #2 was

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W 288	Continued From page 35 outside but she couldn't see DSP #2 in the video so he was not in Individual #3's line of sight. ASM #3 stated she reported this information to her supervisor who directed her to initiate the above documented investigation. ASM #3 confirmed Individual #3's behavior plan did not document directives to lock the individual outside of the home. On 5/25/16 at 6:00 p.m., ASM #1 (the ICF supervisor) and ASM #2 (the QIDP [qualified intellectual disabilities profession]) were made aware of the above concern. The facility policy titled, "Behavior and Facility Practices. Section 6-1: Behavior Supports" documented in part, "1. (Name of facility) will provide, support, guidance and positive intervention to assist residents in maintaining and/or gaining control over their behavioral responses to situations and stimuli...e. staff will only use positive and approved behavioral interactions (i.e. verbal praise, rewards systems, positive reinforcement) with individuals living at (name of facility)...k. Behavior Support Plans and interventions will not be utilized for the convenience orf (sic) staff or in place of an active treatment program..." No further information was presented prior to exit.	W 288		
W 389	483.460(m)(1)(ii) DRUG LABELING Labeling for drugs and biologicals must include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.	W 389	**W389** **How corrective action will be accomplished forthis deficient practice:** The ICF Nurse Manager discarded the vial of PPD solution per manufacturer's guidelines.	6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G065	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 389	Continued From page 36 This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to label an applicable expiration date on medication in one of one medication room. The facility staff failed to label an applicable open date/expiration date on one vial of Aplisol PPD (purified protein derivative) solution (a medication used in the diagnosis of tuberculosis [lung infection]) (1). Per manufacturer's instructions, the medication must be discarded 30 days after being opened. The findings include: On 5/24/16 at 5:35 p.m., observation of the medication room refrigerator was conducted. One vial of PPD solution was observed opened and approximately one eighth full. The vial and the box containing the vial failed to document an open date. At this time, an interview was conducted with RN (registered nurse) #1. RN #1 confirmed the PPD solution was used for individuals at the facility. RN #1 stated there was one dose left because the PPD solution was administered to the individuals the beginning of April for their annual tuberculosis tests. RN #1 was asked when the medication expired. RN #1 looked at the vial and stated the medication expired in March 2017. RN #1 was asked if there was any specific manufacturer's instructions regarding expiration after the medication was opened. RN #1 reviewed the manufacturer's instructions and stated the medication needed to be discarded because it should be discarded 30 days after being opened.	W 389	**Assurance that other residents are protected from the possibility of the deficiency:** The ICF Nurse Manager checked to confirm that there are no other open, unlabeled, or expired vials of medications present in the program. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** LPNs or the Nurse Manager will conduct monthly checks to ensure expiration dates are within range on opened medications. Any vials of multi-dose medications will be labeled with expiration dates once opened. Medications will be discarded when they expire per manufacturer's guidelines. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Pharmacist will conduct checks to ensure there are no expired medications in the facility. **Date of Completion:** 6/7/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 389	Continued From page 37 The manufacturer's instructions documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." On 5/25/16 at 6:00 p.m., ASM (administrative staff member) #1 (the ICF [intermediate care facility] supervisor) was made aware of the above findings. The facility policy titled, "Health Care- Section 7-11: Medication Storage, Transfer, Disposal" documented in part, "It is the policy of (name of facility) that the management of medication will be documented and monitored to ensure proper transfer, storage, and disposal according to state and federal regulations..." the policy failed to document further information regarding the above concern. No further information was presented prior to exit. (1) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134	W 389		