PRINTED: 09/19/2017 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DNSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		49G014	B. WING				09/08/2017	
	ROVIDER OR SUPPLIER	JP HOME		8207	ET ADDRESS, CITY, STATE, ZIP CO WOLFTRAP RD INA, VA 22180	DE		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENT	S	W 0	00				
	Intermediate Care Intellectual Disabilit 9/6/17 through 9/8/compliance with 42 for Intermediate Care Retarded. The Life follow. The census in this time of the survey. of four current India # 2, # 3, and # 4).	nnual Medicaid survey for Facilities for Persons with ies (ICF/ID) was conducted 17. The facility was not in CFR Part 483 Requirements re Facilities for the Mentally Safety Code survey report will 11 bed facility was 9 at the The survey sample consisted ridual reviews (Individuals # 1,				REO OCT VDH	EIVEL 10 2017 COLO	
W 111	483.410(c)(1) CLIE	NT RECORDS	W 1				10/10/17	
	recordkeeping syst	evelop and maintain a em that documents the client's treatment, social information, te client's rights.	1. The guardifiled in receive	4 conse an for s the Cli	for Individual #1-1a. ents for individual #1 were ser ignature. Once returned they nical Record. QIDP in charge vision regarding complete and	will be will	10/18/17	
	Based on staff intereview it was determined to ensure the and accurate for the survey sample, and la. For Individual #	s not met as evidenced by: erview and clinical record mined that the facility staff clinical record was complete ree of four individuals in the ividuals # 1, # 4, and # 3. 1 the facility staff failed to bying consents (four) were	time the 3. Progress will continued ensured 4. The randor	ete and ney will gram Di mplete e that co Office o n qualit	receive retraining on maintai accurate clinical record. Duri audit their assigned individua rector, Social Worker and/or a quarterly Clinical Record audi onsents are accurate and curr of Mission Effectiveness will contain ty audits twice a year to ensurance aregards to client records	ing which als record. Lead QIDP its to ent. onduct	10/18/17	
	signed and in the c for Release of Prot	linical record: "Authorization ected Health Information."	1. Staf	f respor	for Individual #1-1b. nsible for completion of Progr		10/18/17	
	1b. For Individual # ensure that there w 8/27/17.	1 the facility staff failed to as a "Progress Note" for	regard 2. Duri	ling com	or Individual #1 will receive su inpletion of daily progress note f meetings, Progress Note con red to ensure proper understa	es. npletion	10/18/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNA STANDARD. 1015/17

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.

(X6) DATE

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		49G014	B. WING	<u> </u>	09/08/2017			
NAME OF	ROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE				
MINERV	A FISHER HALL GRO	UP HOME		8207 WOLFTRAP RD VIENNA, VA 22180				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLETI			
W 111	Continued From pa	age 1	W	111				
	2a. For Individual # 4 the facility staff failed to ensure that the following consents were signed and in the clinical record: "Authorization for Release of Protected Health Information."		inclu there 4. Le	IDP's will review all data collection sheets uding progress notes every shift to ensure the are no gaps in documentation. ead Q will review documentation weekly	10/18/17			
	information in the "l	4 there was incorrect Progress Notes" - reference 2015 was in the ISP (Individual	lapse audit	uding, Progress Notes to ensure there are no e in completion. Program Director will rand t records monthly to ensure compliance wi we noted standard.	o domly			

3a. For individual # 3 no documentation was noted in the progress notes to indicate that on 4/11/17 the individual was transported without a safety device that was outlined in the Fall Protocol of the current ISP.

3b. For Individual # 3 the facility staff failed to ensure that the ISP (individual service plan) under "Outcomes & Activities" did not contain the following statement "See day program plan for support activities and instruction for this goal."

The findings include:

1a. For Individual # 1 the facility staff failed to ensure that the following consents (four) were signed and in the clinical record: "Authorization for Release of Protected Health Information."

Individual # 1 was admitted to the facility on 11/14/11 with diagnoses that included but were not limited to mild intellectual disability (1), anxiety, dementia Alzheimer's type, osteoarthrosis, osteoporosis, and hyperlipidemia.

During a clinical record review the following consents for "Authorization for Release of

483.410(c)(1) for Individual #4-2a. 1. The consents for individual #4 were sent to guardian for signature. Once returned they will be filed in the Clinical Record. QIDP in charge will receive supervision regarding complete and accurate clinical record. 2. QIDP's will receive retraining on maintaining a complete and accurate clinical record. During which time they will audit their assigned individuals record. 3. Program Director, Social Worker and/or Lead QIDP will complete quarterly Clinical Record audits to ensure that consents are accurate and current. 4. The Office of Mission Effectiveness will conduct random quality audits to ensure compliance in regards to client records. 483.410(c)(1) for Individual #4-2b. 1. The current ISP for individual #4 will be updated to include only information pertaining to the current retraining in regards to maintaining accurate files. 3. QIDP's will submit ISP's prior to due date, to the

- plan. The QIDP in charge will receive supervision and 2. QIDP's will receive retraining on completion of the
- ISP, while also auditing the ISP's of their current individual caseload for accuracy.
- Program Director, to be reviewed for accuracy. 4. The Office of Mission Effectiveness will conduct random quality audits to ensure compliance in regards to client records.

10/18/17..... 10/18/17 10/18/17..... 10/18/1710/18/17..... 10/18/17..... 10/18/17..... 10/18/17

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

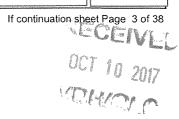
Event ID: LESO11



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 CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OŅ</u>	<u>лв NC</u>	<u>0. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		TE SURVEY
		49G014	B. WING	;		09	9/08/2017
 NAME OF	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		UD HOME		82	207 WOLFTRAP RD		
MINERV	A FISHER HALL GRO	UP HOME		V	IENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 111	Continued From pa	age 2	W	111	,		
	Protected Health In	formation" were found to be	483.41	10(c)	(1) for Individual #3-3a.		10/18/17
unsigned: Day Program (name identified),					ponsible for completion of Progress Note	e on	
		es Board, Physician (name of	3		or Individual #3 will receive supervision		***************
		tified), and (name of a	regard	ling c	details need when completing daily progi	ress	
		pany). Further review of the	notes.				
clinical record revealed that the most recent 2. During staff meetings, Progress Note completing staff meetings and Progress Note completing staff meetings and Progress Note completing staff meetings and Progress Note completing staff meeting staff m							10/18/17
	signed consents we	ere dated 12/22/10.	1		be included will be reviewed to ensure pr	roper	*******************
	During an interview	on 9/6/17 at 2:00 p.m. with			ding of standard.		40/40/47
	ASM (administrativ	e staff member) # 1, the	1		vill review all data collection sheets inclu-	aing	10/18/17
		a request for the most recent	1		otes every shift to ensure accuracy and		10/18/17
	signed consents wa	as made.	compl		iess. will review documentation weekly includ	ing	10/18/17
	m tutumitan	0/7/17 at 4:05 = m with	4		lotes to ensure they are accurate and	''''6'	***************************************
	During an interview	on 9/7/17 at 4:05 p.m. with stated that the consents for					
		ld have been signed but they	complete. Program Director will randomly audit records monthly to ensure compliance with the abo				***************************************
	were not.		noted	stan	dard.		
		on 9/8/17 at 9:50 a.m. this			(1) for Individual #3-3b.		10/18/17
	-	scussed with ASM # 1, the	1		rent ISP for individual #3 will be corrected	3	***************************************
	program manager.				e information pertaining to the day progr	ram	***************************************
	No further informat	ion was provided prior to exit.	1		n charge will receive supervision and in regards to maintaining accurate files.		10/18/17
		•	1	~	vill receive retraining on completion of the	ne ISP	10, 10, 17
	(1) Mild intellectual	disability is defined as an			, while also auditing the ISP's of their cur		
		it (IQ) in the range of 50-69.	1		caseload for accuracy.		
		as obtained from the website:	ŧ	_	ram Director will review upcoming plans		10/18/17
	https://www.ncbi.nii	m.nih.gov/medgen/10044	includ	ing o	outcomes, prior to their start date, to ens	sure	
			accura				10/18/17
	1b. For Individual #	1 the facility staff failed to			ce of Mission Effectiveness will conduct	arda	
	ensure that there w 8/27/17.	ras a "Progress Note" for			uality audits to ensure compliance in rega ecords.	ZUIE	revenoussossessessesses
	ASM # 1, the progr	on 9/7/17 at 4:05 p.m. with am manager, a request for gress Note was requested.	Yandesananananananananananananananan				

During an interview on 9/8/17 at 9:50 a.m. this



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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			O	<u> MB NO. 0938-0391</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G014	B. WING	;	overage and the second	09/08/2017
NAME OF I	PROVIDER OR SUPPLIER	And the state of t		STI	REET ADDRESS, CITY, STATE, ZIP CODE	
MINERV	A FISHER HALL GRO	HOME	ļ	ı	07 WOLFTRAP RD	
MILLATIONS	4 FIGHER HALL ONG	OF HOWE		VIF	ENNA, VA 22180	The second secon
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
W 111	Continued From pa	age 3	W	111		
		ed with ASM # 1, who stated				
	what is going on in Individual has an IS that outlines a prog build skills. If there daily skill building a	e used daily to communicate the Individuals life - each SP (individual Service Plan) gram that helps the individual to e is not a note for each of the activities then there is no t the ISP program is being				
	No further informat	tion was provided prior to exit.				
	ensure that the follo signed and in the cl for Release of Prote	# 4 the facility staff failed to owing consent (one) was dinical record: "Authorization rected Health Information."				
	5/19/15 with diagno	admitted to the facility on oses that included but were not other transfer and seizures.				
	consent for "Author Protected Health In unsigned. This con Further review of th	cord review the following rization for Release of aformation was found to be assent was for a physician. The clinical record revealed that and naming this physician was				
	ASM (administrative	on 9/6/17 at 2:00 p.m. with e staff member) # 1, the a request for the most recent s made.				





During an interview on 9/7/17 at 4:05 p.m. with

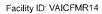
PRINTED: 09/19/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> DMB NO. 0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G014	B. WING		09/08/2017
	PROVIDER OR SUPPLIER	UP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 8207 WOLFTRAP RD VIENNA, VA 22180	
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
W 111	Individual # 4 shoul not. ASM # 1 then consent dated 9/6/2 During an interview issue was again disprogram manager. No further information 1. Severe intellectured disorders character capacity and difficus such as managing routines, or social indisability originates result from physical cerebral palsy, or fras lack of stimulation This information was https://report.nih.gott.aspx?csid=100	stated that the consent for d have been signed but it was presented a newly signed 17. on 9/8/17 at 9:50 a.m. this scussed with ASM # 1, the ion was provided prior to exit. al disability refers to a group of rized by a limited mental lty with adaptive behaviors money, schedules and interactions. Intellectual before the age of 18 and may I causes, such as autism or om nonphysical causes, such on and adult responsiveness. as obtained from the website: by/nihfactsheets/ViewFactShee	W 1	111	
	information in the "la program from 20" Service Plan).	4 there was incorrect Progress Notes" - reference to 15 was in the ISP (Individual rent ISP dated 07/01/2017			
	through 07/30/2018 Outcome # 1: Self- "Support Activities of Individual # 4) parti by brushing my tee	ent ISP dated 07/01/2017 3 documented the "Desired care and independence." & Instructions: (Name of cipates in my self-care routine th daily with a soft bristle f will inform (Name of			



Individual # 4) that it is time to brush his teeth. 2.



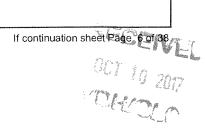






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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				Or	<u>NR NO.</u>	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTI				E SURVEY PLETED
		49G014	B. WING	i			09/	08/2017
NAME OF I	PROVIDER OR SUPPLIER		1	STREET AD	ODRESS, CITY, STATE, ZIF	P CODE	······································	
MINERV	A FISHER HALL GRO	UP HOME			FTRAP RD VA 22180			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C EACH CORRECTIVE ACTI OSS-REFERENCED TO TO DEFICIENCY	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
W 111	toothbrush then appassist (Name of Inchand assistance. 4) is unable to comcomplete it for him. documentation. From When the progress additional program Independence" proprogram was dated was documented in the Current ISP as 08/31/2015 I dress 1. (Name of Individual his choice to wear following the Individual (Name of Individual head first than put Individual head first	ne of Individual # 4)'s bely toothpaste. 3. Staff will lividual # 4) with hand over . When (Name of Individual # plete the task, staff will 5. Complete the necessary equency: Daily." notes were reviewed an under the "Self Care and gram was inserted. This 08/31/2015. This program the progress notes but not in follows: "Date Range: myself by putting on my shirt. and # 4) will choose the shirt of or the day. 2. Staff will hand # 4) the shirt he chooses. 3. # 4) will put the shirt over his his arms through the sleeves. (name of Individual # 4) to pull of his shirt down if necessary. We the needed documentation." documented in the Progress en done. on 9/7/17 at 4:05 p.m. with stated the reference to a was a computer error and	W	111				
	No further informati	on was provided prior to exit.						



3a. For individual # 3 no documentation was

noted in the progress notes to indicate that on

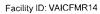
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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	S OMB NO. 0938-03				
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED	
		49G014	B. WING		(09/08/2017	
	PROVIDER OR SUPPLIER	UP HOME	I	STREET ADDRESS. CITY, STATE, Z 8207 WOLFTRAP RD VIENNA, VA 22180			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 111	safety device that we Protocol of the curre Individual # 3 was a 2/5/13 with diagnos limited to: profound autism (2), osteoped During a review of Individual # 3 dated documentation that without a seatbelt at Review of Individual # 3 dated documentation that without a seatbelt at Review of Individual # 3 dated documents a "Fall Indocuments a "Fall Indocumented: "Weat am traveling in a vertravel." During an interview DSP (direct support (DSP # 4) was taking her day program. It (in the vehicle) and adjuster in the vehicle and adjuster in the vehicles, but did che find the seatbelt addividual # 3) in the belt without the seat driving I noticed that out of her seatbelt Individual # 3).	al was transported without a was outlined in the Fall ent ISP. admitted to the facility on less that included but were not intellectual disability (1), enia, and seizure disorder.		111			



record (progress notes) that the seatbelt adjuster was not used during transport. DSP stated that



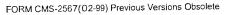






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		AND HUMAN SERVICES			0		938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			T		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE S	
		49G014	B. WING			09/08	8/2017
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		UD UOME		82	07 WOLFTRAP RD		
MINERVA	FISHER HALL GRO	UP HOME	e de la company	VII	ENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 111	During an interview ASM # 1, Individual progress notes that were reviewed. AS opportunity to prese time and was unab information for the During an interview issue was again disprogram manager. No further informate the characterized by a difficulty with adapt managing money, social interactions. before the age of 1 causes, such as an nonphysical causes.	at she (DSP # 4) was nat documentation. You on 9/7/17 at 10:42 a.m. with I # 3's ISP and each daily towas lacking documentation is M # 1 was given the ent any documentation at this le to provide any further progress notes outlined above. You on 9/8/17 at 9:50 a.m. this is scussed with ASM # 1, the scussed with ASM # 1, the limited mental capacity and tive behaviors such as schedules and routines, or Intellectual disability originates 8 and may result from physical utism or cerebral palsy, or from s, such as lack of stimulation weness. This information was	W	1111			
	t.aspx?csid=100	ov/nihfactsheets/ViewFactShee					



/autism/index.cfm

website:

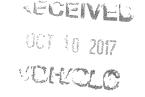
disorder (ASD), is a disorder that causes impairment in social interaction, as well as the presence of repetitive, restricted behaviors and interests. This information was obtained from the

https://www.niehs.nih.gov/health/topics/conditions









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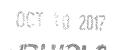
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G014	B. WING			09/08/2017
NAME OF I	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
MINERV	A FISHER HALL GRO	UP HOME			WOLFTRAP RD INA, VA 22180	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
W 111	Continued From pa	ine 8	W	111		
	(3) Seatbelt adjuste	er is a device used to prevent slipping out of her seatbelt per	•			
	ensure that the ISP "Outcomes & Activition following statement	3 the facility staff failed to (individual service plan) under ties" did not contain the :: "See day program plan for and instruction for this goal."				
	in the ISP (individual dated 03/1/2017 that Activities" the follow documented: under Individual # 3) uses stimulation" Under	r "Desired Outcome: (Name of vibrating sensory objects for r "Support Activities & lay program plan for support				
	ASM # 1, the progra	on 9/7/17 at 10:45 a.m. with am manager, this concern was stated that it was an error.				
		on 9/8/17 at 9:50 a.m. this cussed with ASM # 1, the				
W 159	No further informati 483.430(a) QIDP	ion was provided prior to exit.	W ·	159		
	integrated, coordina qualified intellectua This STANDARD is Based on residenti interview, it was def	treatment program must be ated and monitored by a I disability professional. Is not met as evidenced by: al record review and staff termined that the facility staff to the QIDP (Qualified)				

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

Event ID: LESO11

Facility ID: VAICFMR14

If continuation sheet Page 9 of 38



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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391				
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	()	X3) DATE SURVEY COMPLETED		
		49G014	B. WING			09/08/2017		
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
		UD UOME		8207 WOLFTRAP RD				
MINERVA	A FISHER HALL GRO	UP HOME		VIENNA, VA 22180				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD B			
W 159	Continued From pa	ae 9	W ·	159				
		ies Professional) coordinated,		O(a) for Individual #1		10/18/17		
		itored an individual's active	š	QIDP in charge will receive supervision	and			
		for four of four individuals in		ng in regards coordinating and monito				
		Individuals # 1, # 2, # 3, and #	active t	reatment. During staff meetings,		•••••		
	4.			entation and how to document individ				
		e e e e e e e e e e e e e e e e e e e		giene and health habits program will b	e			
		to coordinate and monitor the		to ensure staff understanding		***************************************		
		an for Individual # 1 to ensure iene and health habits		ng team meetings, all individuals ISP		10/18/17		
	program was accur	ately implemented		ill be reviewed with staff to ensure p	roper			
	program was accur	atery implemented.		tanding and documentation.		40/40/47		
	2. The QIDP failed	to coordinate and monitor the		's will review all data collection and		10/18/17		
		an for Individual # 2 to ensure		ss notes each shift to ensure that data	a is	10/18/17		
		giene and Organization of	ŧ.	ed completely, correctly and in		10/16/17		
		s program was accurately	\$	rable terms. ram Director will review progress no	ntac			
	implemented.			ta collections sheets weekly to ensure				
	a. The OIDD foiled:	to coordinate and monitor the		ollection is done in measurable terms				
		an for Individual # 3 to ensure		of Mission Effectiveness will periodica				
		-care activity to improve her		ecords to ensure compliance with the				
		dence was accurately	\$	listed corrections.	2000			
	implemented.	•			Innovitation			
	·		483.43	O(a) for Individual #2	***************************************	10/18/17		
		to coordinate and monitor the	4	QIDP in charge will receive supervision a	and			
		n for Individual # 4 to ensure	\$	ng in regards to coordinating and				
		ticipation in his self-care		ring active treatment. During staff				
	implemented.	teeth daily was accurately		gs, implementation and how to docum	ent			
	impiementeu.		1	ual #2's hygiene and organization of				
	The findings include	e:	1 .	al belongings program will be review to)			
				staff understanding ng team meetings, all individuals ISP	and	10/18/17		
		to coordinate and monitor the	£	ng team meetings, an murrituals isr ill be reviewed with staff to ensure p		10/18/17		
	active treatment pla	an for Individual # 1 to ensure		etanding and documentation.	oher			
		oved her hygiene and health		P's will review all data collection and	niversacientes	10/18/17		
	habits program was	accurately implemented.	3	ss notes each shift to ensure that data	a is			

Individual # 1 was admitted to the facility on

11/14/11 with diagnoses that included but were not limited to mild intellectual disability (1),

measurable terms.

collected completely, correctly and in



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	DS EOR MEDICARE	& MEDICAID SERVICES			OM	3 NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			3) DATE SURVEY COMPLETED
		49G014	B. WING	j		09/08/2017
NAME OF F	PROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	CODE	
MINERV	A FISHER HALL GRO	UP HOME		8207 WOLFTRAP RD VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BI	(X5) E COMPLETION TE DATE
W 159	Continued From pa	age 10	W	159		
a o Ir P d w	anxiety, dementia Alzheimer's type, osteoarthrosis, osteoporosis, and hyperlipidemia. Individual # 1's current ISP (Individual Service Plan) dated 01/01/2017 through 12/31/2018 documented "Desired Outcome: I (Individual # 1) would like to improve hygiene and health habits."			gram Director will review progress recollections sheets weekly to ensure to tion is done in measurable terms. The sign Effectiveness will periodically and to ensure compliance with the above the sign of the sig	that data The office audit	10/18/17
				ctions. 30(a) for Individual #3.		10/18/17
	A. Support Activities & Instructions: (Name of Individual # 1) performs oral care which includes, but is not limited to brushing her teeth and using her water pik twice a day." Under "Support Instructions" it documented, "1. Prompt (name of Individual # 1) of the time and the need to perform oral care. 2. Support with collecting needed items with verbal prompts. 3. Support with preparing the tooth brush, water pik, etc. with verbal prompts. 4. Give verbal prompts how to complete the task fully. 5. Give (name of Individual # 1) reinforcement for participating and review areas that can be improved." "Frequency: Daily."		1. The retrain monit meeti individuo ens 2. Dur data vunder 3. QIE progracollecterms 4. Pro	e QIDP in charge will receive superviously in regards to coordinating and foring active treatment. During staffings, implementation and how to do dual #3's Self Care program will be resure staff understanding. The staff to ensure standing and documentation. OP's will review all data collection are ess notes each shift to ensure that of the ted completely, correctly and in meaning and Director will review progress of gram Director will review progress.	ocument reviewed SP and e proper and data is easurable notes and	10/18/17
	Individual # 1) brus "Support Instruction (Name of Individua to brush her hair. 2 needed items with prompts how to con (name of Individual	s & Instructions: "(Name of hes her hair once daily." Underns" it documented, "1. Prompt I # 1) of the time and the need. Support with collecting verbal prompts. 3. Give verbal mplete the task fully. 5. Give # 1) positive reinforcement for eview areas that can be ency: Daily."	collec of Mis recore correc	collections sheets weekly to ensure tion is done in measurable terms. T ssion Effectiveness will periodically a ds to ensure compliance with the ab ctions.	The office audit	
		e" for Individual # 1 dated 5/17 were reviewed. The	vaeeeeeeeeeeeeeeee			

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health habits program.

progress notes failed to evidence accurate implementation of Individual # 1's hygiene and

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			JIVID 140. 0000 0001
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49G014	B. WING		09/08/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MINIERVA	FISHER HALL GRO	UP HOME		8207 WOLFTRAP RD	
MILLATTICAL				VIENNA, VA 22180	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLETION
W 159	Continued From pa	age 11	W	159	
			483.4	30(a) for Individual #4.	10/18/17
	**On 8/23/17 Morni	ing Shift documented,		e QIDP in charge will receive supervision ar	
	"Individual's Partici	pation: Individual actively		ning in regards to coordinating and monito	oring
	participated-She br	rush (sic) her teeth and hair."		e treatment. During staff meetings,	
	**On 8/22/17 Even	ing Shift documented,		mentation and how to document individu	
	"Individual's Partici	pation: Individual actively	*	eeth brushing outcome will be reviewed to	1
	participated-(initials	s of Individual # 1) did (sic) her	ensur	e staff understanding. ring team meetings, all individuals ISP and	data 10/19/17
	hygiene before she	went for bed this evening,		e reviewed with staff to ensure proper	uata 10/16/17
	staff member watch	hed her while she did it. She	1	rstanding and documentation.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	brush (sic) her teet	h and hair."		DP's will review all data collection and prog	1
		Chiff de companhe d		s each shift to ensure that data is collected	20, 20, 2,
	**On 8/24/17 Morn	ing Shift documented, pation: Individual actively		eletely, correctly and in measurable terms.	
	narticipated (name	of Individual # 1) brushed her		ogram Director will review progress notes a	ind 10/18/17
	teeth and hair when	n DSP prompted her to do so."	data	collections sheets weekly to ensure that da	ita
	teeth and han more			ction is done in measurable terms. The off	ce 🌡
				ssion Effectiveness will periodically audit	***************************************
		ing Shift documented,	8	ds to ensure compliance with the above lis	ted
	"Individual's Partici	pation: Individual actively	corre	ctions.	****
	participated-(initials	s of Individual # 1) did her			
	hygiene before she	e went for bed this evening, hed her while she did it."			03-00 C
	Stall member watc	ned her willie she did it.			
	On 8/27/17 No pr	rogress provided for this date."			*************************************
	**On 8/28/17 Even	ing Shift documented,			
	"Individual's Partici	pation: Individual actively	NO.		
	participated-(initials	s of Individual # 1) did her	***************************************		150000000000000000000000000000000000000
	hygiene when she	was supposed to before she	***************************************		
	went for bed for the	e night tonight."			water
	Distance on intomical	v on 9/7/17 at 9:50 a.m. with	***************************************		riceres
	OSM (other staff m	nember) # 1, QIDP (Qualified			***************************************
	Intellectual Disabili	ties Professional), the purpose			*********
	of the ISP was disc	cussed. OSM # 1 stated that			and a second
		ery day and staff work the			

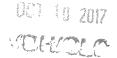
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program consistently every day. When asked what the responsibility of the QIDP was, OSM # 1

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		49G014	B. WING		09	9/08/2017
	PROVIDER OR SUPPLIER A FISHER HALL GRO	UP HOME		STREET ADDRESS, CITY, STATE, ZIP COL 8207 WOLFTRAP RD VIENNA, VA 22180	ЭE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
W 159	to follow the ISP. Of monitored on a weet problem she would. During an interview ASM (administrative Program Director at of a QIDP were disting the responsibilities coordinating the ISI assisting in development and ASM # 1 statement ASM # 1 statement is a goal the	ne responsibility of all the staff OSM # 1 stated that she ekly basis and if she saw a	W 1	159		
	ASM # 1, Individual progress notes that were reviewed. AS opportunity to prese time and was unablinformation for the The facility's policy Retardation Profes QMRP is responsible coordination, monit Individual Service Factive treatment in Qualified Intellectual Monitoring Of Service Review consumer in	on 9/7/17 at 10:42 a.m. with I # 1's ISP and each daily twas lacking documentation IM # 1 was given the ent any documentation at this le to provide any further progress notes outlined above. "8.1 Qualified Mental sional" documented, "The ole for the integration, oring and development of the Plan, and to ensure quality the program." Under "8.1.2 al Disabilities Professional ices" it documented, "A. records to include clinical, cal to ensure prescribed				

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treatment and services are being implemented correctly, documented appropriately and that any

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				IND NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
		49G014	B. WING			09/0	08/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GRO	UP HOME			07 WOLFTRAP RD ENNA, VA 22180		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	DBE	(X5) COMPLETION DATE
W 159	program services."	ve been incorporated into	W	159			
	NOTE: QDIP and (professional.	QMRP refer to the same					
	intelligence quotier This information wa	disability is defined as an at (IQ) in the range of 50-69. as obtained from the website: m.nih.gov/medgen/10044					
	No further informat	ion was provided prior to exit.					
	active treatment plathis Individual's Hy	to coordinate and monitor the an for Individual # 2 to ensure giene and Organization of s program was accurately					
	1/21/12 with diagno	admitted to the facility on oses that included but were not e intellectual disability (1), gastroesophageal reflux teopenia.	t				
	through 02/28/2018 Outcome: A. (Namminutes and work violean off all soiled ibriefs into garbage Individual # 2) to put	rent ISP dated 03/01/2017 B documented the "Desired he of Individual # 2) to take 15 with support staff modeling to tems (linen, pajamas and put) from her bed. B. (Name of at laundry into washer and ther the dryer only, three times a	٦				
	Individual # 2) to pl	s & Instructions: 1. (Name of ace soiled items in her hampe ge can, each morning after	r				

02/1/07/2017

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awaking for the day. 2. (Name of Individual # 2)

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CONTENS OF OUR MEDIC	JI (I C G WILDIO) IID OLI (VIOLO			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED
	49G014	B. WING		09/08/2017
NAME OF PROVIDER OR SUP MINERVA FISHER HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 8207 WOLFTRAP RD VIENNA, VA 22180	`
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
			ž.	

W 159 Continued From page 14

to ask any questions of staff in regard to cleaning bed. 3. (Name of Individual # 2) to engage in verbal conversation about tasks with staff modeling cleaning and organizing bed with her (how she is feeling, her thoughts, any concerns she may have). 4. (Name of Individual # 2) to perform tasks to clean and organize her bed in the morning for 15 minutes. 5. Please take into consideration (Name of Individual # 2)'s health status at all times. She may not be able at times to demonstrate all tasks completely." "Frequency: Daily."

B. Support Activities & Instructions: "1. (Name of Individual # 2) to be assisted by support staff modeling putting laundry into the washing machine and then the dryer with her. 2. (Name of Individual # 2) to put her laundry into the washer and dryer only with support staff assistance. 3. (Name of Individual #2) to talk and ask any questions for further clarification of how to clean and dry laundry while performing these tasks with staff. 4. (Name of Individual # 2) to talk with support staff modeling and assisting her with any concerns, comments, feelings and/or thoughts. 5. Please take into consideration (Name of Individual # 2)'s health status at all times. She may not be able at times to demonstrate all tasks completely. Therefore, support staff to assist further by cleaning and organizing the remainder of her clothing and bedroom." "Frequency: Daily." Three times a week.

The "Progress Note" for Individual # 2 dated 8/23/17 through 9/5/17 were reviewed. The progress notes failed to evidence accurate implementation of Individual # 2's hygiene and health habits program.

W 159

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Event ID: LESO11

Facility ID: VAICFMR14

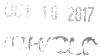
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CENTER	(2 FOR MEDICARE	& MEDICAID SERVICES				T
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
		49G014	B. WING			09/08/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
MINERVA	A FISHER HALL GRO	UP HOME		8207 WOLFTRAP RD VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	macananioro to ti	ON SHOULD IE APPROP	BE COMPLÉTION
W 159	"Individual's Participarticipated-(Name soiled items in her I	ge 15 ng Shift documented, pation: Individual actively of Individual # 2) to place namper and briefs in garbage. I # 2) did not do laundry during	W	159		
	"Individual's Particip participated-Staff p	end Shift documented, pation: Individual actively rompt (sic) and supported her provide everything she need."				
	"Individual's Particip	end Shift documented, pation: Individual actively of Individual # 2) did her and support."				
	"Individual's Particip participated-(Name staff with picking or	end Shift documented, pation: Individual actively of Individual # 2) assisted at her outfit for the day and she er with assistant (sic) from				
	"Individual's Participarticipated-(Name	end Shift documented, pation: Individual actively of Individual # 2) put laundry e put the clean cloth (sic) her done."				
	Individual # 2) to ta support staff model (linen, pajamas and her bed. And this is that Outcome "B. (National Properties)	tion of Outcome "A (Name of ke 15 minutes and work with ing to clean off all soiled items d put briefs into garbage) from s the only time in two weeks Name of Individual # 2) to put and then when finished into e times a week." Outcome A				

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was to be done daily and outcome B was to be

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	i 014 B.	3. WING		
				09/08/2017
NAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GROUP HOME		8	STREET ADDRESS, CITY, STATE, ZIP CODE 3207 WOLFTRAP RD VIENNA, VA 22180	
(X4) ID SUMMARY STATEMENT OF DEFICE PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION

W 159 Continued From page 16 done three times a week.

> During an interview on 9/7/17 at 10:37 a.m. with ASM # 1, Individual # 2's ISP and each daily progress notes that was lacking documentation were reviewed. ASM # 1 was given the opportunity to present any documentation at this time and was unable to provide any further information for the progress notes outlined above.

No further information was provided prior to exit.

- (1) Moderate intellectual disability refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactShee t.aspx?csid=100
- (2) Cerebral palsy-- a group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpals y.html.
- (3) Gastroesophageal reflux disease-- Stomach contents to leak, or reflux, into the esophagus and irritate it. This information was obtained from the website:

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

W 159

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Event ID: LESO11

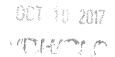
Facility ID: VAICFMR14

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	MR NO:	<u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '		CONSTRUCTION		SURVEY
		49G014	B. WING	************		09/0	8/2017
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	A FISHER HALL GRO	UP HOME			07 WOLFTRAP RD		
WILLACTOR	THORER HALL ON			VI	ENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 159	active treatment plathis Individual's self health and indepenimplemented. Individual # 3 was a 2/5/13 with diagnos limited to: profound autism (2), osteope Individual # 3's currithrough 02/28/2018 Outcome: (Individual activities to improve would like to improve w	to coordinate and monitor the an for Individual # 3 to ensure f-care activities to improve her dence was accurately admitted to the facility on see that included but were not intellectual disability (1), enia, and seizure disorder. The time of the matter of the matt		59			
	The "Progress Note	e" for Individual # 3 dated					

8/23/17 through 9/5/17 were reviewed. The progress notes failed to evidence accurate



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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				JIVID INO. 0936-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G014	B. WING	·		09/08/2017
NAME OF F	ROVIDER OR SUPPLIER			\$	TREET ADDRESS, CITY, STATE, ZIP CODE	
MINICOVA	A FISHER HALL GRO	HOME		1	207 WOLFTRAP RD	
MINATIVA	A FISHER HALL ORO	OT FIGHT		V	IENNA, VA 22180	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
W 159	independence prog	nge 18 ndividual # 3's hygiene and gram (tooth brushing and	W	159		
	"Individual's Participarticipated-Goal a **On 8/25/17 Eveni "Individual's Participarticipated-staff m Individual # 3) hair her pajamas this ex **On 8/30/17 Eveni "Individual's Participarticipated-staff m changing her for th **On 8/30/17 Eveni "Individual's Participarticipated-(Initials in her care manage **On 8/31/17 Morni "Individual's Partici	ing Shift documented, pation: Individual actively ember brushes her hair after				
	During an interview ASM # 1, Individua progress notes that were reviewed. AS opportunity to present the supportunity the supportunity to present the supportunity to present the supportunity to present the supportunity the supportunity the supportunity the supportunity the supportunity the supportunity the sup	off her pants and top with orts from DSP." on 9/7/17 at 10:42 a.m. with I # 3's ISP and each daily twas lacking documentation BM # 1 was given the ent any documentation at this leto provide any further.				

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information for the progress notes outlined above.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	49G014	B. WING		09/08/2017
NAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GRO	UP HOME	•	STREET ADDRESS, CITY, STATE, ZIP CODE 8207 WOLFTRAP RD VIENNA, VA 22180	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TO THE ADDROLL TO THE ADDROLL	D BE COMPLETION
			į	

W 159 Continued From page 19

No further information was provided prior to exit.

(1) Profound -- Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website:

https://report.nih.gov/nihfactsheets/ViewFactShee t.aspx?csid=100

(2) Autism, also known as autism spectrum disorder (ASD), is a disorder that causes impairment in social interaction, as well as the presence of repetitive, restricted behaviors and interests. This information was obtained from the website:

https://www.niehs.nih.gov/health/topics/conditions /autism/index.cfm

4. The QIDP failed to coordinate and monitor the active treatment plan for Individual # 4 to ensure this Individual's participation in his self-care routine to brush his teeth daily was accurately implemented.

Individual # 4 was admitted to the facility on 5/19/15 with diagnoses that included but were not limited to: severe intellectual disability (1), osteoporosis, anemia, and seizures.

Individual # 4's current ISP dated 07/01/2017 through 07/30/2018 documented the "Desired Outcome # 1. Self-care and independence.

W 159

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Facility ID: VAICFMR14



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CENTERS FOR ME	EDICARE	& MEDICAID SERVICES			MB NO. 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G014	B. WING		09/08/2017
NAME OF PROVIDER OR	SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MINERVA FISHER H	ALL GRO	UP HOME		8207 WOLFTRAP RD	
MINERVATIONER	ALL ONG	· · · · · · · · · · · · · · · · · · ·		VIENNA, VA 22180	
PREFIX (EACH	DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
W 159 Continued	l From pa	age 20	W 1	59	
	-	& Instructions: (Name of			
Individual	#4) parti	cipates in my self-care routine			
		th daily with a soft bristle f will inform (Name of			
Individual	1. 1. Stat # 4) that	it is time to brush his teeth. 2.			
Staff will r	inse (Nar	ne of Individual # 4)'s			
		ply toothpaste. 3. Staff will dividual # 4) with hand over			
		1. When (Name of Individual #			
4) is unab	le to com	plete the task, staff will			
		5. Complete the necessary equency: Daily."			
document	alion. Fi	equency. Daily.			
		es" for Individual # 4 dated 5/17 were reviewed. The			
		ed to evidence accurate			
		Individual # 4's self-care			
independe	ence (too	th brushing).			
Review of	the "Pro	gress Notes" dated 8/24/17			
		Individual # 4 revealed no this Desired Outcome for			
		implemented.			
		on 9/7/17 at 10:42 a.m. with			
		I # 4's ISP and each daily t was lacking documentation			**
were revie	wed. AS	SM # 1 was given the			
opportunit	y to pres	ent any documentation at this			
		le to provide any further progress notes outlined above.			
No further	· informat	ion was provided prior to exit.			
		al disability refers to a group of rized by a limited mental			

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capacity and difficulty with adaptive behaviors

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Facility ID: VAICFMR14

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OLIVILINO I ON MILON	JACE OF WILD TO AND OF TAKEOFO		10.0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	X3) DATE SURVEY COMPLETED
	49G014	B. WING	09/08/2017
NAME OF PROVIDER OR SUP		STREET ADDRESS, CITY, STATE, ZIP CODE 8207 WOLFTRAP RD VIENNA, VA 22180	
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
routines, or so disability origi result from ph cerebral palsy as lack of stim This informati https://report.r t.aspx?csid=1	iging money, schedules and ocial interactions. Intellectual nates before the age of 18 and may ysical causes, such as autism or or or from nonphysical causes, such ulation and adult responsiveness. on was obtained from the website: hih.gov/nihfactsheets/ViewFactShe	1	
As soon as the formulated a control of the formulated and the following and frequency and frequency	e interdisciplinary team has client's individual program plan, ust receive a continuous active gram consisting of needed and services in sufficient number to support the achievement of the ntified in the individual program	483.440(d)(1) for Individual #3 1. Staff supporting individual #3 at the time of the incident will receive disciplinary action and retraining on the fall protocol. During staff meetings the fall protocol and proper use of the seat belt adjuster with the seat belt and proper was also belt and pr	10/18/17
Based on sta review, it was failed to ensur services cons Plan for one of sample, Indiv	RD is not met as evidenced by: ff interview and clinical record determined that the residential staf e an Individual was receiving istent with the Individual Support f four Individuals in the survey idual # 3. siled to implement Individual # 3's	supporting documentation. LPN's will review protocols on a quarterly basis to ensure that they a	re 10/18/17
Fall Protocol r The findings in Individual # 3 2/5/13 with dia	elated to safe transport.	will conduct periodic program audits including adherence to individual protocols to ensure compliance with the above listed corrections.	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO</u>	<u>). 0938-0391</u>
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		49G014	B. WING	Accompanies		09	9/08/2017
	PROVIDER OR SUPPLIER	UP HOME		820	REET ADDRESS, CITY, STATE, ZIP CODE 7 WOLFTRAP RD ENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	autism (2), osteoped A review of the incide Individual # 3 dated documentation that without a seatbelt at Review of Individual plan) dated 03/01/2 documents a "Fall Edocumented: "Weat am traveling in a vertravel." During an interview DSP (direct support (DSP # 4) was taking her day program. "(in the vehicle. We on (3). I did not check the office and adjuster. I put (Narvehicle and used the adjuster. As we we of Individual # 3) was sitting on the seat." she was the only stable During an interview ASM # 1, the concert Protocol not being find # 1 was given the offurther documentation.	dent accident report for 4/11/17 revealed Individual # 3 was transported djuster and incurred an injury. If # 3's ISP (individual service 017 through 02/28/2018 Protocol". This Falls Protocol r Seatbelt adjuster every time I whicle or have 2 staff support on 9/7/17 at 8:55 a.m. with a staff) # 4 stated that she ing (Name of Individual # 3) to I put (Name of Individual # 3) re was no seat belt adjuster in the other vehicles, but did dould not find the seatbelt ine of Individual # 3) in the e seat belt without the seatbelt are driving I noticed that (name as out of her seatbelt but was DSP # 4 also confirmed that aff member in the vehicle. on 9/7/17 at 10:42 a.m. with a seat belt may be a seat belt without # 3's Fall followed was reviewed. ASM pportunity to present any		249			

(1) Profound -- Refers to a group of disorders characterized by a limited mental capacity and



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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB MO). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		49G014	B. WING		09	/08/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		UDUOME		8207 WOLFTRAP RD		
MINERVA	A FISHER HALL GRO	OP HOME		VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
W 240	Cantinued From po	ngo 23	W 2	240		
VV 249	Continued From pa		V V Z	-49		
	managing money	ive behaviors such as schedules and routines, or				
	social interactions	Intellectual disability originates				
	before the age of 1	8 and may result from physical				
	causes, such as au	itism or cerebral palsy, or from				
	nonphysical causes	s, such as lack of stimulation				
		veness. This information was				
	obtained from the	vensite: ov/nihfactsheets/ViewFactShee				
	t.aspx?csid=100	JV/III/IIacis/Iccis/VicWi doto/Icc				
	•					
	(2) Autism, also kn	own as autism spectrum				
	disorder (ASD), is	a disorder that causes				
	prosence of repetit	al interaction, as well as the ive, restricted behaviors and				
	interests. This info	mation was obtained from the				
	website:					
		h.gov/health/topics/conditions/				
	autism/index.cfm					
	(3) Seathelt adjuste	er is a device used to prevent				
	Individual # 3 from	slipping out of her seatbelt per				
	facility staff.					
W 252	483.440(e)(1) PRC	GRAM DOCUMENTATION	W 2	252		
	Data rolative to acc	complishment of the criteria		10(e)(1) for individual #1, #2, #3, #4	11 '	/18/17
		ndividual program plan		ing staff meetings, the imperativeness o	11	
	objectives must be	documented in measurable		ing data completely, correctly and in	- 11	
	terms.		1	rable terms will be reviewed. Data shee roduced as a way to accurately and	ts will ······	
			1	rable document progress on outcomes.		
				ing team meetings, all individual's ISP	10/	/18/17
	This STANDARD	is not met as evidenced by:		mes and data sheets will be reviewed wi	11	
	Based on staff inte	erview, clinical record review	3	o ensure proper understanding and		
	and facility docume	ent review it was determined	docum	nentation.	.10	/18/17
	that the facility staf	f failed to collect data of	3	P's will review all data collection and pro	11	acquiris para
	objectives accurate	ely for four of four individuals in	\$	each shift to ensure that data is collecte	- 11	анососовия
	the survey sample.	Individual # 1, # 2, # 3, and #	comple	etely, correctly and in measurable terms	i.	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OI	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G014	B. WING		09/08/2017
NAME OF F	PROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE	
MINERVA	NAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 252 Continued From page 24 4. 1. Facility staff failed to document the data collection of Individual # 1's ISP (Individual Support Plan Outcome/Goal for hygiene and health habits program accurately. 2. Facility staff failed to document the data collection of Individual # 2's ISP Outcome/Go for Hygiene and Organization of personal belongings program accurately. 3. Facility staff failed to document the data collection of Individual # 3's ISP Outcome/Go for health and independence accurately. 4. Facility staff failed to document the data collection of Individual # 4's ISP Outcome/Go for self-care routine to brush his teeth daily accurately. The findings include: 1. Facility staff failed to document the data collection of Individual # 1's ISP (Individual # 1's ISP	UP HOME	1	207 WOLFTRAP RD	
MILLATOR				/IENNA, VA 22180	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
W 252	Continued From pa	age 24	W 252		
	4.			D: 1 III :	
	collection of Individ Support Plan Outco health habits progra. 2. Facility staff faile collection of Individ for Hygiene and Or belongings program. 3. Facility staff faile collection of Individ for health and independent of Individication of In	ual # 1's ISP (Individual ome/Goal for hygiene and am accurately. d to document the data ual # 2's ISP Outcome/Goal ganization of personal accurately. d to document the data ual # 3's ISP Outcome/Goal pendence accurately. d to document the data ual # 4's ISP Outcome/Goal ual # 4's ISP Outcome/Goal	and data data colle office of I audit reco	in Director will review progress notes collection sheets weekly to ensure that ction is done in measurable terms. The Mission Effectiveness will periodically ords to ensure compliance with the ed corrections.	10/18/17
	accurately.				
	collection of Individ	ual # 1's ISP (Individual ome/Goal for hygiene and			
	11/14/11 with diagn	admitted to the facility on loses that included but were ntellectual disability (1), Alzheimer's type,			

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osteoarthrosis, osteoporosis, and hyperlipidemia.

Individual # 1's current ISP (Individual Service Plan) dated 01/01/2017 through 12/31/2018 documented "Desired Outcome: I (Individual # 1) would like to improve hygiene and health habits."

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G014	B. WING		09/08/2017
	PROVIDER OR SUPPLIER A FISHER HALL GROU	ЈР НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 8207 WOLFTRAP RD VIENNA, VA 22180	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC' ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
W 252	Individual # 1) perform the water pik twice a substructions" it docu Individual # 1) of the perform oral care. 2 needed items with with preparing the toverbal prompts. 4. Complete the task fundividual # 1) reinformation in the complete the task fundividual # 1) reinformatical prompts.	ge 25 s & Instructions: (Name of orms oral care which includes, brushing her teeth and using a day." Under "Support mented, "1. Prompt (name of etime and the need to s. Support with collecting rerbal prompts. 3. Support both brush, water pik, etc. with Give verbal prompts how to ully. 5. Give (name of orcement for participating and an be improved." "Frequency:	W 2	52	•
	Individual # 1) brush "Support Instruction (Name of Individual to brush her hair. 2. needed items with v prompts how to com (name of Individual).	a & Instructions: "(Name of nes her hair once daily." Under s" it documented, "1. Prompt # 1) of the time and the need Support with collecting erbal prompts. 3. Give verbal nplete the task fully. 5. Give # 1) positive reinforcement for view areas that can be ncy: Daily."			
	8/23/17 through 9/5/progress notes failed implementation of Ir health habits progration **On 8/23/17 Morning "Individual's Particip	" for Individual # 1 dated '17 were reviewed. The d to evidence accurate ndividual # 1's hygiene and m. ng Shift documented, ation: Individual actively ush (sic) her teeth and hair."			

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**On 8/23/17 Evening Shift documented, "Individual's Participation: Individual actively participated-(initials of Individual # 1) did her

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OIAID IAC). U930-U39 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` `		CONSTRUCTION		TE SURVEY MPLETED
		49G014	B. WING			09	0/08/2017
	PROVIDER OR SUPPLIER	UP HOME		8207	EET ADDRESS, CITY, STATE, ZIP CODE WOLFTRAP RD		
771114				VIE	NNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 252	Continued From pa	age 26	W:	252			
	hygiene before she staff member watc brush (sic) her teef	e went for bed this evening, hed her while she did it. She h and hair."					
	"Individual's Partici participated-(name	ing Shift documented, pation: Individual actively of Individual # 1) brushed her n DSP prompted her to do so."					
	"Individual's Partici participated-(initials hygiene before she	ing Shift documented, pation: Individual actively s of Individual # 1) did her went for bed this evening, hed her while she did it."					
	**On 8/27/17 No pi	ogress provided for this date."					
	"Individual's Partici	ing Shift documented, pation: Individual actively s of Individual # 1) did her was supposed to before she e night tonight."					
	OSM (other staff m Intellectual Disabili of the ISP was disc the ISP is used ever program consisten what the responsib stated that it was the to follow the ISP. (monitored on a we problem she would	on 9/7/17 at 9:50 a.m. with member) # 1, QIDP (Qualified ties Professional), the purpose cussed. OSM # 1 stated that ery day and staff works the tly every day. When asked illity of the QIDP was, OSM # 1 he responsibility of all the staff DSM # 1 stated that she ekly basis and if she saw a speak to the staff.					
	ASM (administrativ	on 9/7/17 at 10:09 a.m. with re staff member) # 1, the and QIDP, the responsibilities					

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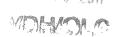
		·····			000
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION DING	(X3) DATE SURVE COMPLETED	Y
	49G014	B. WING		09/08/201	7
NAME OF PROVIDER OR SUPPLIE	₹		STREET ADDRESS, CITY, STATE, ZIP COD	E	White contract contract
MINERVA FISHER HALL GR	OUP HOME		8207 WOLFTRAP RD VIENNA, VA 22180		
PREFIX (EACH DEFICIEN	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE COMPLE	ÉTION
W 252 Continued From r	age 27	\/\/ 3	252		

of a QIDP were discussed. ASM # 1 stated that the responsibilities of the QIDP include coordinating the ISP (Individual Support Plan), assisting in developing goals, monitoring, and revising the program (ISP), and ensuring that ISP is being implemented. When asked what "daily" meant ASM # 1 stated that it should be done daily and if it is a goal that should be done daily it should be worked daily no matter what day of the week."

During an interview on 9/7/17 at 10:42 a.m. with ASM # 1, Individual # 1's ISP and each daily progress notes that was lacking documentation were reviewed. ASM # 1 was given the opportunity to present any documentation at this time and was unable to provide any further information for the progress notes outlined above.

NOTE: QDIP and QMRP refer to the same professional. DSP refers to direct support personal.

The facility's policy "4.1 Individual Service Plan (ISP)" documented, "4.1.4 Individual Service Plan (ISP) Development. H. Data Collection: Data collection is recorded on all objectives/desired outcomes in a format that accurately represents the consumer's progress. Data is tracked, documented in measurable terms and analyzed to ensure that appropriate objectives/desired outcomes and interventions/support strategies are in place for the consumer. On-going documentation is kept in the progress notes regarding the progress, changes or significant events relating to the functioning of the consumer."



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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G014	B. WING		09/08/2017
NAME OF F	ROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP COL	DE
MINERVA	A FISHER HALL GRO	UP HOME		8207 WOLFTRAP RD VIENNA, VA 22180	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLÉTION
W 252	1) Mild intellectual intelligence quotien This information was https://www.ncbi.nlr 2. Facility staff faile collection of Individ for Hygiene and Orbelongings program Individual # 2 was a 1/21/12 with diagnolimited to: moderate	disability is defined as an t (IQ) in the range of 50-69. It is obtained from the website: m.nih.gov/medgen/10044 If the document the data and the disability of personal in accurately. If the disability on the disability (1), gastroesophageal reflux	W 2	252	
	1/21/12 with diagnoral limited to: moderate cerebral palsy (2), go disease (3), and os Individual # 2's curr through 02/28/2018 Outcome: A. (Namminutes and work work of all soiled it briefs into garbage) Individual # 2) to puwhen finished into tweek."	admitted to the facility on uses that included but were not intellectual disability (1), gastroesophageal reflux teopenia. The documented the "Desired e of Individual # 2) to take 15 with support staff modeling to tems (linen, pajamas and put from her bed. B. (Name of it laundry into washer and then the dryer only, three times a sea. Instructions: 1. (Name of			
		s & instructions: 1. (Name of ace soiled items in her hamper			

and briefs in garbage can, each morning after awaking for the day. 2. (Name of Individual # 2)



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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION			SURVEY PLETED
		49G014	B. WING				09/0	08/2017
	PROVIDER OR SUPPLIER	UP HOME		820	EET ADDRESS, CITY, STATE, ZIP 7 WOLFTRAP RD NNA, VA 22180	CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
W 252	bed. 3. (Name of Ir verbal conversation modeling cleaning a (how she is feeling, she may have). 4. perform tasks to cleat the morning for 15 is consideration (Name	s of staff in regard to cleaning advidual # 2) to engage in about tasks with staff and organizing bed with her her thoughts, any concerns (Name of Individual # 2) to ean and organize her bed in minutes. 5. Please take into e of Individual # 2)'s health She may not be able at times	W 2	52				
	Individual # 2) to be modeling putting lau machine and then to Individual # 2) to put and dryer only with (Name of Individual questions for furthe and dry laundry white staff. 4. (Name of less upport staff modelic concerns, comment Please take into contradividual # 2)'s heat may not be able at the completely. Therefor further by cleaning a	s & Instructions: "1. (Name of assisted by support staff undry into the washing ne dryer with her. 2. (Name of the laundry into the washer support staff assistance. 3. # 2) to talk and ask any relarification of how to clean the performing these tasks with andividual # 2) to talk with any as, feelings and/or thoughts. 5. Insideration (Name of alth status at all times. She imes to demonstrate all tasks ore support staff to assist and organizing the remainder pedroom." "Frequency: Daily."						
	8/23/17 through 9/5, progress notes faile	" for Individual # 2 dated /17 were reviewed. The d to evidence accurate ndividual # 2's hygiene and						

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health habits program.

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CENTER	13 LOU MEDICALLE	Q MEDICAID SERVICES	·		CIVID I	10. 0000-000 i
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
		49G014	B. WING)		09/08/2017
	PROVIDER OR SUPPLIER	UP HOME		STREET ADDRESS, CITY, STATE, ZIP C 8207 WOLFTRAP RD VIENNA, VA 22180	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION DATE
W 252	"Individual's Particip participated-(Name soiled items in her h	ge 30 ng Shift documented, pation: Individual actively of Individual # 2) to place namper and briefs in garbage. # 2) did not do laundry during	W:	252		
	"Individual's Particip participated-Staff pr	kend Shift documented, pation: Individual actively compt (sic) and supported her provide (sic) everything she				
	"Individual's Particip	end Shift documented, pation: Individual actively of Individual # 2) did her nd support."				
	"Individual's Particip participated-(Name staff with picking ou	nd Shift documented, ation: Individual actively of Individual # 2) assisted t her outfit for the day and she r with assistant (sic) from				
	"Individual's Particip participated-(Name	nd Shift documented, ation: Individual actively of Individual # 2) put laundry put the clean cloth (sic) her lone."				
	Individual # 2) to tak support staff modeli (linen, pajamas and her bed. And this is that Outcome "B. (N	on of Outcome "A (Name of e 15 minutes and work with ng to clean off all soiled items put briefs into garbage) from the only time in two weeks ame of Individual # 2) to put and then when finished into				

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the dryer only, three times a week." Outcome A

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OINID INC	<u>J. 0936-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		ATE SURVEY MPLETED
		49G014	B. WING			09	9/08/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
MINERV	A FISHER HALL GRO	UP HOME			7 WOLFTRAP RD NNA, VA 22180		
(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 APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 252	Continued From pa	ge 31	W:	252			
		y and outcome B was to be					
	ASM # 1, Individual progress notes that were reviewed. AS opportunity to prese time and was unablinformation for the progress of the progress	on 9/7/17 at 10:37 a.m. with #2's ISP and each daily was lacking documentation M # 1 was given the ent any documentation at this e to provide any further progress notes outlined above. On was provided prior to exit. The ectual disability refers to a characterized by a limited difficulty with adaptive managing money, schedules stal interactions. Intellectual before the age of 18 and may causes, such as autism or om nonphysical causes, such and adult responsiveness. In sobtained from the website: v/nihfactsheets/ViewFactShee					
	(2) Cerebral palsy affect a person's ab balance and posture obtained from the w	a group of disorders that illity to move and to maintain e. This information was vebsite: .gov/medlineplus/cerebralpals					
	contents to leak, or	eal reflux disease Stomach reflux, into the esophagus information was obtained from					

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

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	10 1 ON MEDIOMIL	. O MEDIO/ND OFFICE	·		CIVID INC. 0000 0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49G014	B. WING)	09/08/2017
	PROVIDER OR SUPPLIER	UP HOME		STREET ADDRESS, CITY, STATE, ZIP COD 8207 WOLFTRAP RD VIENNA, VA 22180	ÞΕ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE COMPLÉTION
W 252	collection of Individual for health and indep Individual # 3 was a 2/5/13 with diagnos limited to: profound autism (2), osteope Individual # 3's curr through 02/28/2018 Outcome: (Individual activities to improve and would like to imhabits." A. "Support Activitie Individual # 3) brush morning and evenin (Name of Individual routine. 2. Inform (I the routine, that it is Support (Name of Individual # 3) to brushing and rinsing B. "Support Activitie Individual # 3) to brushing and rinsing B. "Support Activitie Individual # 3) disrol Inform (Name of Individual her pants and tops. # 3)." The "Progress Note"	ge 32 d to document the data ual # 3's ISP Outcome/Goal bendence accurately. Idmitted to the facility on es that included but were not intellectual disability (1), nia, and seizure disorder. ent ISP dated 03/01/2017 documented the "Desired al # 3) participates in self care her health and independence prove hygiene and health s & Instructions: (Name of nes her teeth during her g hygiene routine. 1. Inform # 3) it is time for her hygiene Name of Individual # 3) during teeth brushing time. 3. ndividual # 3) with putting rush. 3. (Sic) Provide (Name hand to hand support during g. Frequency: Daily." s & Instructions: (Name of bes during hygiene routine. 1. lividual # 3) it is time for her Demonstrate and support # 3) to disrobe by taking off 3. Praise (Name of Individual "for Individual # 3 dated '17 were reviewed. The	W	252	

implementation of Individual # 3's hygiene and

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO). 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		49G014	B. WING			05	0/08/2017
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINERV	A FISHER HALL GRO	UP HOME			207 WOLFTRAP RD		
				VI	IENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 252	Continued From pa	ge 33	W 2	252			
	independence prog disrobing).	ram (tooth brushing and				•	
	"Individual's Particip	ng Shift documented, pation: Individual actively chieved as implemented."					
	"Individual's Particip participated-staff me	ng Shift documented, pation: Individual actively ember brushes (Name of after she being changed into ening tonight."					
	"Individual's Particip	ng Shift documented, ation: Individual actively ember brushes her hair after evening tonight."					
	"Individual's Particip participated-(Initials	ng Shift documented, ation: Individual actively of Individual # 3) participated ment to the best of her ability."					
	"Individual's Particip participated-(Name her hands and took	ng Shift documented, ation: Individual actively of Individual # 3) she washed off her pants and top with rts from DSP (Direct Service					
	ASM # 1, Individual a progress notes that were reviewed. ASM opportunity to present	on 9/7/17 at 10:42 a.m. with # 3's ISP and each daily was lacking documentation # 1 was given the any documentation at this to provide any further					

information for the progress notes outlined above.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(OMB NO). 093 8-0391
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		ONSTRUCTION	(X3) DA7	TE SURVEY MPLETED
		49G014	B. WING			ng	/08/2017
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	700/2017
MINERV	A FISHER HALL GRO	UP HOME			WOLFTRAP RD		
	CUMBARY OTA	TENENT OF DEFICIENCIES	······································	VIEN	NNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 252	Continued From pa	ge 34	W	252			
	No further information was provided prior to exit.						
	characterized by a lidifficulty with adaptimanaging money, social interactions. before the age of 18 causes, such as au nonphysical causes and adult responsive obtained from the white https://report.nih.got.aspx?csid=100 (2) Autism, also know disorder (ASD), is a impairment in social presence of repetitivinterests. This inform website:	fers to a group of disorders imited mental capacity and ve behaviors such as schedules and routines, or Intellectual disability originates and may result from physical tism or cerebral palsy, or from a such as lack of stimulation eness. This information was rebsite: w/nihfactsheets/ViewFactShee wwn as autism spectrum disorder that causes a interaction, as well as the re, restricted behaviors and mation was obtained from the sh.gov/health/topics/conditions					
	collection of Individu	I to document the data all # 4's ISP Outcome/Goal to brush his teeth daily					
	5/19/15 with diagnos	dmitted to the facility on ses that included but were not ellectual disability (1), a, and seizures.					
	through 07/30/2018	ent ISP dated 07/01/2017 documented the "Desired are and independence.					

"Support Activities & Instructions: (Name of



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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	. 0938- 0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		TE SURVEY MPLETED
		49G014	B. WING			09	/08/2017
NAME OF	PROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE	, ,,	, , , , , , , , , , , , , , , , , , , ,
MINERV	A FISHER HALL GRO	UP HOME			ENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 252	by brushing my tee toothbrush. 1. Staff Individual # 4) that Staff will rinse (Nantoothbrush then appassist (Name of Indhand assistance. 4) is unable to complete it for him. documentation. From Review of the "Programmer of through 8/26/17 for documentation that teeth brushing was During an interview ASM # 1, Individual progress notes that were reviewed. ASI opportunity to preset the time and was unable information for the progress of the programmer of	cipates in my self-care routine th daily with a soft bristle f will inform (Name of t is time to brush his teeth. 2. ne of Individual # 4)'s oly toothpaste. 3. Staff will ividual # 4) with hand over. When (Name of Individual # olete the task, staff will 5. Complete the necessary equency: Daily." Irress Notes" dated 8/24/17 Individual # 4 revealed no this Desired Outcome for implemented. on 9/7/17 at 10:42 a.m. with # 4's ISP and each daily was lacking documentation	W 2	!52			

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STATEMENT OF DEFICIENCIES (X1) P	PROVIDER/SUPPLIER/CLIA	(V2) A # 1	TIDLE CONCEDUCATION	I
	DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	49G014	B. WING		09/08/2017
NAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8207 WOLFTRAP RD VIENNA, VA 22180	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEI	BE PRECEDED BY FULL	ID PREF TAG		D BE COMPLETION
W 420 483.470(b)(4)(iv) CLIENT The facility must provide functional furniture, approneds. This STANDARD is not read a determined that the facility the environment in good andividual's bedrooms, round the findings include: During observation on 9/6 revealed the following: In Room # 7 there was a the door. This hole was rediameter of approximately of the door was a mirror a mirror the paint was peelimirror there was a recline the paint was worn off. In Room # 8 approximate light switch the paint was window the paint was window the paint was peelimit and a hole just above the right of the bedroom of the right of the closet encodamage with exposed dry. On 9/7/17 at 10:00 a.m. a with ASM (administrative)	met as evidenced by: and staff interview, it was ty staff failed to maintain repair for three of nine roms # 7, # 8, and # 11. 6/17 at 9:50 a.m. hole in the wall behind round and had a ry four inches. To the left and to the left side of the reand behind the recliner ely 2 ½ feet below the realing. Under the realing and the top or the realing bare wood. ght switch and above re two areas of peeling re the baseboard. To door was a closet. To losure there was r wall and missing paint.	1. A wneede will for until i 2.Resi site re enviror good 3.The check reque 4.The prograin good will ed	70(b)(4)(iv) Fork order was submitted for repair/painting ork order was submitted for repair/painting of in bedrooms #7,8 and 11. Residential star llow up weekly with the maintenance staff its repair. Its repair. It dential staff will complete daily program wiews to include completion of an onmental checklist to ensure items are in repair. It weekly and submit needed work order	10/18/17

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

above mentioned observations. ASM # 1 stated

Event ID: LESO11

Facility ID: VAICFMR14

If continuation sheet Page 37 of 38



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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			Olvir iv	<u>U. 0938-039 I</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G014	B. WING)	- (9/08/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 8207 WOLFTRAP RD	TE, ZIP CODE			
MINERVA	FISHER HALL GRO	UP HOME	:	VIENNA, VA 22180			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE SIENCY)	(X5) COMPLETION DATE	
W 420	Continued From pa	age 37	W	420			
	that the actual building is owned by the county and that work orders must be sent to the county. ASM # 1 further stated that she would search the work orders that had been sent to see if the issues had been noted. A request for any environmental maintenance policy was requested at this time. During an interview on 9/8/17 at 9:00 a.m. with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional) the process for having environmental issues repaired was discussed. OSM # 1 stated that when her staff tells her there is an issue she will submit a work order and copy the program manager. OSM # 1 stated that any staff on any shift is able to submit a work order.						
	Although some oth the work orders the	er issues were found to be on a above listed issues were not.					