STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G073	A. BUILDING _____ B. WING _____	04/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/10/18 through 04/12/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the written emergency plan included the services the facility would be able to provide during an emergency. The findings include: On 04/11/18 at 1:05 p.m. a review and interview	E 007	E 007 1. The emergency plan will be revised to include a description of the services the facility would be able to provide during an emergency. 2. The emergency plan for all ICF programs will likewise be revised to include a description of the services the facility would be able to provide during an emergency. 3. The program manager will review the emergency plan annually and make any needed revisions to ensure that the description of the services that the facility would be able to provide during an emergency is still accurate. 4. Any time changes to the emergency plan are proposed by the program manager, he or she will forward the document to the ID Residential Coordinator or designee for final review to ensure that the description of the services that the facility would be able to provide during an emergency is recorded accurately in the plan. 5. Date of completion will be by 5/9/18.	5/9/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephen L. Curtis	ID Residential Coordinator	5/1/18

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

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E 007	Continued From page 1 of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager and ASM # 3, assistant regional coordinator. Review of the facility's emergency preparedness plan failed to evidence of documentation that the written emergency plan included the services the facility would be able to provide during an emergency. ASM # 1 stated, "We don't have it." On 04/11/18 at 5:00 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings No further information was provided prior to exit.	E 007		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015	E 015 1. Policy and procedures will be revised to include a description of how sewage and waste disposal will be managed in the event of an emergency. 2. The policy and procedure for all ICF programs will likewise be revised to include a description of how sewage and waste disposal will be managed in the event of an emergency. 3. The program manager will review the policy annually and make any needed revisions to ensure that the description of how sewage and waste disposal will be managed in the event of an emergency is still accurate. 4. Any time changes to policy and procedures are proposed by the program manager, he or she will forward the document to the ID Residential Coordinator or designee for final review to ensure that the description of how sewage and waste disposal will be managed in the event of an emergency is recorded accurately in the plan. 5. Date of completion will be by 5/9/18.	5/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 015	Continued From page 2	E 015		

safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):]
Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This STANDARD is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to develop policies and procedures to provide for sewage and waste disposal.

The findings include:

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E 015	Continued From page 3 On 04/11/18 at 1:05 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager and ASM # 3, assistant regional coordinator. Review of the facility's emergency preparedness plan failed evidence that the facility had developed policies and procedures to provide for sewage and waste disposal. ASM # 1 stated, "We don't have that." On 04/11/18 at 5:00 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings No further information was provided prior to exit.	E 015		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 026	E 026 1. Policy and procedures will be revised to include a description of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. 2. The policy and procedure for all ICF programs will likewise be revised to include a description of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. 3. The program manager will review the policy annually and make any needed revisions to ensure that the description of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver is still accurate. 4. Any time changes to policy and procedures are proposed by the program manager, he or she will forward the document to the ID Residential Coordinator or designee for final review to ensure that the description of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver is recorded accurately in the plan. 5. Date of completion will be by 5/9/18.	5/9/18

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E 026	Continued From page 4	E 026		

*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.
This STANDARD is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to evidence documentation that the policies and procedures in the emergency plan describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver.

The findings include:

On 04/11/18 at 1:05 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager and ASM # 3, assistant regional coordinator. Review of the facility's emergency preparedness plan failed to evidence documentation that the policies and procedures in the emergency plan describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. ASM # 1 stated, "We don't have anything concerning a state of emergency."

On 04/11/18 at 5:00 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings

No further information was provided prior to exit.

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E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. The findings include: On 04/11/18 at 1:05 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager and ASM # 3, assistant regional	E 032	E 032 1. The emergency communication plan will be revised to include a description of primary and alternate means for communicating with facility staff, federal, state, tribal, and local emergency management agencies during an emergency. 2. The emergency plan for all ICF programs will likewise be revised to include a description of primary and alternate means for communicating with facility staff, federal, state, tribal, and local emergency management agencies during an emergency. 3. The program manager will review the emergency plan annually and make any needed revisions to ensure that the description of primary and alternate means for communicating with facility staff, federal, state, tribal, and local emergency management agencies during an emergency is still accurate. 4. Any time changes to the emergency plan are proposed by the program manager, he or she will forward the document to the ID Residential Coordinator or designee for final review to ensure that the description of primary and alternate means for communicating with facility staff, federal, state, tribal, and local emergency management agencies during an emergency is recorded accurately in the plan. 5. Date of completion will be by 5/9/18.	5/9/18

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E 032	Continued From page 6 coordinator. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. ASM # 1 stated, "We don't have that." On 04/11/18 at 5:00 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings No further information was provided prior to exit.	E 032	E 033 1. The emergency communication plan will be revised to include a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care during an emergency. In addition, the policy and procedures will be revised to address the means the facility will use to release patient information to include the general condition and locations of patients during an emergency. 2. The emergency plan for all ICF programs will likewise be revised to include a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care during an emergency. In addition, the policy and procedures will be revised to address the means the facility will use to release patient information to include the general condition and locations of patients during an emergency. 3. The program manager will review the emergency plan annually and make any needed revisions to ensure that the method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care during an emergency is still accurate. In addition, the policy and procedures will be reviewed/revised annually to ensure that the means the facility will use to release patient information to include the general condition and locations of patients during	5/9/18
E 033	Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of	E 033		

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E 033	Continued From page 7 patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan. In addition, the facility staff failed to provide evidence of documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. The findings include: On 04/11/18 at 1:05 p.m. a review and interview	E 033	an emergency is still accurate. 4. Any time changes to the emergency plan are proposed by the program manager, he or she will forward the document to the ID Residential Coordinator or designee for final review to ensure that the method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care during an emergency is still accurate. In addition, the policy and procedures will be reviewed by the ID Residential Coordinator or designee to ensure that they address the means the facility will use to release patient information to include the general condition and locations of patients during an emergency. 5. Date of completion will be by 5/9/18.	5/9/18

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E 033	Continued From page 8 of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager and ASM # 3, assistant regional coordinator. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan. Review of the facility's emergency preparedness plan failed to evidence documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. ASM # 1 stated, "We don't have that in our plan." On 04/11/18 at 5:00 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings No further information was provided prior to exit.	E 033	E 034 1. The emergency communication plan will be revised to include a means of providing information about the facility's needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee during an emergency. 2. The emergency plan for all ICF programs will likewise be revised to include a means of providing information about the facility's needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee during an emergency. 3. The program manager will review the emergency plan annually and make any needed revisions to ensure that the means of providing information about the facility's needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee during an emergency is still accurate. 4. Any time changes to the emergency plan are proposed by the program manager, he or she will forward the document to the ID Residential Coordinator or designee for final review to ensure that the means of providing information about the facility's needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee during an emergency is recorded accurately in the plan. 5. Date of completion will be by 5/9/18.	5/9/18
E 034	Information on Occupancy/Needs CFR(s): 483.475(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its	E 034		

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E 034	Continued From page 9	E 034		

ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

*[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

This STANDARD is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to provide evidence of documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy.

The findings include:

On 04/11/18 at 1:05 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility)

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E 034	Continued From page 10 manager and ASM # 3, assistant regional coordinator. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan. In addition, review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a means of providing information about their occupancy. ASM # 1 stated, "We don't have that in our plan." On 04/11/18 at 5:00 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings No further information was provided prior to exit.	E 034		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based	E 039		

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E 039	Continued From page 11 exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the	E 039	E 039 1. The program manager will document evidence of the facility's efforts to identify a full scale community based exercise if the program is unable to participate in one. If the facility is able to participate in a full scale community based exercise, the program manger will document evidence of the facility's exercise analysis, and response and how the facility updated its emergency program based on the exercise analysis. 2. The program managers for all ICF programs will likewise document evidence of the facility's efforts to identify a full scale community based exercise if the program is unable to participate in one. If the facility is able to participate in a full scale community based exercise, the program manger will document evidence of the facility's exercise analysis, and response and how the facility updated its emergency program based on the exercise analysis. 3. The program manager will document evidence annually of the facility's efforts to identify a full scale community based exercise if the program is unable to participate in one. If the facility is able to participate in a full scale community based exercise, the program manger will document evidence annually of the facility's exercise analysis, and response and how the facility updated its emergency program based on the exercise analysis. 4. At least once a year, the ID Residential Coordinator or designee will review evidence of the facility's efforts to identify a full scale community based exercise if the program is unable to participate in one. If the facility is able to participate in a full	5/9/18

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E 039	Continued From page 12 [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one. In addition, the facility failed to provide documentation of the facility's exercise analysis, and response and how the facility updated its emergency program based on the exercise analysis. The findings include: On 04/11/18 at 1:05 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager and ASM # 3, assistant regional coordinator. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one. In addition, review of the facility's emergency preparedness plan failed to evidence documentation of the facility's exercise analysis, and response and how the facility updated its emergency program based on the exercise analysis. ASM # 1 stated, "We don't have that in our plan." On 04/11/18 at 5:00 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings.	E 039	scale community based exercise, at least once annually the ID Residential Coordinator or designee will request and review evidence of the facility's exercise analysis, and response and how the facility updated its emergency program based on the exercise analysis. 5. Date of completion will be by 5/9/18.	

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E 039	Continued From page 13 No further information was provided prior to exit.	E 039		
W 000	INITIAL COMMENTS An unannounced annual Medicaid ICF/IDD Health Care Certification survey was conducted 04/10/18 through 04/12/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Mentally Retarded. The Life Safety Code survey report will follow. The census in this four bed facility was four at the time of the survey. The survey sample consisted of two current Individual reviews (Individuals #1 and #2).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure the clinical record was complete and accurate for two of two individuals in the survey sample, Individuals # 1 and # 2. 1. The facility staff failed to ensure the residential clinical record contained Individual # 1's QIDP (Qualified Intellectual Disabilities Professional) monthly reviews for February and March 2018. 2a. The facility staff failed to ensure the	W 111	W111 1. **How corrective action will be accomplished for individual #1**: Facility staff will ensure that the clinical record for individual #1 contains QIDP monthly reviews for each month, including February and March 2018. **Assurance that other residents are protected from the possibility of the deficiency**: Facility staff will ensure that the clinical record for each individual contains QIDP monthly reviews for each month. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: The Program Manager will review the clinical record to ensure that the QIDP monthly reviews are present for each individual for each month. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The ID Residential Assistant Coordinator will check the clinical record for each individual each month to ensure that the QIDP monthly reviews have been completed. **Date of Completion**: 5/9/18	5/9/18

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W 111	Continued From page 14 residential clinical record contained Individual # 2's QIDP (Qualified Intellectual Disabilities Professional) monthly reviews for February and March 2018. 2b. The facility staff failed to ensure the QIDP's (Qualified Intellectual Disabilities Professional) quarterly review and the PCP (Person Centered Plan) were accurate for Individual # 2. The findings include: 1. The facility staff failed to ensure the residential clinical record contained Individual # 1's QIDP (Qualified Intellectual Disabilities Professional) monthly reviews for February and March 2018. Individual # 1 was a 59 year-old male, who was admitted to (Name of Group Home) on 01/20/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), seizures (2), dysphagia (3), gastroesophageal reflux disease (4), osteopenia (5), and hypertension (6). Review of Individual # 1's residential paper clinical record and residential EHR (electronic health record) at (Name of Group Home) failed to evidence the monthly QIDP notes for February and March 2018. On 04/11/18 at 4:00 p.m., an interview was conducted with ASM (administrative staff member) # 2, assistant ICF (Intermediate Care Facility) manager. When asked for Individual # 1's QIDP notes for February and March 2018 ASM # 2 stated, "We're unable to locate the notes."	W 111	W111 2a. **How corrective action will be accomplished for individual #2:** Facility staff will ensure that the clinical record for individual #2 contains QIDP monthly reviews for each month, including February and March 2018. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will ensure that the clinical record for each individual contains QIDP monthly reviews for each month. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The Program Manager will review the clinical record to ensure that the QIDP monthly reviews are present for each individual for each month. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The ID Residential Assistant Coordinator will check the clinical record for each individual each month to ensure that the QIDP monthly reviews have been completed. **Date of Completion:** 5/9/18 W111 2b. **How corrective action will be accomplished for individual #2:** Facility staff will review the quarterly review and the PCP (Person Centered Plan) to ensure that they are accurate for individual #2.	5/9/18 5/9/18

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W 111	Continued From page 15 On 04/12/18 at 1:00 p.m., an interview was conducted with ASM # 1, ICF manager. When asked for Individual # 1's QIDP notes for February and March 2018 ASM # 1 stated, "We don't have them." The facility's policy "Governing Body and Management Section 1-5: Documentation" documented, " Policy Statement: It is the policy of (Name of Group Home) that documentation will be kept accurate, contemporaneous, pertinent and confidential in a secure orderly manner for each resident." The facility's policy "Governing Body and Management Section 1-4: record Keeping" documented, "3. The records will contain and document the resident's relevant information, health care information, active treatment documentation, social information, and protection of the individual's rights, such as communications, correspondence, program plans (including outside service programs), progress summaries, activity plans and participation, incidents, consent forms and all medical information. This information will be accurate and functional." On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions.	W 111	**Assurance that other residents are protected from the possibility of the deficiency**: The facility staff will review the quarterly review and the PCP (Person Centered Plan) to ensure that they are accurate for each individual. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: Facility staff will ensure that each quarterly and PCP (Person Centered Plan) for each individual is accurate and each is a representation of what progress has been made toward outcomes. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The Program manager will review each quarterly and PCP (Person Centered Plan) for each individual to ensure that they are accurate and representative of what progress has been made toward outcomes for each individual. **Date of Completion:** 5/9/18	

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Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

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

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807.

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

2a. The facility staff failed to ensure the residential clinical record contained Individual # 2's QIDP (Qualified Intellectual Disabilities

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Professional) monthly reviews for February and March 2018.

Individual # 2 was a 54 year-old male, who was admitted to (Name of Group Home) on 01/18/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), cerebral palsy (2), dysphagia (3), osteopenia (4), and gout (5).

Review of Individual # 2's residential paper clinical record and residential EHR (electronic health record) at (Name of Group Home) failed to evidence the monthly QIDP notes for February and March 2018.

On 04/11/18 at 4:00 p.m., an interview was conducted with ASM (administrative staff member) # 2, assistant ICF (Intermediate Care Facility) manager. When asked for Individual # 2's QIDP notes for February and March 2018 ASM # 2 stated, "We're unable to locate the notes."

On 04/12/18 at 1:00 p.m., an interview was conducted with ASM # 1, ICF manager. When asked for Individual # 2's QIDP notes for February and March 2018 ASM # 1 stated, "We don't have them."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with

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adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A 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/cerebralpalsy.html.

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

(4) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807.

(5) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm.

2b. The facility staff failed to ensure the QIDP's (Qualified Intellectual Disabilities Professional) quarterly review and the PCP (Person Centered Plan) were accurate for Individual # 2.

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The PCP (Person Centered Plan) for (Name of Group Home) dated 10/01/2017 through 09/30/2018 for Individual # 2 documented, "1b. With maximum hand-overhand assistance, (Individual # 2) put his arms into his shirt sleeves daily. Success is measured when he completes this task a with supports as outlined 5 (five) days in a row. 2b. With maximum hand-overhand assistance, (Individual # 2) washes his torso with the washcloth for 10 seconds. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 2c. With touch prompts and verbal prompts (Individual # 2) lift his hips for 5 (five) seconds while changing his briefs. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 5b. With no more than two verbal prompts, (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this a task with supports as outlined five days in a row."

The data collection sheets from the (Name of Group Home) dated 10/01/2017 through 03/31/2018 documented, "1b. With maximum hand-overhand assistance, (Individual # 2) put his arms into his shirt sleeves daily. Success is measured when he completes this task a with supports as outlined 5 (five) days in a row. 2b. With maximum hand-overhand assistance, (Individual # 2) washes his torso with the washcloth for 10 seconds. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 2c. With touch prompts and verbal prompts (Individual # 2) lift his hips for 5 (five) seconds while changing his briefs. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 5b.

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With no more than two verbal prompts, (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this a task with supports as outlined five days in a row." Further review of the data collection sheets revealed PCP outcomes 1b was met in October, November, December 2017 and January, February and March 2018; 2b was met in February 2018; 2c was met in March 2018 and 5b was met in October, November, December 2017 and January, February and March 2018.

The PCP (Person Centered Plan) for (Name of Day Program) dated 10/01/2017 through 09/30/2018 for Individual # 2 documented, "2c. With touch prompts and verbal prompts (Individual # 2) lift his hips for 5 (five) seconds while changing his briefs. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 4. Twice daily (Individual # 2) grasps his toothbrush in his right hand for 5 (five) seconds while staff dependently places toothpaste on the toothbrush. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 5b. With no more than two verbal prompts, (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this task with supports as outlined five days in a row."

The data collection sheets from the (Name of Day Program) dated 10/01/2017 through 03/31/2018 documented, "2c. With touch prompts and verbal prompts (Individual # 2) lift his hips for 5 (five) seconds while changing his briefs. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 4. Twice daily (Individual # 2) grasps his

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toothbrush in his right hand for 5 (five) seconds while staff dependently places toothpaste on the toothbrush. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 5b. With no more than two verbal prompts, (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this task with supports as outlined five days in a row." Further review of the data collection sheets revealed PCP outcomes 2c was met in February 2018; 4. Met in February 2018 and 5b met on February and March 2018."

The quarterly review dated "January 1, 2018 First Quarter" for Individual # 2's PCP outcomes 1b and 5b documented, "Stability."

The PCP (Person Centered Plan) for (Name of Group Home) dated 10/01/2017 through 09/30/2018 and the PCP for (Name of Day Program) dated 10/01/2017 through 09/30/2018 for Individual # 2 failed to evidence revision of the PCP outcomes 1b, 2b, 2c, 4 and 5b.

On 04/10/18 at approximately 5:20 p.m., an interview was conducted with ASM # 3, assistant residential coordinator. When asked to describe the process for outcomes/goal that have been met, ASM # 1 stated, "The outcome/goal gets revised upon completion of the outcome/goal." ASM # 3 further stated, "The PCP should be updated or revised as needed and at least quarterly." ASM #1 then reviewed the PCP dated 10/01/2017 through 09/30/2018, the PCP for (Name of Day Program) dated 10/01/2017 through 09/30/2018, the data collection sheets dated 10/01/2017 through 03/31/2018 and quarterly review dated "January 1, 2018 First

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W 111	Continued From page 22 Quarter for Individual # 2. ASM # 1 was asked if the quarterly review was accurately documented, based on the data collection. ASM # 1 stated, "No. The quarterly review should have documented the goal/outcomes were met." When asked if the PCPs where accurate ASM stated, "No. They should have been revised for the outcomes that were met. On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings. No further information was provided prior to exit.	W 111		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on residential program record reviews, day program record review, facility document review and staff interview, it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate and monitor the individuals' active treatment programs for two of two individuals in the survey sample, Individuals # 1 and # 2. 1a. The QIDP failed to complete Individual # 1's monthly reviews for February and March 2018. 1b. The QIDP failed to develop PCP (Person Centered Plan) to support Individual # 1's move toward independence.	W 159	W 159 1a. **How corrective action will be accomplished for individual #1**: The QIDP will ensure that the clinical record for individual #1 contains QIDP monthly reviews for each month, including February and March 2018. **Assurance that other residents are protected from the possibility of the deficiency**: The QIDP will ensure that the clinical record for each individual contains QIDP monthly reviews for each month. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: The Program Manager will review the clinical record to ensure that the QIDP monthly reviews are present for each individual for each month. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The ID Residential Assistant Coordinator will check the clinical record for each individual each month to ensure that the QIDP monthly reviews have been completed. **Date of Completion**: 5/9/18	5/9/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 23 2a. The QIDP failed to complete Individual # 2's monthly reviews for February and March 2018. 2b. The QIDP failed to develop PCP (Person Centered Plan) to support Individual # 2's move toward independence. 2c. The QIDP failed to implement Individual #2's PCP outcome # 13, communication. The findings include: 1a. The QIDP failed to complete Individual # 1's monthly reviews for February and March 2018. Individual # 1 was a 59 year-old male, who was admitted to (Name of Group Home) on 01/20/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), seizures (2), dysphagia (3), gastroesophageal reflux disease (4), osteopenia (5), and hypertension (6). Review of Individual # 1's residential paper clinical record and residential EHR (electronic health record) at (Name of Group Home) failed to evidence the monthly QIDP notes for February and March 2018. On 04/11/18 at 4:00 p.m., an interview was conducted with ASM (administrative staff member) # 2, assistant ICF (Intermediate Care Facility) manager. When asked for Individual # 1's QIDP notes for February and March 2018 ASM # 2 stated, "We're unable to locate the notes." On 04/12/18 at 1:00 p.m., an interview was conducted with ASM # 1, ICF manager. When	W 159	W 159 1b. **How corrective action will be accomplished for individual #1**: The QIDP will revise the PCP (Person Centered Plan) to ensure that outcomes are developed to support individual #1's move toward independence. **Assurance that other residents are protected from the possibility of the deficiency**: The QIDP will review and revise all PCP's (Person Centered Plans) as needed to ensure that outcomes are developed to support each individual's move toward independence. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: The QIDP will extract outcomes from the Comprehensive Functional and Clinical Assessments to establish outcomes to support each individual's move towards independence. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The annual PCP for each client will be reviewed by the program manager prior to submission deadlines to ensure that outcomes support each individual's move toward independence. **Date of Completion**: 5/9/18	5/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 159	Continued From page 24 asked for Individual # 1's QIDP notes for February and March 2018 ASM # 1 stated, "We don't have them." On 04/12/18 at 12:50 p.m., an interview was conducted with ASM (administrative staff member) # 1, ICF (Intermediate Care Facility) manager. When asked who the QIDP was ASM # 1 stated, "It was (OSM [other staff member] # 1) who is no longer here. She left in March (2018)." When asked who took on the QIDPs responsibilities ASM # 1 stated, "I did. The new QIDP will start on 04/23/18." ASM #1 was asked to describe the QIDPs responsibilities. ASM # 1 stated, "Coordinating IDT (interdisciplinary) meetings, follow up with providers, completing assessments and ensuring assessments are completed. Developing PCP (Person Centered Plans), conduct PCP meetings, complete monthly and quarterly reviews, visit day programs, ensure active treatment programs are being implemented at the residence and day programs, reviewing records at day programs and residential homes are complete and accurate." The facility's policy "Facility Staffing Section 4-2: Qualified Intellectual Disabilities Professional" documented, "I. Monitors active treatment and services being provided by observation and making visits to offsite services and documents this information on a monthly summary for each individual." On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings. No further information was provided prior to exit.	W 159	W 159 2a. **How corrective action will be accomplished for individual #2**: The QIDP will ensure that the clinical record for individual #2 contains QIDP monthly reviews for each month, including February and March 2018. **Assurance that other residents are protected from the possibility of the deficiency**: The QIDP will ensure that the clinical record for each individual contains QIDP monthly reviews for each month. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: The Program Manager will review the clinical record to ensure that the QIDP monthly reviews are present for each individual for each month. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The ID Residential Assistant Coordinator will check the clinical record for each individual each month to ensure that the QIDP monthly reviews have been completed. **Date of Completion**: 5/9/18	5/9/18

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W 159	Continued From page 25 Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (5) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807. (6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr	W 159	W 159 2b. **How corrective action will be accomplished for individual #2**: The QIDP will revise the PCP (Person Centered Plan) to ensure that outcomes are developed to support individual #2's move toward independence. **Assurance that other residents are protected from the possibility of the deficiency**: The QIDP will review and revise all PCP's (Person Centered Plans) as needed to ensure that outcomes are developed to support each individual's move toward independence. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: The QIDP will extract outcomes from the Comprehensive Functional and Clinical Assessments to establish outcomes to support each individual's move towards independence. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The annual PCP for each client will be reviewed by the program manager prior to submission deadlines to ensure that outcomes support each individual's move toward independence. **Date of Completion**: 5/9/18	5/9/18

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W 159	Continued From page 26 essure.html. 1b. The QIDP failed to develop PCP (Person Centered Plan) to support Individual # 1's move toward independence. On 04/11/18 Individual # 1's PCP (Person Centered Plan) dated 02/21/2018 through 02/20/2019 located in Individual # 1's residential clinical record was reviewed at (Name of Group Home). Individual # 1's PCP documented, "Outcomes Important To/or #: 3a. Communication Protocol. (Individual # 1) communicates in von-verbal ways; those that support him are aware of how to best support him to work towards independence in all areas of his life. 5. Eating Protocol. (Individual # 1) is offered visual oversight and verbal prompting throughout the entire duration of his meals." Further review of Individual; # 1's PCP outcomes # 3a and # 5 failed to evidence measurable goals. The CFA (comprehensive functional assessment) for Individual # 1 dated 01/30/18 documented, "2. Communication: e) Understands simple words, phrases or instructions - 3=sometimes; 3. Task Learning Skills: h) Recognize persons, places, events, objects in their community? - 3=sometimes; 4. Personal/Self-Care: b) Perform dining functions? - 3=Supervision." On 04/12/18 at approximately 1:00 p.m., and interview was conducted with ASM (administrative staff member) # 1, ICF (Intermediate Care Facility) manager and ASM # 3, assistant residential coordinator. When asked to describe the process for developing outcomes/goals into measurable terms, ASM # 1 stated, "We use the CFAs. The scoring refers to the level of	W 159	W159 2c. **How corrective action will be accomplished for Individual #2:** The QIDP will monitor to ensure implementation of the active treatment outcome involving communication for Individual #2. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will monitor to ensure implementation of all outcomes in 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 review data to ensure outcome implementation is being recorded accurately by staff. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will review all data collection at a minimum of monthly to ensure that implementation is being recorded accurately. Date of Completion: 5/9/18	5/9/18

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assistance. If the individual is scored as being totally dependent then a measurable outcome for that area would not be developed." After reviewing Individual # 1's PCP dated 02/21/2018 through 02/20/2019 and CFA dated 01/30/18, ASM # 1 was asked about Individual # 1's communication and eating protocols. ASM # 1 stated, "They should have been developed as measurable outcomes."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

2a. The QIDP failed to complete Individual # 2's monthly reviews for February and March 2018.

Individual # 2 was a 54 year-old male, who was admitted to (Name of Group Home) on 01/18/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), cerebral palsy (2), dysphagia (3), osteopenia (4), and gout (5).

Review of Individual # 2's residential paper clinical record and residential EHR (electronic health record) at (Name of Group Home) failed to evidence the monthly QIDP notes for February and March 2018.

On 04/11/18 at 4:00 p.m., an interview was conducted with ASM (administrative staff member) # 2, assistant ICF (Intermediate Care Facility) manager. When asked for Individual # 2's QIDP notes for February and March 2018 ASM # 2 stated, "We're unable to locate the notes."

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On 04/12/18 at 1:00 p.m., an interview was conducted with ASM # 1, ICF manager. When asked for Individual # 2's QIDP notes for February and March 2018 ASM # 1 stated, "We don't have them."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A 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/cerebralpalsy.html.

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

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(4) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807.

(5) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm.

2b. The QIDP failed to develop PCP (Person Centered Plan) to support Individual # 2's move toward independence.

On 04/11/18 Individual # 2's PCP (Person Centered Plan) dated 10/01/2017 through 09/30/2018 located in Individual # 2's residential clinical record was reviewed at (Name of Group Home). Individual # 2's PCP documented, "Outcomes Important To/or #: "12. (Individual # 2) is encouraged to utilize the eye gaze method to make choices." Further review of Individual; # 2's PCP outcomes # 12 failed to evidence measurable goals.

The CFA (comprehensive functional assessment) for Individual #2 dated 09/29/17 documented, "2. Communication: a) Indicates wants by pointing, vocal noises, or signs? - 3 = sometimes."

On 04/12/18 at approximately 1:00 p.m., and interview was conducted with ASM (administrative staff member) # 1, ICF (Intermediate Care Facility) manager and ASM # 3, assistant residential coordinator. When asked to describe the process for developing outcomes/goals into measurable terms, ASM # 1 stated, "We use the CFAs. The scoring refers to the level of

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assistance. If the individual is scored as being totally dependent then a measurable outcome for that area would not be developed." After reviewing Individual # 2's PCP dated 10/01/2017 through 09/30/2018 and CFA dated 09/29/17, ASM # 1 was asked about Individual # 2's communication outcome. ASM # 1 stated, "It's a protocol. It should have been developed as a measurable outcome."

The facility's policy "Facility Staffing Section 4-2: Qualified Intellectual Disabilities Professional" documented, "Ensure that the PCP is reflective of the criteria for Active Treatment, plans, interventions, tasks analysis, data collection, etc."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

2c. The QIDP failed to implement Individual #2's PCP outcome # 13, communication.

The PCP (Person Centered Plan) dated 10/01/2017 through 09/30/2018 documented, "# 13. I communicate with my family. I am supported to communicate with my family either via (by) phone or Skype for at minimum 5 (five) minutes once monthly." Under "Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found" it documented in part, "A "+ (plus sign)" is recorded for meeting outcome criteria per the indicated level of support. A "- (minus sign)" is recorded for requiring a higher level of support."

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W 159	Continued From page 31 The facility's "PCP Outcome Data Collection" sheet dated 11/01/17 through 11/30/17 for Individual # 2 documented, "Outcome # 13. I communicate with my family. I am supported to communicate with my family either via (by) phone or Skype for at minimum 5 (five) minutes once monthly." Under "Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found" it documented in part, "A "+ (plus sign)" is recorded for meeting outcome criteria per the indicated level of support. A "- (minus sign)" is recorded for requiring a higher level of support." Further review of the "PCP Outcome Data Collection" sheet dated 11/01/17 through 11/30/17 for outcome # 13 was blank. On 04/12/18 at approximately 2:30 p.m., an interview was conducted with ASM (administrative staff member) # 2, the assistant ICF (Intermediate Care Facility) manager. After reviewing the "PCP Outcome Data Collection" sheet dated 11/01/17 through 11/30/17 for Individual # 2's outcome # 13, ASM # 2 stated, "I can't say the program was implemented." On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings. No further information was provided prior to exit.	W 159		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence.	W 240	W 240 1. **How corrective action will be accomplished for individual #1**: Facility staff will revise the PCP (Person Centered Plan) to ensure that outcomes are developed to support individual #1's move toward independence. **Assurance that other residents are protected from the possibility of the deficiency**: Facility staff will review and revise all PCP's (Person Centered Plans) as needed to ensure that outcomes are developed to support each individual's move toward independence. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: Facility staff will extract outcomes from the Comprehensive Functional and Clinical Assessments to establish outcomes to support each individual's move towards independence. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The annual PCP for each client will be reviewed by the program manager prior to submission deadlines to ensure that outcomes support each individual's move toward independence. **Date of Completion**: 5/9/18	5/9/18

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W 240	Continued From page 32 This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to develop ISPs (Individual Service Plans) to support individual's move toward independence for two of two individuals in the survey sample, Individuals # 1 and # 2. 1. The facility staff failed to develop PCP (Person Centered Plan) outcomes to support Individual # 1's progress toward independence. 2. The facility staff failed to develop PCP (Person Centered Plan) outcomes to support Individual # 2's progress toward independence. The findings include: 1. The facility staff failed to develop PCP (Person Centered Plan) outcomes to support Individual # 1's progress toward independence. Individual # 1 was a 59 year-old male, who was admitted to (Name of Group Home) on 01/20/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), seizures (2), dysphagia (3), gastroesophageal reflux disease (4), osteopenia (5), and hypertension (6). On 04/11/18 Individual # 1's PCP (Person Centered Plan) dated 02/21/2018 through 02/20/2019 located in Individual # 1's residential clinical record was reviewed at (Name of Group Home). Individual # 1's PCP documented, "Outcomes Important To/or #: 3a. Communication Protocol. (Individual # 1) communicates in	W 240	W 240 2. **How corrective action will be accomplished for individual #2**: Facility staff will revise the PCP (Person Centered Plan) to ensure that outcomes are developed to support individual #2's move toward independence. **Assurance that other residents are protected from the possibility of the deficiency**: Facility staff will review and revise all PCP's (Person Centered Plans) as needed to ensure that outcomes are developed to support each individual's move toward independence. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: Facility staff will extract outcomes from the Comprehensive Functional and Clinical Assessments to establish outcomes to support each individual's move towards independence. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The annual PCP for each client will be reviewed by the program manager prior to submission deadlines to ensure that outcomes support each individual's move toward independence. **Date of Completion**: 5/9/18	5/9/18

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von-verbal ways; those that support him are aware of how to best support him to work towards independence in all areas of his life. 5. Eating Protocol. (Individual # 1) is offered visual oversight and verbal prompting throughout the entire duration of his meals." Further review of Individual; # 1's PCP outcomes # 3a and # 5 failed to evidence measurable goals.

The CFA (comprehensive functional assessment) for Individual # 1 dated 01/30/18 documented, "2. Communication: e) Understands simple words, phrases or instructions - 3=sometimes; 3. Task Learning Skills: h) Recognize persons, places, events, objects in their community? - 3=sometimes; 4. Personal/Self-Care: b) Perform dining functions? - 3=Supervision."

On 04/12/18 at approximately 1:00 p.m., and interview was conducted with ASM (administrative staff member) # 1, ICF (Intermediate Care Facility) manager and ASM # 3, assistant residential coordinator. When asked to describe the process for developing outcomes/goals into measurable terms, ASM # 1 stated, "We use the CFAs. The scoring refers to the level of assistance. If the individual is scored as being totally dependent then a measurable outcome for that area would not be developed." After reviewing Individual # 1's PCP dated 02/21/2018 through 02/20/2019 and CFA dated 01/30/18, ASM # 1 was asked about Individual # 1's communication and eating protocols. ASM # 1 stated, "They should have been developed as measurable outcomes."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

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No further information was provided prior to exit.

Reference:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

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

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807.

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

2. The facility staff failed to develop PCP (Person Centered Plan) outcomes to support Individual # 2's progress toward independence.

Individual # 2 was a 54 year-old male, who was admitted to (Name of Group Home) on 01/18/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), cerebral palsy (2), dysphagia (3), osteopenia (4), and gout (5).

On 04/11/18 Individual # 2's PCP (Person Centered Plan) dated 10/01/2017 through 09/30/2018 located in Individual # 2's residential clinical record was reviewed at (Name of Group Home). Individual # 2's PCP documented, "Outcomes Important To/or #: "12. (Individual # 2) is encouraged to utilize the eye gaze method to make choices." Further review of Individual; # 2's PCP outcomes # 12 failed to evidence measurable goals.

The CFA (comprehensive functional assessment) for Individual # 1 dated 09/29/17 documented, "2. Communication: a) Indicates wants by pointing, vocal noises, or signs? - 3 = sometimes."

On 04/12/18 at approximately 1:00 p.m., and interview was conducted with ASM (administrative staff member) # 1, ICF (Intermediate Care Facility) manager and ASM # 3, assistant residential coordinator. When asked to describe the process for developing outcomes/goals into measurable terms, ASM # 1 stated, "We use the

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CFAs. The scoring refers to the level of assistance. If the individual is scored as being totally dependent then a measurable outcome for that area would not be developed." After reviewing Individual # 2's PCP dated 10/01/2017 through 09/30/2018 and CFA dated 09/29/17, ASM # 1 was asked about Individual # 2's communication outcome. ASM # 1 stated, "It's a protocol. It should have been developed as a measurable outcome."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A 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/cerebralpalsy.html.

(3) A swallowing disorder. This information was

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W 240	Continued From page 37 obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807. (5) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement active treatment according to the PCP (Person Centered Plan) for one of two individuals in the survey sample, Individual #2. The facility staff failed to implement Individual #2's PCP outcome # 13, communication.	W 249	W249 **How corrective action will be accomplished for Individual #2**: Facility staff will implement the active treatment outcome involving communication for Individual #2. **Assurance that other residents are protected from the possibility of the deficiency**: Facility staff will implement the active treatment outcome involving communication 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 review data to ensure outcome implementation is being recorded accurately by staff. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The program manager and assistant manager will review all data collection at a minimum of monthly to ensure that implementation is being recorded accurately. **Date of Completion**: 5/9/18	5/9/18

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The findings include:

Individual # 2 was a 54 year-old male, who was admitted to (Name of Group Home) on 01/18/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), cerebral palsy (2), dysphagia (3), osteopenia (4), and gout (5).

The PCP (Person Centered Plan) dated 10/01/2017 through 09/30/2018 documented, "# 13. I communicate with my family. I am supported to communicate with my family either via (by) phone or Skype for at minimum 5 (five) minutes once monthly." Under "Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found" it documented in part, "A "+ (plus sign)" is recorded for meeting outcome criteria per the indicated level of support. A "- (minus sign)" is recorded for requiring a higher level of support."

The facility's "PCP Outcome Data Collection" sheet dated 11/01/17 through 11/30/17 for Individual # 2 documented, "Outcome # 13. I communicate with my family. I am supported to communicate with my family either via (by) phone or Skype for at minimum 5 (five) minutes once monthly." Under "Describe how this will be provided based on individual preferences, (support instructions) and location where program strategy can be found" it documented in part, "A "+ (plus sign)" is recorded for meeting outcome criteria per the indicated level of support. A "- (minus sign)" is recorded for requiring a higher level of support." Further review of the "PCP Outcome Data Collection" sheet dated 11/01/17

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through 11/30/17 for outcome # 13 was blank.

On 04/12/18 at approximately 2:30 p.m., an interview was conducted with ASM (administrative staff member) # 2, the assistant ICF (Intermediate Care Facility) manager. After reviewing the "PCP Outcome Data Collection" sheet dated 11/01/17 through 11/30/17 for Individual # 2's outcome # 13, ASM # 2 stated, "I can't say the program was implemented."

The facility's policy "Active Treatment Section 5-3" documented, "8. Implementation of services will be purposeful (mirroring normal living experiences such as leisure and social activities), ongoing, consistent and targeted at training, treatment, and health services. Staff will encourage the individual to acquire, develop, and express functional skills and adaptive behaviors necessary to function with as much self-determination and independence as possible, as well as preventing the loss of such functional skills and independence."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

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

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W 249	Continued From page 40 responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) 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/cerebralpalsy.html. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807. (5) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm.	W 249		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview, facility document review	W 255	W255 **How corrective action will be accomplished for individual #2**: Facility staff will ensure that the active treatment programs of dressing, washing, personal care, tooth brushing, and medication management are reviewed and revised for individual #2. **Assurance that other residents are protected from the possibility of the deficiency**: Facility staff will ensure that the active treatment programs for each individual are reviewed and revised as needed. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: Facility staff will ensure that each quarterly and PCP (Person Centered Plan) for each individual is accurate and each is a representation of what progress has been made toward outcomes. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The program manager will review each quarterly and PCP (Person Centered Plan) for each individual to ensure that they are accurate and representative of what progress has been made toward outcomes for each individual. **Date of Completion**: 5/9/18	5/9/18

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and clinical record review it was determined that the facility staff failed to review or revise the active treatment program for one of two individuals in the survey sample, Individuals # 2.

The facility staff failed to ensure the active treatment program of dressing, washing, personal care, tooth brushing and medication management were reviewed or revised for Individual # 2.

The findings include:

Individual # 2 was a 54 year-old male, who was admitted to (Name of Group Home) on 01/18/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), cerebral palsy (2), dysphagia (3), osteopenia (4), and gout (5).

The PCP (Person Centered Plan) for (Name of Group Home) dated 10/01/2017 through 09/30/2018 for Individual # 2 documented, "1b. With maximum hand-overhand assistance, (Individual # 2) put his arms into his shirt sleeves daily. Success is measured when he completes this task a with supports as outlined 5 (five) days in a row. 2b. With maximum hand-overhand assistance, (Individual # 2) washes his torso with the washcloth for 10 seconds. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 2c. With touch prompts and verbal prompts (Individual # 2) lift his hips for 5 (five) seconds while changing his briefs. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 5b. With no more than two verbal prompts, (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this

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task a with supports as outlined five days in a row."

The data collection sheets from the (Name of Group Home) dated 10/01/2017 through 03/31/2018 documented, "1b. With maximum hand-overhand assistance, (Individual # 2) put his arms into his shirt sleeves daily. Success is measured when he completes this task a with supports as outlined 5 (five) days in a row. 2b. With maximum hand-overhand assistance, (Individual # 2) washes his torso with the washcloth for 10 seconds. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 2c. With touch prompts and verbal prompts (Individual # 2) lift his hips for 5 (five) seconds while changing his briefs. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 5b. With no more than two verbal prompts, (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this task a with supports as outlined five days in a row." Further review of the data collection sheets revealed PCP outcomes 1b was met in October, November, December 2017 and January, February and March 2018; 2b was met in February 2018; 2c was met in March 2018 and 5b was met in October, November, December 2017 and January, February and March 2018.

The PCP (Person Centered Plan) for (Name of Day Program) dated 10/01/2017 through 09/30/2018 for Individual # 2 documented, "2c. With touch prompts and verbal prompts (Individual # 2) lift his hips for 5 (five) seconds while changing his briefs. Success is measured when (Individual # 2) completes this task a with

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supports as outlined 5 (five) days in a row. 4. Twice daily (Individual # 2) grasps his toothbrush in his right hand for 5 (five) seconds while staff dependently places toothpaste on the toothbrush. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 5b. With no more than two verbal prompts. (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this task a with supports as outlined five days in a row."

The data collection sheets from the (Name of Day Program) dated 10/01/2017 through 03/31/2018 documented, "2c. With touch prompts and verbal prompts (Individual # 2) lift his hips for 5 (five) seconds while changing his briefs. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 4. Twice daily (Individual # 2) grasps his toothbrush in his right hand for 5 (five) seconds while staff dependently places toothpaste on the toothbrush. Success is measured when (Individual # 2) completes this task a with supports as outlined 5 (five) days in a row. 5b. With no more than two verbal prompts, (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this task a with supports as outlined five days in a row." Further review of the data collection sheets revealed PCP outcomes 2c was met in February 2018; 4. Met in February 2018 and 5b met on February and March 2018."

The quarterly review dated "January 1, 2018 First Quarter" for Individual # 2's PCP outcomes 1b and 5b documented, "Stability."

The PCP (Person Centered Plan) for (Name of

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Group Home) dated 10/01/2017 through 09/30/2018 and the PCP for (Name of Day Program) dated 10/01/2017 through 09/30/2018 for Individual # 2 failed to evidence revision of the PCP outcomes 1b, 2b, 2c, 4 and 5b.

On 04/10/18 at approximately 5:00 p.m., an interview was conducted with ASM (administrative staff member) # 1, ICF manager. When asked to describe the process for outcomes/goal that have been met, ASM # 1 stated, "We track progress monthly and quarterly. It's my impression that if the goal is met in the first month, the goal is continued for the quarter and the goal is updated or revised at the end of the quarter." When asked to describe the process if the goal/outcome is met in the last month of the quarter, ASM # 1 stated, "I would consult with the assistant residential coordinator."

On 04/10/18 at approximately 5:20 p.m., an interview was conducted with ASM # 3, assistant residential coordinator. When asked to describe the process for outcomes/goal that have been met, ASM # 1 stated, "The outcome/goal gets revised upon completion of the outcome/goal." ASM # 3 further stated, "The PCP should be updated or revised as needed and at least quarterly." ASM #1 then reviewed the PCP dated 10/01/2017 through 09/30/2018, the PCP for (Name of Day Program) dated 10/01/2017 through 09/30/2018, the data collection sheets dated 10/01/2017 through 03/31/2018 and quarterly review dated "January 1, 2018 First Quarter for Individual # 2. ASM # 1 was asked if the PCP outcomes of 1b. dressing, 2b. washing, 2c. personal care, 4 tooth brushing and 5b. medication management, were revised or reviewed, ASM # 1 stated, "No. They should

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have been revised."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A 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/cerebralpalsy.html.

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

(4) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807.

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	49G073	A. BUILDING _____ B. WING _____	04/12/2018

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WOLFE STREET ICF ID	815 WOLFE STREET FREDERICKSBURG, VA 22401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 255	Continued From page 46 (5) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm.	W 255		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. 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 ensure nursing services were provided in accordance with the individual's need for one of two individuals during the medication administration observation. The facility staff failed to ensure Individual # 1's medication of lactulose (1) was administered. The findings include: Individual # 1 was a 59 year-old male, who was admitted to (Name of Group Home) on 01/20/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (2), seizures (3), dysphagia (4), gastroesophageal reflux disease (5), osteopenia (6), and hypertension (7). On 04/11/18 at approximately 7:20 a.m., the medication administration observation was conducted with LPN (licensed practical nurse) # 1. At 7:50 a.m., LPN # 1 began dispensing the medication for Individual # 1 in the medication	W 331	W331 **How corrective action will be accomplished for individual #1**: Facility staff will ensure that individual #1's medication of lactulose is administered. **Assurance that other residents are protected from the possibility of the deficiency**: Facility staff will ensure that each individual's medication is administered. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur**: Facility staff will ensure that any residual lactulose solution remaining in the individual's cup after consumption will be poured into a spoon and the individual will be supported with consuming the remaining medication from the spoon. **How the facility plans to monitor its performance to make sure that solutions are sustained**: The nurse manager will review administration procedures with all staff and conduct periodic surveillance checks and supervision to ensure compliance with the procedures. **Date of Completion**: 5/9/18	5/9/18

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room. Among the medication being prepared for Individual # 1 was lactulose. LPN # 1 poured the lactulose from the supply bottle into a plastic calibrated medication cup until it measured 15 ml (milliliters) in the medication cup. LPN # 1 pour the 15 mls of lactulose into a drinking glass containing approximately six to eight ounces of juice. LPN # 1 left the medication room, accompanied Individual # 1 from the hallway into the medication room, and seated Individual #1 in a chair. LPN # 1 administered the lactulose to Individual # 1 by handing Individual # 1 the cup containing the lactulose and juice mixture. Individual # 1 took the cup in his hand and began to drink the lactulose and juice mixture while LPN # 1 provided verbal prompting to Individual # 1 to drink and hand-over hand assistance tipping the cup to consume the medication. Individual # 1 was compliant and cooperative during the medication administration. After consuming the lactulose and juice mixture LPN # 1 provided Individual # 1 approximately eight ounces of water to drink. Individual # 1 was observed drinking approximately half of the water. Further observation of the cup that contained the lactulose and juice revealed a small amount left in the bottom of the cup. After Individual # 1 finished drinking the water, LPN # 1 verbally prompted Individual # 1 to get up from the chair. Individual # 1 got up from the chair, LPN # 1 gathered the cup containing the rest of the water and the cup containing the remaining lactulose and juice and accompanied Individual # 1 out of the medication room and to the dining room where a staff member assisted Individual # 1 to a chair at the dining room table for breakfast. LPN # 1 then went to the kitchen sink with the cup containing the water and the cup containing the remaining lactulose and juice. LPN # 1 emptied

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the cup of water into the kitchen sink then started to empty the cup of the remaining lactulose and juice. At that time, this surveyor stopped LPN # 1 from emptying the cup of lactulose and juice and asked LPN # to measure the remaining amount. LPN # 1 went back to the medication room and poured the lactulose and juice mixture into a plastic calibrated medication cup. Observation of the medication cup revealed five mls of the mixture. LPN # 1 was asked to read the medication cup and LPN #1 verbally confirmed there was five mls of the medication mixture remaining. LPN # 1 stated, "He didn't drink it all. I didn't know there was that much left. He should have taken all of the medication." LPN # 1 then asked a staff member to bring Individual # 1 back into the medication room and LPN # 1 assisted Individual # 1 in holding the medication cup and Individual # 1 then consumed the remaining lactulose and juice.

The "E-Script (electronic script) New Prescription Request" for Individual # 1 dated and electronically signed by the physician on 04/06/2018 documented, "Lactulose 10 GM (grams) / 15 ML (milliliter) Oral Solution. Directions: 15 Milliliter two times daily."

The MAR (medication administration record) dated April 2018 for Individual # 1 documented, "Lactulose 10 GM (grams) / 15 ML (milliliter) Oral Solution. Directions: 15 Milliliter two times daily." Further observation of the MAR revealed LPN # 1's initials on 04/11/18 at 8:00 a.m., indicating the medication was administered.

On 04/11/18 at 9:15 a.m., an interview was conducted with RN (registered nurse) # 1. After reviewing the medication administration

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observation of Individual # 1's lactulose RN # 1 was asked to describe to procedure for administering liquid medication mixed with other liquids. RN # 1 stated, "There should not be a measurable amount left. They (individual) needs to consume all of it to get the correct dosage."

On 04/11/18 at 9:45 a.m., an interview was conducted with LPN # 1. When asked to describe the procedure to ensure all liquid medications are consumed when mixed with other liquids, LPN # 1 stated, "Make sure they drink it all and that there isn't any left." LPN #1 was asked what she was going to do with the remaining lactulose and juice mixture that was left in Individual # 1's cup prior to this surveyor asking her to measure the remaining amount. LPN # 1 stated, "I was about to dump it out and rinse out the cup."

The facility's policy "Medication Management and Administration" documented, "z. Measure any liquid form of medication and administer. Ensure the individual has swallowed this medication."

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) A synthetic sugar used to treat constipation. It is broken down in the colon into products that pull water out from the body and into the colon. This water softens stools. Lactulose is also used to reduce the amount of ammonia in the blood of patients with liver disease. It works by drawing ammonia from the blood into the colon where it is

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removed from the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682338.html.

(2) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(3) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

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

(5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(6) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807.

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W 331	Continued From page 51 (7) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	W 331		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to implement infection control practices when serving an individuals' dinner plate. The facility staff failed to ensure their fingers did not come into contact with food contact surface of a plate guard (1) on Individual # 1's dinner plate. The findings include: On 04/10/18 at 5:50 p.m., an observation of the dinner meal at (Name of Group Home) was conducted. The four individuals who reside at (name of Group Home) were seated around the dining room table. Individual # 1 was seated in a standard dining room chair. A staff member placed the individual's plates on the kitchen counter with the appropriate dietary consistencies and portions for each individual. Individual # 1's food was a chopped texture on his plate. DSP (direct support professional) # 1 was observed attaching a plate guard to Individual # 1's dinner plate. Further observation of DSP # 1 attaching	W 455	W455 **How corrective action will be accomplished for Individual #1**: Facility staff will wear gloves per standard infection control precautions at all times when when serving a dinner plate to individual #1. **Assurance that other residents are protected from the possibility of the deficiency**: Facility staff will wear gloves per standard infection control precautions at all times when when serving a dinner plate to each individual. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** All facility staff will read the RACSB Infection Control Policy again and will sign a statement of understanding of the information therein. The Infection Control Policy will be reviewed and discussed at the next mandatory staff meeting. **How the facility plans to monitor its performance to make sure that solutions are sustained**: ICF Management will intermittently observe facility staff to ensure that they are wearing gloves per standard infection control precautions at all times when serving individuals their dinner plates. **Date of Completion**: 5/9/18	5/9/18

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the plate guard on the plate revealed her bare fingers on the inside of the plate guard, the food contact surface.

The (Name of Group Home) "Meal Time Guidelines" revised 04.2018 for Individual # 1 documented, "Adaptive Equipment. Plate: Plate Guard. Dycem Mat."

The (Name of Group Home's) "Standing Orders February 2018" for Individual # 1 documented in part, "Plate guard."

On 04/11/18 at 3:30 p.m., an interview was conducted with DSP (direct support professional) # 1. When asked if she recalled placing the plate guard on Individual # 1's dinner plate before serving Individual # 1's dinner, DSP # stated, "Yes." When asked to describe how to attach the plate guard on to a plate, DSP # 1 stated, "Stretch the plate guard open, and place it on the edge of the plate keeping your fingers on the edges." When asked if bare fingers should touch the inside of the plate guard, DSP # 1 stated, "No." DSP # 1 further stated she recalled placing her fingers on the inside of the plate guard when before serving Individual # 1's dinner.

On 04/12/18 at approximately 2:00 p.m., ASM (administrative staff member) # 1, ICF manager was made aware of the findings.

No further information was provided prior to exit.

References:
(1) Made of a heavy-duty clear plastic, which fits plates up to 10 inches in diameter. This clear plate guard provides a barrier for a person to push their food against, and can be used

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W 455	Continued From page 53 discreetly while dining out. This information was obtained from the website: https://www.caregiverproducts.com/extra-large-clear-plate-guard.html.	W 455		