PRINTED: 12/06/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G070	B. WING		11/29/2018	
BURKE	PROVIDER OR SUPPLIER		1 8	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 BURKE ROAD BURKE, VA 22015	11/29/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D.R.F. COMPLETION	
	An unannounced E survey was conduct 11/29/18. Correction compliance with 42 Requirement for Lo Roles Under a Wain CFR(s): 483.475(b) ((b) Policies and proceding policies and proceding and implement for his section. The policies and the communication this section. The policies and update minimum, the policies and update with section 10 (8) (6) (6) (C) (iv), (7) (7) (7) (7) (8) (8) (9) (10) (10) (10) (10) (10) (10) (10) (10	CFR Part 483.73, ng-Term Care Facilities. ver Declared by Secretary (8) redures. The [facilities] must hent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be ed at least annually. At a es and procedures must g:] (1), or (9)] The role of the ver declared by the Secretary, section 1135 of the Act, in the d treatment at an alternate by emergency management (33.748(b):) Policies and role of the RNHCI under a the Secretary, in accordance Act, in the provision of care as site identified by emergency s. not met as evidenced by: view and facility document ined that the facility staff		Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) All of individuals and staff were effected by deficiency and citation. To correct and insure no individuals at staff are effected in the future the BurilD the Emergency Preparedness Plan reviewed and modified for compliance facility role under a waiver declared be Secretary, in accordance with 1135 of with care and treatment of Burke Roal individuals at an alternate site. A train will occur at the January Burke ICF I meeting to review the content of the additional procedures related to care attreatment at an alternative site. The Community Residences Risk Management Committee will review the Emergency Plan specific to Burke ICF Drive Group Home on annual basis. The Clinical Director will ensure and monitor all new and existing program staff are on the emergency preparedness plan be reviewing the staff training sign in she	the and ke ICF will be e to y the the Act d ning D team and he ID	

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 program participation.

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G070	B. WING		11/	29/2018	
BURKE	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9392 BURKE ROAD BURKE, VA 22015	1 1.077	2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	LD BE COMPLETA		
E 026	Continued From page 1		E 02	26	-		
	The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver.						
	The findings include	:					
	On 11/28/18 at approximately 1:00 p.m., a review of the facility's emergency preparedness plan and interview was conducted with ASM (administrative staff member) # 1, program manager. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 1 stated that the facility did not have it.						
	(administrative staff	oximately 6:00 p.m. ASM member) # 1, program aware of the findings.					
W 000	No further information INITIAL COMMENTS	on was obtained prior to exit. S	W 00	o			
	Intermediate Care Fi Intellectual Disabilitie 11/26/18 through 11/ compliance with 42 (for Intermediate Care	nnual Medicaid survey for acilities for Persons with es (ICF/ID) was conducted (29/18. The facility was not in CFR Part 483 Requirements e Facilities for the Mentally Safety Code survey report will					
I	time of the survey. T	x bed facility was six at the The survey sample consisted dual reviews (Individuals # 1,					

	EMENT OF DEFICIENCIES (X1) PROVID				OMB NO. 0938-039	
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G070	B. WING		44 100 100 40	
BURKE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1932 BURKE ROAD BURKE, VA 22015	11/29/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ORF COMPLETIO	
	recordkeeping systemealth care, active to and protection of the and protection of the This STANDARD is Based on staff interreview it was determed and accurate for one survey sample, Individual record (Name of Group Hose Current reviewed con Evaluation." 1b. The clinical record (Name of Group Home Compart Home Compa	velop and maintain a em that documents the client's reatment, social information, e client's rights. In not met as evidenced by: view and clinical record hined that the facility staff clinical record was complete e of four individuals in the vidual # 2. Ind for Individual # 2 at the me) failed to evidence a by of the "Psychological Individual # 2 at the me) revealed the "(Name of any) Authorization For d Health Information" was	W 000	The Residential QIDP will complete record review on Individual #2 to e	inical pgical The d ted 2 by based will eview at all pgical ensure ye of eir he	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G070	B. WING		11/29/2018	
BURKE	PROVIDER OR SUPPLIER		93:	REET ADDRESS, CITY, STATE, ZIP CODE 32 BURKE ROAD JRKE, VA 22015	610Zibaiii	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
	epilepsy (2) dyspha Review of Individua of Group Home) rev "Psychological Eval Further review of In failed to evidence a evaluation for Indivi On 11/28/18 at 11:2 conducted with ASN member) # 1, progn Individual # 2's mos evaluation. After re (electronic health re # 1 stated, "It wasn't psychological evalua When asked to dest for ensuring the EHI and clinical record of psychologist will eith evaluation to the gro EHR or the clinical r process was followed psychological evalua wasn't done. I called fifteen minutes ago of current evaluation." On 11/28/18 at 6:00 staff member) # 1, p Group Home) was in finding.	erate intellectual disability (1), gia (3) and hypertension (4). Il # 2's clinical record at (Name vealed Individual # 2's uation" dated "June 2017." dividual # 2's clinical record current psychological	W 111			
	References:		94			

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/06/2018 FORM APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
		49G070	B. WING	44 0000040	
NAME OF	PROVIDER OR SUPPLIER	Company of the second	STF	REET ADDRESS, CITY, STATE, ZIP CODE	11/29/2018
BURKE	icf ið			2 BURKE ROAD RKE, VA 22015	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE COMPLETION
	(1) Refers to a group by a limited mental adaptive behaviors schedules and routintellectual disability 18 and may result from the website: https://www.report.nctSheet.aspx?csid= (2) A brain disorder recurring seizures. Clusters of nerve ce send out the wrong strange sensations a strangely. They may or lose consciousne obtained from the whitps://www.nlm.nih.sorders.html. (4) High blood press obtained from the websites of the w	p of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. or originates before the age of rom physical causes, such as palsy, or from nonphysical cheef of stimulation and adult his information was obtained with gov/NIH factsheets/ViewFa 100 that causes people to have The seizures happen when lis, or neurons, in the brain signals. People may have and emotions or behave or have violent muscle spasms ss. This information was ebsite: gov/epilepsy.html. order. This information was ebsite: gov/medlineplus/swallowingdicure. This information was	W 111		
	(Name of Group Ho Group Home Compa	ord for Individual # 2 at the me) revealed the "(Name of Iny) Authorization For d Health Information" was			

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO	LTIPLE CONSTRUCTION DING	(X3) D/	(X3) DATE SURVEY COMPLETED	
11		49G070	B. WING		4,	/29/2018	
NAME OF F		T		STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		115315019	
(X4) ID PREFIX TAG			ID PREFI TAG		ULD BE	(XS) COMPLETION DATE	
	Review of Individual reviewed at (Name "(Name of Group He For Release Of Provindividual #2 was in statement "Initial all the form documents (information), Treatr Evaluation, Oral Col Provider, Social Hist Discharge, Medical Discharge, Medical Discharge Summany Evaluation, Medicati (specify)." Further mone of these items or check off. On 11/28/18 at 11:40 conducted with ASM member) #1, progrational #2's "(National #2's ")) On 11/28/18 at 6:00 staff member) #1, pigroup Home) was minding.	I # 2's clinical record was of Group Home) revealed; ome Company) Authorization tected Health Information" for complete. Under the record items to be released" ed, "Vocational informent Plan, Psychiatric mmunication with Service tory, Progress Notes, Reports/Consultations, y, Diagnosis, Psychological ion Record and Other eview of this section reveal or records had been initialed of a.m., an interview was a (administrative staff am manager regarding me of Group Home etion For Release Of formation" form. When asked the ease for completing the form, a guardian checks off the enome) and/ or the group	W				

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STATEMENT OF DEFICIENCIES (7) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION 3. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		49G070	B. WING				
NAME OF BURKE	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	111/	29/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETIO DATE	
	The facility must e Therefore, the facility must e Therefore, the facility reatment and care treatment and care the streatment and care the streatment and care the streatment and care the streatment and care treatment and	collents RIGHTS a)(7) Insure the rights of all clients. Illity must ensure privacy during e of personal needs. Is not met as evidenced by: Ations and staff interviews it that the facility staff failed to the use of a catheter collection individuals in the survey # 2. Illed to provide a privacy bag or # 2's catheter collection bag. Ite: a 56-year-old female, who was of Group Home) on 11/24/14. Ilnical record included but were erate intellectual disability (1), agia (3) and hypertension (4). O p.m., an observation was dent # 2 at (Name of Day pproximately 1:10 p.m. to 1:30 was engaged in a music group consisted of teen other individuals and staff members. Observation of aled she was sitting in her hidst of the group. Individual #	W 13 W 13	lensiire nrivacy tor the use of a	catheter by cy bag or in bag of on a privacy in bag italned ecember ger will ting is to all ger will ort is being	12/30/1	

STATEMEN' AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G070	B. WING			1/29/2018	
BURKE	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		1/20/20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(XS) COMPLETION DATE:	
	rear wheel. Observed bag failed to eviden privacy bag. Further collection bag reveat was clearly visible. Individual # 2 was a manicure activity. Owneelchair revealed hooked onto the left front of the rear where catheter collection is covered or inside a observation of the crevealed that it contivisible. On 11/27/18 at 1:50 conducted with OSM (Name of Day Progressialist, who was group. When asked for ensuring Individual catheter collection is cover it up." On 11/27/18 at 1:55 conducted with LPN at (Name of Day Prodescribe the procedus 2's privacy regarding LPN # 2 stated, "The When asked to mea was visible in the coll Individual # 2's wheels scale printed on the and stated, "Approxision of 11/28/18 at approximation of the collection of the and stated, "Approxision of the collection of the and stated, "Approxision of 11/28/18 at approximation of the collection of the and stated, "Approxision of the collection of the collectio	ration of the catheter collection ce the bag covered or inside a probservation of the catheter aled that it contained urine and At approximately 1:30 p.m., noved to a smaller group for a Observation of Individual # 2's I a catheter collection bag toutside of the wheelchair, in sel. Observation of the pag failed to evidence the bag privacy bag. Further atheter collection bag ained urine and was clearly p.m., an interview was A (other staff member) # 1, ram's) Community Integrated overseeing Individual # 2's I to describe the procedure all # 2's privacy regarding the ag, OSM # 1 stated, "I would p.m., an interview was (licensed practical nurse) # 2 pgram). When asked to ure for ensuring Individual # 1 the catheter collection bag, bag should be covered." sure the amount of urine that election bag, LPN # 2 went to olichair, leaned down, read the outside of the collection gab mately 300 milliliters."	W 1				
	interview was condu	cted with RN (registered				1 1	

		AND HUMAN SERVICES		ş	PRINTED:	12/06/2018 PPROVED
		& MEDICAID SERVICES			MB NO. C	938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G070	B. WING	T CARBANIA AA MARABAN AA MARABAN AA A	44 55 55 55	
NAME OF	PROVIDER OR SUPPLIER	A	1	STREET ADDRESS, CITY, STATE, ZIP CODE	11/28	2/2018
BURKE	ICF ID			332 BURKE ROAD BURKE, VA 22015	100	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE ((X5) COMPLETION OATE
	nurse) # 1 for (Nam 1, at (Name of Grou Individual # 2's cath and LPN # 1 stated from the hospital or catheter. We didn't # 1 stated, "I went of When asked why In privacy bag when sl RN # 1 and LPN # 1 we've had someone asked if it was a prive 2's catheter collection #1 and LPN # 1 state On 11/28/18 at 6:00 staff member) # 1, p Group Home) was in finding. No further information References: (1) Refers to a group by a limited mental of adaptive behaviors a schedules and routin Intellectual disability 18 and may result from autism or cerebral por causes, such as lack responsiveness. The from the website: https://www.report.ni ctSheet.aspx?csid=1 (2) A brain disorder t recurring seizures. T	ne of Group Horne) and LPN # up Horne). When asked about neter collection bag, RN #1 I that Individual # 2 came back november ninth with the get a privacy bag then." RN out yesterday and got one." advidual # 2 didn't have a the first acquired the catheter, I stated, "This is the first time with a catheter." When vacy concern for Individual # on bag not to be covered, RN ted, "Yes. I p.m. ASM (administrative program manager of (Name of made aware of the above on was provided prior to exit. I of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. originates before the age of om physical causes, such as alsy, or from nonphysical c of stimulation and adult is information was obtained ith.gov/NIHfactsheets/viewFa	W 130			

		A MEDICAID SERVICES			<u> NNR MÓ</u>	<u>. 0938</u> -0391	
STATEMEN' AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G070	8. WING		111	/29/2018	
BURKE	PROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 1332 BURKE ROAD BURKE, VA 22015		20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTM (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETION DATE	
	terms. 2a. The QIDP failed copy of Individual # was in the clinical re Home). 2b. The QIDP failed Individual # 2's "(Na Company) Authoriz: Protected Health Information of Individual # 2's "(Na Company) Authoriz: Protected Health Information of Individual Service February of Individual # 1 was a admitted to (Name of Diagnoses in the clinical limited to: mode autistic disorder (2) disorder (3) and and Individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy life standard individual # 1's current through 12/31/2018 Outcomes: (Name of have a healthy	I to ensure a current reviewed 2's "Psychological Evaluation" acord at the (Name of Group I to ensure clinical record for time of Group Home ation For Release Of formation" was completed. It to ensure the outcome/goal thy Life Style" on the ISP Plan) for Individual # 1 was trable terms. 69-year-old female, who was of Group Home) on 10/19/15. Inical record included but were rate intellectual disability (1), obsessive-compulsive trate intellectual disability (1), obsessive-compulsive ania (4). Intellectual # 1) would like to thyle. Support Activities & dividual # 1) will exercise her therapy pulley each day at 70% or 12 consecutive months. 1. (Individual # 1) will be the to exercise. 2. (Individual with getting her exercise at 3. (Individual # 1) will hold thise pulley and staff will hold	W 159	Continued from page 10 The Residential Program Manager also complete a thorough record of all other individuals to ensure the individuals have a current Psychol evaluation in the records and also ensure that all individuals have thoroughly completed authorization release of protected health informations. The Program Manager will review process to ensure compliance and prevent further deficiencies. Mission Effectiveness and or the Contractor will also conduct quarterly record reviews to prevent deficientials.	eview hat all ogical on for nation the	12/30/18	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		E SURVEY
ANDPLAN	DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		(00)	APLETED
		49G070	B, WING			111	/29/2018
NAME OF	PRÓVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BURKE	ICF ID		İ		332 BURKE ROAD URKE, VA 22015		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	GI CI	П	PROVIDER'S PLAN OF CORRECTE	W	(XS)
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	×	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	DBF	COMPLET ON DATE
W 159	Continued From pa	an 11		_	· · · · · · · · · · · · · · · · · · ·		
		•	W 1	59			
	the opposite end, 4	l. (Individual # 1) will exercise by extending her arms out as	[1
	far as it can do so ti	hat the device will move		- 1			1
	towards the staff as	sisting her. 5. She will		1			
	continue exercising	for 10-15 minutes as					
	tolerated. 6. (Indivi	dual # 1) will be praised for					
	her efforts. 7. Staff	will document her progress					
	in her daily progress	notes. 8. Data will be		H			
	reviewed Monthly by	y the QIDP (Qualified					
	Intellectual Disabiliti	es Professional). 9. When					
	(Individual # 1) com	pletes exercising her arms for		- 1			
i	10-15 minutes each	day for 12 consecutive					i
	months, she will hav	e achieved this goal."					
	During an interview	on 11/28/19 at approximately					1
	4:40 nm with ASM	(administrative staff		1			
	member) # 1 the nr	ogram manager for (Name of					
	Group Home), the Is	SP for Individual # 1 was					
- 1	reviewed. ASM # 1	was asked how					
	"outcomes/goals" w	ere written: ASM # 1 stated			83		
	that an outcome/goa	al is written in measurable					[
	terms to determine	progress. After reviewing the					i 1
	desired outcome for	Individual # 1, "(Individual #		- 1			[
ļ	1) will exercise her a	ırms by using her therapy					[[
	pulley each day at 7	0% (percent) accuracy for 12					[!
	consecutive months	." ASM # 1 was asked if the					
	she could identify wi	in measurable term and if					ļ ļ
]		nat was being measured to ASM # 1 stated, "No. We					
	meant to measure h	ow well she is able to					
	complete the duration	on of the exercise." When					
	asked to describe th	e role and responsibilities of					
ľ	the QIDP, ASM # 1	stated, "They provide direct					
	support services, wo	ork with the individuals, be the					i
	contact between the	legal guardians and the					
[interdisciplinary tean	n. ASM #1 stated, *Thev		Ì			"
	develop ISPs, provid	le activity support to the					1
	individuals, ensure a	ctive treatment programs are					
	being done at the gr	oup home and the day					

PRINTED: 12/06/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 49Q070 **B. WING** 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD **BURKE ICF ID BURKE, VA 22015** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) W 159 Continued From page 12 W 159 programs, train the DSPs (direct support professionals) under the supervision of the program manager, oversee the running of the shifts, checking equipment for safety and that it is in good working order. They ensure the clinical records at the group home and day program are accurate and ensuing the ISP goals and data collection are measurable and accurate." When asked if it was the responsibility of the QIDP to ensure the exercise outcome was developed measurable terms to determine progress, ASM #1 stated, "Yes." When asked to speak with the QIDP who responsible. ASM # 1 stated that she was no longer with (Name of Group Home) and the new QIDP had started on 11/25/18 and was in training. On 11/28/18 at 6:00 p.m. ASM (administrative staff member) # 1, program manager of (Name of Group Home) was made aware of the above findina. 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/ViewFa

ctSheet.aspx?csid=100

(2) A neurological and developmental disorder

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G070	B. WING		111	29/2018	
ł	NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			BTREET ADDRESS, CITY, STATE, 2IP CODE 2332 BURKE ROAD BURKE, VA 22015		23/2016	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	N SHOULD BE CO E APPROPRIATE		
	that begins early in throughout a persor acts and interacts wand learns. This infithe website: https://www.nlm.nihrumdisorder.html. (3) A common, chroin which a person hithoughts (obsession (compulsions) that I repeat over and over obtained from the whttp://www.nimh.nihompulsive-disorder- (4) Low iron. This in the website: https://www.nlm.nih. 1b. The QIDP failed of Individual # 1's IS outcome/goal was diterms. Review of (Name of Notes" for Individual through 10/31/2018 collection of the outcestyle in measurable During an interview 4:40 p.m., with ASM member) # 1, the progroup Home), the IS reviewed. ASM # 1	childhood and lasts n's life. It affects how a person with others, communicates, corrnation was obtained from gov/medlineplus/autismspect nic and long-lasting disorder as uncontrollable, reoccurring as) and behaviors ne or she feels the urge to wr. This information was ebsite: gov/health/topics/obsessive-c ocd/index.shtml. formation was obtained from gov/medlineplus/anemia.html to ensure the data collection P (Individual Support Plan) ocumented in measurable Group Home) "Progress # 1 dated 10/01/2018 failed to evidence data come exercise/healthy life terms. on 11/28/19 at approximately (administrative staff ogram manager for (Name of GP for Individual # 1 was was asked to review collection dated 10/01/2018	W 159				

DEPAR	TMENT OF HEALT	H AND HUMAN SERVICES		P	RINTED:	12/06/2018 APPROVED
CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			MB NO.	0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIE		87	REET ADDRESS, CITY, STATE, ZIP CODE	11/2	9/2018
BURKE		70 THE	0.0	32 BURKE ROAD URKE, VA 22015		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RF	(XS) COMPLETION DATE
	exercise/healthy lishe could identify determine progress meant to measure complete the dura asked if it was the ensure the data consume the difference outcome in measurable terrown was no longer with the new QIDP who responsives no longer with the new QIDP had training. On 11/28/18 at 6:0 staff member) # 1, Group Home) was finding. No further information of lindividual # 2 was in the clinical recopy of Individual # 2 was admitted to (Name Diagnoses in the clinical individual # 2 was admitted to (Name Diagnoses in the clinical limited to: mode epilepsy (2) dysphareviewed at (Name	fe style. ASM # 1 was asked if what was being measured to is. ASM # 1 stated, "No. We how well she is able to tion of the exercise." When responsibility of the QIDP to bilection for Individual # 1's was developed and monitored ins, ASM #1 stated, "Yes." is surveyor could speak with the sible, ASM # 1 stated that she in (Name of Group Home) and started on 11/25/18 and was in 0 p.m. ASM (administrative program manager of (Name of made aware of the above tion was provided prior to exit. In the cord at the (Name of Group Home) and in the formulation at the example of the stated that the income a current reviewed 2's "Psychological Evaluation" ecord at the (Name of Group Home) on 11/24/14, inical record included but were erate intellectual disability (1), agia (3) and hypertension (4).	W 159			
	record revealed Ind Evaluation" dated ".	lividual # 2's "Psychological June 2017." Further review of cal record failed to evidence a				

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) D	(X3) DATE SURVEY COMPLETED	
		49G070	B. WING			1/29/2018	
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			STREET ADDRESS, CITY, STATE, ZIP CO 9332 BURKE ROAD BURKE, VA 22015	DOE	7/20/2010		
(X4) ID PRIEFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 159	current psychologic On 11/28/18 at 11:2 conducted with ASM member) # 1, progr Individual # 2's mos evaluation. After re (electronic health re # 1 stated, "It wasn' psychological evalu When asked to des for ensuring the EH and clinical record of psychological evalu psychological evalu psychological evalu psychological evalu psychological evalu psychological evalu wasn't done. I calle fifteen minutes ago current evaluation." responsibility of the "Psychological Evalu Individual # 2 was in stated, "Yes." Wher speak with the QIDF stated that she was	al evaluation for Individual # 2. 5 a.m., an interview was if (administrative staff am manager regarding at current psychological view of Individual # 2's EHR record) and clinical record ASM if iled, I only found the ation dated June 2017." cribe the process they follow R (electronic health record) contain the most recent ations, ASM # 1 stated, "The ner mail, fax, or email the pup home and it is filed in the ecord." When asked if the d for Individual # 2's current ation, ASM # 1 stated, "It d the psychologist about and asked her to fax the When asked if it was the QIDP to ensure the uation" dated "June 2017 for the clinical record, ASM # 1 asked if this surveyor could who responsible, ASM # 1 no longer with (Name of the new QIDP had started on	W 1!	59			
	staff member) # 1, p Group Home) was n finding.	p.m. ASM (administrative rogram manager of (Name of nade aware of the above					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G070	B. WING	e (respective	11	/29/2018	
	NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		14412010	
(X4) ID PREFIX TAG			(D PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
Ħ	by a limited mental adaptive behaviors schedules and routi Intellectual disability 18 and may result from the website: https://www.report.nctSheet.aspx?csid= (2) A brain disorder recurring seizures. To clusters of nerve celestrangely. They may or lose consciousne obtained from the wehttps://medlineplus.g. (3) A swallowing discobtained from the wehttps://www.nlm.nih.sorders.html. (4) High blood press obtained from the wehttps://www.nlm.nih.sorders.html.	p of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions, originates before the age of rom physical causes, such as easy, or from nonphysical k of stimulation and adult his information was obtained with a causes people to have that causes people to have that causes people to have that causes people may have and emotions or behave thave violent muscle spasms ss. This information was ebsite: gov/epilepsy.html. Dorder. This information was ebsite: gov/medlineplus/swallowingdi ure. This information was ebsite: gov/medlineplus/highbloodpr to ensure clinical record for me of Group Home	W 1	59			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49G070	B. WING			44 /	29/2018
BURKE I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 9392 BURKE ROAD BURKE, VA 22015	CODE	11/2	28/2018
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		ON SHOULD B IE APPROPRIA	BE ATE	(X5) COMPLETION DATE
	reviewed at (Name 2's clinical record re Home Company) Al Protected Health In Under the statemen released" the form of (information), Treati Evaluation, Oral Co Provider, Social His Discharge, Medical Discharge Summan Evaluation, Medicat (specify)." Further in none of these items check off. On 11/28/18 at 11:4 conducted with ASM member) # 1, progra Individual # 2's "(Na Company) Authoriza Protected Health Information to describe the process ASM #1 stated, "The items to be released nurse (at the group home staff." When incomplete, ASM #1 to see more informations sked if it was the reensure the "(Name of Authorization For Refinformation" form we "Yes." When asked with the QIDP who rethat she was no long the statement of the process	I # 2's clinical record was of Group Home). Individual # Inveated "(Name of Group uthorization For Release Of Idormation" to be incomplete. It "Initial all record items to be documented, " Vocational Informent Plan, Psychiatric mmunication with Service tory, Progress Notes, Reports/Consultations, y, Diagnosis, Psychological ion Record and Other review of this section reveal or records were initialed or records were initialed or or records were initialed or	W	159			

PRINTED: 12/06/2018 FORM APPROVED

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TPLE CONSTRUCTION NG	THE STATE OF THE PERSON OF THE	NO. 0938-03 DATE SURVEY COMPLETED
AUGUS I	4	49G070	B. WING			11/29/2018
BURKE	PROVIDER OR SUPPLIE	P		STREET ADDRESS, C 9332 BURKE ROAD BURKE, VA 2201		1112012010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIO E OATE
W 159	On 11/28/18 at 6: staff member) # 1 Group Home) was finding. No further informal INDIVIDUAL PROCER(s): 483.440(c). The objectives of must be expressed provide measural.	00 p.m. ASM (administrative , program manager of (Name of s made aware of the above	W 18	3A Exercise/H for Individual measurable to objective to b terms and ens is collected in The Program I QIDPs on writ during the Demeeting. The Residenti also complete of all other inc	ensure the outcome/go lealthy Life Style on the #1 is written in erms by updating the e written in measurable suring the data collection measurable terms. Manager will train the ing measurable goals cember 2018 staff ial Program Manager will a thorough record revie dividuals to ensure that a	n n ew afi
	and facility docum that the facility sta measurable terms the survey sample. The facility staff fa (person-centered person-centered person-centered person for Individual The findings included individual # 1 was admitted to (Name Diagnoses in the cont limited to: mod autistic disorder (2 disorder (3) and ar Individual # 1's cur	ent review it was determined if falled to develop objectives in for three of three individuals in in Individual # 1. illed to define the ISP plan) outcome/goal "3A. ifs Style" in measureable al # 1. de: a 69-year-old female, who was of Group Home) on 10/19/15. dinical record included but were lerate intellectual disability (1), obsessive-compulsive		The Program I process to ens prevent furthe Mission Effect Director will a	Manager will review the Sure compliance and er deficiencies. iveness and or the Clinic Iso conduct quarterly is to prevent deficiencies	al

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49Q 070	B. WING	B. WING		2062018
NAME OF	PROVIDER OR SUPPLIER	111		STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	29/2018
BURKE	BURKE ICF ID		1	9932 BURKE ROAD BURKE, VA 22015		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	send out the wrong strange sensations strangely. They may or lose consciousne obtained from the whitps://medlineplus (3) A swallowing dis obtained from the whitps://www.nlm.nih.sorders.html. (4) High blood press obtained from the whitps://www.nlm.nih.sorders.html. QIDP CFR(s): 483.430(a) Each client's active to integrated, coordinate qualified intellectual This STANDARD is Based on residential day program record was determined that Intellectual Disabilitied coordinate and moniprograms for two of its sample, Individuals for the QIDP failed "3A. Exercise/Health (Individual Service P developed in measure	signals. People may have and emotions or behave have violent muscle spasms iss. This information was ebsite: gov/epilepsy.html. order. This information was ebsite: gov/medlineplus/swallowingdi sure. This information was ebsite: gov/medlineplus/swallowingdi sure. This information was ebsite: gov/medlineplus/highbloodpr reatment program must be ted and monitored by a disability professional. not met as evidenced by: I program record reviews, review and staff interview, it the QIDP (Qualified as Professional) falled to tor the active treatment four individuals in the survey if 1 and # 2. to ensure the outcome/goal by Life Style" on the ISP lan) for Individual # 1 was	W 130	Individual #1 and Individual #2. The Quill ensure the outcome/goal 3A Exercised Healthy Life Style on the ISP for Individual written in measurable terms by upd the objective to read in measurable terms the QIDP will review and monitor the collection of Individual #1 on a month basis to ensure it is documented in measurable terms. The Program Manager will train the Qi writing measurable goals and collectin measurable data during the December staff meeting.	s for IDP cise/dual #1 ating rms. data y DP on g 2018 v for p ritten QIDP a cal l c	12/30/18
	of Individual # 1's ISF	O ensure the data collection O (Individual Support Plan)	_		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MUL A. BUILD	TIPLE CONSTRI	UCTION	Or	(X3) DAT	. 0938-0391 E SURVEY IPLETED
<u> </u>	49 Q 070	B. WING	¥			11/	29/2018
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			STREET ADD 9332 BURK BURKE, V		RIP CODE		28/20/10
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFI TAG	K (EA	PROVIDER'S PLAN OF ACH CORRECTIVE ACT SS-REFERENCED TO DEFICIENCE	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
Outcomes: (Name of Ind have a healthy life style. Instructions: 3A. (Individ arms by using her therap (percent) accuracy for 12 Support Instructions: 1. (informed that it is time to # 1) will be assisted with pulley from the closet. 3. one end of the exercise p the opposite end. 4. (Indher arms with staff by exitar as it can go so that the towards the staff assisting continue exercising for 10 tolerated. 6. (Individual her efforts. 7. Staff will din her daily progress note reviewed Monthly by the Intellectual Disabilities Professive (Individual # 1) completes 10-15 minutes each day if months, she will have act During an interview on 11 4:40 p.m., with ASM (adminember) # 1, the program Group Home), the ISP for reviewed. ASM # 1 was a "outcomes/goals" were withat an outcome/goal is witerms to determine program desired outcome for Individual each day at 70% (pronsecutive months." AS outcome was written in mishe could identify what with determine progress. ASM	ividual # 1) would like to Support Activities & ual # 1) will exercise her by pulley each day at 70% consecutive months. Individual # 1) will be exercise. 2. (Individual getting her exercise. (Individual # 1) will hold dividual # 1) will hold dividual # 1) will exercise tending her arms out as e device will move g her. 5. She will 0-15 minutes as # 1) will be praised for focument her progress is. 8. Data will be QIDP (Qualified ofessional). 9. When is exercising her arms for for 12 consecutive inleved this goal." //28/19 at approximately individual # 1 was asked how ritten; ASM # 1 stated written; ASM # 1 stated written; asked how ritten; ASM # 1 stated written; asked how ritten; asked if the leasurable term and if as being measured to	W 2	31				

STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILO	TIPLE CONSTRUCTION		(X3) DA1	TE SURVEY MPLETED
2 3	Z	49G070	B. WING			144	MD/201 B
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		TION SHOULD THE APPROPI	BE	(XS) COMPLETION DATE
1	complete the durati The facility's policy (ISP)" documented, (Name of Corporati contain at a minimu measurable objecti addressing each ide Service Plan (ISP) I Goals/Outcomes ar Outcomes: The obje be expressed in temprovide measurable On 11/28/18 at 6:00 staff member) # 1, p Group Home) was r finding. No further information References: (1) Refers to a group by a limited mental of adaptive behaviors as schedules and routin Intellectual disability 18 and may result fr autism or cerebral p causes, such as lact responsiveness. Th from the website: https://www.report.ni	how well she is able to on of the exercise." "4.1 Individual Service Plan ("4.1.3 Procedures: C. on) ensures that an ISP will Im: 4. Goals/outcomes and ves/desired outcomes for entified need. 4.1.4 Individual Development. E. old Objectives/Desired ectives / desired outcomes will ms that are behavioral and indexes of progress." I. p.m. ASM (administrative program manager of (Name of nade aware of the above on was provided prior to exit. I. p. of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. Originates before the age of om physical causes, such as alsy, or from nonphysical colored in information was obtained in gov/NIHfactsheets/ViewFa	W 2				
	that begins early in o	d developmental disorder					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G070	B. WING		11/	29/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		2012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	COMPLETION DATE
W 231	acts and interacts wand learns. This interest the website: https://www.nlm.nihrumdisorder.html. (3) A common, chroin which a person hat thoughts (obsession (compulsions) that I repeat over and over obtained from the white://www.nimh.nihompulsive-disorder- (4) Low iron. This in the website:	with others, communicates, iormation was obtained from agov/medlineplus/autismspect onic and long-lasting disorder as uncontrollable, reoccurring as) and behaviors are or she feels the urge to or. This information was rebsite:	W 23	The QIDP will ensure the outcome 3A Exercise/Healthy Life Style on the for Individual #1 is written in measurable terms by updating the objective to be written measurable terms. The Program Manager will train the QIDPs on writing measurable goals during the December 2018 staff meeting. The Residential Program Manager also complete a thorough record rof all other individuals to ensure the individuals have measurable goals measurable data collection in the records.	he ISP e e will eview nat all	12/30/18
W 252	specified in client incobjectives must be determs. This STANDARD is Based on staff interest and facility document that the facility staff measurable terms for the survey sample, I	omplishment of the criteria dividual program plan documented in measurable not met as evidenced by: view, clinical record review at review it was determined failed to develop objectives in or three of three individuals in individual # 1.	W 25	The Program Manager will review process to ensure compliance and prevent further deficiencies. Mission Effectiveness and or the C Director will also conduct quarterly record reviews to prevent deficien	linical	

49G070 B. WING 11/29	29/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252 Continued From page 22 (person-centered plan) outcome/goal "3A. Exercise/Healthy Life Style" in measurable terms. The findings include: Individual # 1 was a 69-year-old female, who was admitted to (Name of Group Home) on 10/19/15. Diagnoses in the clinical record included but were not limited to: moderate intellectual disability (1), autistic disorder (2) obsessive-compulsive disorder (3) and anemia (4). Individual # 1's current ISP dated 01/01/2018 through 12/31/2018 documented, "Desired Outcomes: (Name of Individual # 1) would like to have a healthy life style. Support Activities & Instructions: 3A. (Individual # 1) will exercise her arms by using her therapy pulloy each day at 70% (percent) accuracy for 12 consecutive months. Support Instructions: 1. (Individual # 1) will be informed that it is time to exercise. 2. (Individual # 1) will be assisted with getting her exercise pulley from the closet. 3. (Individual # 1) will bod one end of the exercise pulley and staff will hold the opposite end. 4. (Individual # 1) will exercise her arms with staff by extending her arms out as far as it can go so that the device will move towards the staff assisting her. 5. She will continue exercising for 10-15 minutes as tolerated. 6. (Individual # 1) will be praised for her efforts. 7. Staff will document her progress in her daily progress notes. 8. Data will be reviewed Monthly by the CIDP (Qualified Intellectual Disabilities Professional). 9. When (Individual # 1) completes exercising her arms for 10-15 minutes as chay for 12 consecutive months, she will have achieved this goal." Review of (Name of Group Home) "Progress	

STATEMENT AND PLAN (TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G070	B. WING	Professional States and the control of the control	14	29/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		29/2018	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	Notes" for Individual through 10/31/2018 collection of the out style in measurable. During an interview 4:40 p.m., with ASM member) # 1, the progressed of the coup Home), the literature in place for the complete the duration of the consumer's progressed outcomes in a formation of the consumer's progressed outcomes in a formation of the consumer's progressed outcomes and interval to ensure that appropriate the consumer's progressed outcomes and interval to ensure that appropriate the consumer that appropriate in place for the consumer. The consumer in place for the consumer in place for the consumer. The consumer in place for the c	I # 1 dated 10/01/2018 I failed to evidence data come exercise/healthy life terms. On 11/28/19 at approximately I (administrative staff rogram manager for (Name of SP for Individual # 1 was was asked to review collection dated 10/01/2018 for the outcome for style. ASM # 1 was asked if hat was being measured to ASM # 1 stated, "No. We now well she is able to on of the exercise." 4.1 Individual Service Plan "4.1.4 Individual Service Plan H. Data Collection: Data d on all objectives/desired at that accurately represents press. Data is tracked, sureable terms and analyzed priate objectives/desired rentions/support strategies consumer. On-going pt in the progress notes ess, changes or significant er functioning of the p.m. ASM (administrative rogram manager of (Name of hade aware of the above	W 2				
	No further information	on was provided prior to exit.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G070	8. WING		11/29/2018	
	NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		
(X4) ID PREFIX TAG			ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
W 252	References: (1) Refers to a group by a limited mental adaptive behaviors schedules and routintellectual disability 18 and may result from the website: https://www.report.rctSheet.aspx?csid= (2) A neurological at that begins early in throughout a person acts and interacts wand learns. This infithe website: https://www.nim.nih rumdisorder.html. (3) A common, chroin which a person his thoughts (obsession (compulsions) that he repeat over and over obtained from the whttp://www.nimh.nih ompulsive-disorder-	ap of disorders characterized capacity and difficulty with such as managing money, ines, or social interactions. It is originates before the age of rom physical causes, such as palsy, or from nonphysical ek of stimulation and adult his information was obtained with gov/NIHfactsheets/ViewFauthood and lasts in slife. It affects how a person with others, communicates, formation was obtained from a gov/medlineplus/autismspect which and long-lasting disorder as uncontrollable, reoccurring and behaviors are or she feels the urge to but. This information was rebsite:	W 2			
W coo	•	.gov/medlineplus/anemia.html				
W 368	DRUG ADMINISTR	ATION	W 3	68		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		SURVEY
AND FLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		СОМ	PLETED
<u></u>	49G070	B. WING		11/2	29/2018
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID		8	TREET ADDRESS, CITY, STATE, ZIP CODE 332 BURKE ROAD BURKE, VA 22015	117	10/2010
PRÉFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
that all drugs are admithe physician's orders This STANDARD is n Based on observation staff interview it was d staff failed to administ the physician's orders during the medication The facility staff failed orders for the adminis [ophthalmic prednisold left eye. The findings include: Individual # 3 was a 72 admitted to (Name of 6 Diagnoses in the clinic not limited to: severe in quadriplegia (3) dysph hypertension (6), kerat epilepsy (9). On 11/28/18 at 7:00 a. administration observa LPN (licensed practica Individual # 3 was brown room of the (Name of 6 3 was sitting in a whee LPN # 1 put on a pair of administer eye drops, sandwich Ziploc plastic	administration must assure inlistered in compliance with the incompliance of the control of the event of the eye drops administration observation. It of ollow the physician's administration observation. It of ollow the physician's administration observation. It of ollow the physician's atration of the eye drops one	W 368	The staff responsible for failing to the physician's orders during med administration will be retrained by nursing coordinator to follow the Physician's orders during medicati administration. A medication observation will be conducted by the nursing Coordin ensure the staff responsible for fa follow the doctor's orders are folk the doctor's orders and following medication administration policy a procedures during medication administration. During the December 2018 staff mall program staff will be retrained medication administration policy to include following the physician' or Random medication observations occur by the Program Nurse and/or Program Manager to ensure staff following the medication administration policy to include following the phy orders. Mission Effectiveness and/or the ODirector will randomly conduct medication observations on a qual basis to ensure staff are following medication administration policy to include following the physician's of include following the physician's	ication the on ator to iling to owing the and neeting, on the co ders. will or are ration scian's clinical rterly the o	12/30/18

		& MEDICAID SERVICES			OMB NO	. 0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DAT	TE SURVEY MPLETED
		49G070	B. WING		111	29/2018
BURKE!	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 9332 BURKE ROAD BURKE, VA 22015		2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETIO DATE
W 368	small box containin Suspension 1% (pethe bottle to the MA record), administere #3's right eye, and box. The POS (physician 11/01/18 through 11 documented, "Date 1% suspension. Tathree times a day." The MAR (medicating dated 11/01/18 through 1	ge 26 ne plastic bag, removed a g a bottle labeled "Prednisone rcent)." LPN # 1 compared R (medication administration ed the eye drop into Individual placed the bottle back into the n's order sheet) dated /30/18 for Individual # 3 11/7/18. PRED (prednisone) ke 1 (one) drop(s) in left eye on administration record) ugh 11/30/18 for Individual # 3 11/7/18. PRED (prednisone) ke 1 (one) drop(s) in left eye a.m., an interview was (licensed practical nurse) # of Group Home). When ng the physician's order for if the prednisone eye drops right eye, LPN # 1 stated, "I I should have put it in her left	W 36	88		
	conducted with RN (asked how they ens followed for the adm # 1 stated, "The nun rights. It's the basic When asked if she k than five rights, RN :	a.m., an interview was registered nurse) # 1. When ure the physician's orders ore inistration of medications, RN se should follow the five nursing standard of practice." they that there were more # 1 stated yes. When asked ticular nursing standard of				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE S COMPLI	URVEY
000000000000000000000000000000000000000		49G070	B. WING		11/20	/2018
NAME OF	PROVIDER OR SUPPLIER		933	REET ADDRESS, CITY, STATE, ZIP CODE 12 BURKE ROAD IRKE, VA 22015	1 11128	ZV 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE C	(X5) OMPLETION DATE
	practice, RN # 1 dia "The following information of the following informati	mation is provided in Basic for Practice, 6th edition 2007, pages 349-360) was	W 368			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
le manager		49G070	B. WING		1 4	1/29/2018	
BURKE	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 9392 BURKE ROAD BURKE, VA 22015		II Z SI Z U I O	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO. ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 368	autism or cerebral causes, such as la responsiveness. T from the website: https://report.nih.g. t.aspx?csid=100 (3) Paralysis is the of your body. It hap wrong with the way brain and muscles partial. It can occur body. It can also or be widespread. Pa body, including bot Paralysis of the arr This information we https://medlineplus (4) A swallowing diobtained from the whttps://www.nlm.nil sorders.html.	palsy, or from nonphysical tack of stimulation and adult his information was obtained ov/nihfactsheets/ViewFactShee loss of muscle function in part opens when something goes y messages pass between your. Paralysis can be complete or r on one or both sides of your ccur in just one area, or it can ralysis of the lower half of your th legs, is called paraplegia. In an and legs is quadriplegia. It is as obtained from the website: a gov/paralysis.html.	W 3	68			
	website: https://www.nlm.nit s.html,	n.gov/medlineplus/osteoporosi					
	taken from the web	sure. This information was site: .gov/lowbloodpressure.html.					
	the clear window or condition can lead (was obtained from	n of the tissue of the cornea, in the front of the eye. The to vision loss. This information the website: gov/ency/article/001609.htm.					

STATEMENT	OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	TAYON AM II THE	DI E CONICTORIOTION		. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	CON	re survey MPLETED
	4633	49G070	B. WING	n prosper s	44.	29/2018
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	E0/EV D
BURKE	ICF ID	290		9392 BURKE ROAD BURKE, VA 22015		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD AF	(XS) COMPLETIO DATE
W 369	CFR(s): 483.460(The system for di that all drugs, incl	FRATION (k)(2) rug administration must assure luding those that are , are administered without error.	W 369	The staff responsible for failing the physician's orders during madministration will be retrained nursing coordinator to follow the Physician's orders during medical administration.	edication by the e	12/30/18
	Based on observ staff interview it w staff failed to adm the physician's or during the medica. The facility staff faorders for the adm [ophthalmic prednieft eye. The findings included individual # 3 was admitted to (Name Diagnoses in the conot limited to: seven quadriplegia (3) dy hypertension (6), if epilepsy (9). On 11/28/18 at 7:00	a 72 year-old female, who was e of Group Home) on 12/2/14. Clinical record included but were ere intellectual disability (2), ysphagia (4), osteoporosis (5), ceratitis (7), glaucoma (8) and 00 a.m., the medication		A medication observation will be conducted by the nursing Coord ensure the staff responsible for follow the doctor's orders are for the doctor's orders and following medication administration policiprocedures during medication administration. During the December 2018 staff all program staff will be retrained medication administration policinclude following the physician' Random medication observation occur by the Program Nurse and Program Manager to ensure staffollowing the medication adminipolicy to include following the porders. Mission Effectiveness and feathers.	inator to failing to failing to following g the y and meeting, d on the y to orders. as will /or ff are istration hysician's	
	administration obs LPN (licensed prace Individual # 3 was room of the (Name 3 was sitting in a w LPN # 1 put on a p administer eye dro sandwich Ziploc pl	pervation was conducted with ctical nurse) # 1. At 7:30 a.m., brought into the medication as of Group Home). Individual # wheelchair positioned upright. Dair of latex gloves to ups. LPN # 1 remove a lastic bag from a small bin aal # 3's medications. LPN # 1		Mission Effectiveness and/or the Director will randomly conduct medication observations on a qubasis to ensure staff are followin medication administration policy include following the physician's	arterly g the / to	

	(X3) DATE SURVEY COMPLETED	
49G070 B. WING 11/29	9/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9392 BURKE ROAD BURKE, VA 22015		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 369 Continued From page 30 then reached into the plastic bag, removed a small box containing a bottle labeled "Prednisone Suspension 1% (percent)." LPN # 1 compared the bottle to the MAR (medication administration record), administered the eye drop into Individual # 3's right eye, and placed the bottle back into the box. The POS (physician's order sheet) dated 11/01/18 through 11/30/18 for Individual # 3 documented, "Date: 11/7/18. PRED (prednisone) 1% suspension. Take 1 (one) drop(s) in left eye three times a day." The MAR (medication administration record) dated 11/01/18 through 11/30/18 for Individual # 3 documented, "Date: 11/7/18. PRED (prednisone) 1% suspension. Take 1 (one) drop(s) in left eye three times a day." On 11/28/16 at 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 1, nurse for (Name of Group Home). When asked about following the physician's order for the administration of the prednisone eye drops into Individual # 3's right eye, LPN # 1 stated, "I got the wrong eye. I should have put it in her left eye." On 11/29/18 at 9:55 a.m., an interview was conducted with RN (registered nurse) # 1. When asked how they ensure the physician's orders ore followed for the administration of medications, RN # 1 stated, "The nurse should follow the five rights. If's the basic nursing standard of practice." When asked if she knew that there were more than five rights, RN # 1 stated yes. When asked		

		WINDONID SERVICES	T		OWR M). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
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BURKE				9332 BURKE ROAD BURKE, VA 22015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PHOVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 369	practice, RN # 1 did "The following infor Nursing, Essentials (Potter and Perry, 2 used as a reference administration. To administration, be a medication administration, 2. The 4. The right route, a documentation." On 11/28/18 at 6:00 staff member) # 1, Group Home) was a finding.	mation is provided in Basic for Practice, 6th edition 2007, pages 349-360) was e for medication ensure safe medication aware of the six rights of tration, 1. The right right dose, 3. The right patient, 5. The right time, 6. The right page of p.m. ASM (administrative program manager of (Name of made aware of the above				
	References: (1) Reduces the irrit swelling of eye infla chemicals, heat, ractoreign bodies in the after eye surgery. P medications called and redness by cha system works. This from the website: https://medlineplus.tml. (2) Refers to a groby a limited mental adaptive behaviors schedules and routil intellectual disability	tation, redness, burning, and mmation caused by diation, infection, allergy, or eye. It sometimes is used rednisolone is in a class of steroids. It prevents swelling nging the way the immune information was obtained gov/druginfo/meds/a682794.h up of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. originates before the age of om physical causes, such as				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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BURKE				STREET ADDRESS, CITY, STATE, ZI 9392 BURKE ROAD BURKE, VA 22015	P CODE		20/2010
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W 369	causes, such as lar responsiveness. The from the website: https://report.nlh.got.aspx?csid=100 (3) Paralysis is the of your body. It hap wrong with the way brain and muscles. partial. It can occur body. It can also occur body. It can also occur body, including both Paralysis of the arm This information was https://medlineplus. (4) A swallowing disobtained from the whitps://www.nlm.nih sorders.html. (5) Makes your bon break. This information website: https://www.nlm.nih s.html. (6) Low blood prestaken from the website: https://www.nlm.nih s.html. (7) An inflammation the clear window or condition can lead to was obtained from the clear window or condition can lead	palsy, or from nonphysical ck of stimulation and adult his information was obtained by/nihfactsheets/ViewFactShee closs of muscle function in part pens when something goes messages pass between your Paralysis can be complete or on one or both sides of your cur in just one area, or it can ralysis of the lower half of your niegs, is called paraplegia. In and legs is quadriplegia, as obtained from the website: gov/paralysis.html. Forder. This information was rebsite: I.gov/medlineplus/swallowingdi This information was obtained from the content was site: This information was site: gov/lowbloodpressure.html.	W 36	69			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED
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and teach clients to choices about the unhearing and other dand other dand other dand other devices in interdisciplinary teather disciplinary teather dand staff interview, facility staff failed to wheelchair equipme four individuals in the four individuals in the facility staff faile soft and hard wheelchair equipme four individuals in the findings included individual # 4 was a admitted to (Name Diagnoses in the client fimited to: sever epilepsy (2) cerebrated on 11/28/18 at 6:35 individual # 4 revelected sitting in his work (name of Group House) about the form of the severation of	rnish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces, dentified by the mas needed by the client. Is not met as evidenced by: tions, clinical record review it was determined that the o maintain an individual's ent in good repair for one of the survey sample, Individual # ed to maintain Individual # 4's Ichair lap tray in good repair. In 46 year-old male, who was of Group Home) on 07/15/15, inical record included but were the intellectual disability (1), all palsy (3) and dysphagia (4). Is a.m., an observation of ed he was dressed, neat and wheelchair in the living room at me). Observation Individual # aled there was a soft lap tray	W 43	The Program Manager ordered branew soft and hard wheelchair lap to for individual #4. The QIDP will monitor the condition individual #4's soft and hard lap trans and other adaptive equipment on a basis to ensure all adaptive equipming good repair and replaced as need. The Program Manager will oversee process and monitor the condition individual's adaptive equipment or daily basis to ensure all adaptive equipment is in good repair. Mission Effectiveness and/or the CD Director will ensure adaptive equipment is a large of all individuals are in good repair conducting quarterly site visits.	n of ays a daily nent is ded. the of all a linical ement	12/30/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
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BURKE	PROVIDER OR SUPPLIER		933	REET ADDRESS, CITY, STATE, ZIP CODE 12 BURKE ROAD 17KE, VA 22015		07.1:000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLE	TION
W 436	On 11/28/18 at 3:2 Individual # 4 revel clean sitting in his (name of Group House on the from the wind on the from the vinyl on the vin	O p.m., an observation of led he was dressed, neat and wheelchair in the living room at tome). Observation Individual # paled there was a hard lap tray and of the wheelchair. That dap tray revealed cuts in the and right and left sides stuffing. Insent For Medication" form for mented, "Customized ating system with lap tray" and sed during transportation on bservation of the form the by Individual # 4's "Legally entative" on 6/27/18. In sorder sheet) dated 1/30/18 documented, int. Customized wheelchair in with lap tray" and "Flexible got transportation on vehicle." O p.m., an observation of and hard lap trays was M (administrative staff fram manager at (Name of an observing Individual # 4's ays ASM # 1 agreed that the bor repair. ASM # 1 then for a new hard lay tray from the room. When asked why it al # 4's wheelchair ASM # 1 they or a new hard lay tray from the replaced with the new lap of the replaced with the new lap	W 436			

STATEMENT AND PLAN (FOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
NAME OF 1	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	11/29/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 436	staff member) # 1,	age 35 00 a.m. ASM (administrative program manager of (Name of made aware of the above	W 436		
	References: (1) Refers to a groby a limited mental adaptive behaviors schedules and rou intellectual disabilities and may result autism or cerebral causes, such as la responsiveness. Trom the website:	tion was provided prior to exit. up of disorders characterized capacity and difficulty with such as managing money, tines, or social interactions. The originates before the age of from physical causes, such as palsy, or from nonphysical ck of stimulation and adult his information was obtained mih.gov/NIHfactsheets/ViewFa = 100			
	recurring seizures. clusters of nerve or send out the wrong strange sensations strangely. They may or lose conscious nobtained from the whitps://medlineplus (3) A group of disorability to move and posture. This inforwebsite:	r that causes people to have The seizures happen when ells, or neurons, in the brain a signals. People may have and emotions or behave by have violent muscle spasms ess. This information was ess. This information was evebsite: gov/epilepsy.html. ders that affect a person's to maintain balance and mation was obtained from the l.gov/medlineplus/cerebralpals			

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION 3	CO	TE SURVEY
NAME OF BURKE	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 9332 BURKE ROAD BURKE, VA 22015	11/	29/2018
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	(4) A swallowing diobtained from the vinters://www.nlm.nil sorders.html. DINING AREAS ANDERS: 483,480(d) The facility must proclients who can and clients in wheelchat the staff failed to provide individual to eat at a sindividual to eat at a sindividual in the staff failed to individual # 2 to dining room at (Name Diagnoses in the client limited to: mode epilepsy (2) dysphatological proof to the staff failed to: mode epilepsy (2) dysphatological # 2 was a clean, in her wheeld dining room table and the staff failed to: mode epilepsy (2) dysphatological # 2 was a clean, in her wheeld dining room table and the staff failed to: mode epilepsy (2) dysphatological # 2 was a clean, in her wheeld dining room table and the staff failed to: mode epilepsy (2) dysphatological # 2 was a clean, in her wheeld dining room table and the staff failed to: mode epilepsy (2) dysphatological # 2 was a clean, in her wheeld dining room table and the staff failed to: mode epilepsy (2) dysphatological # 2 was a clean, in her wheeld dining room table and the staff failed to provide the staff failed to pro	sorder. This information was website: n.gov/medlineplus/swaltowingdi ND SERVICE (2) vovide table service for all di will eat at a table, including irs. s not met as evidenced by: tion, staff interview and clinical is determined that the facility de an opportunity for an a table for one of four irvey sample, individuals # 2. ed to provide an opportunity eat breakfast at a table in the me of Group Home).		The staff responsible for failing individual #2 ate breakfast at the dining room at the group he been trained on Active Treatmes ensuring a homelike inclusive environment is provided for indiand all other individuals. All program staff will be trained the December 2018 staff meeti Active Treatment and providing homelike inclusive environment individuals. The Program Manager will obse monitor meals on a weekly basi ensure all individuals eat at the a homelike all-inclusive environ provided for all of the individual Mission Effectiveness and/or the Director will monitor the process conducting quarterly observation ensure all individuals are eating table and mealtimes are all-included homelike environment.	during ng on table and table and table and ment is ls. c Clinical is by ons to at the	12/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G070	B. WING			1/20/2010
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMP	
	while standing in fr Individual # 2 being On 11/28/18 at 1:0 conducted with DS # 1. When asked i breakfast earlier th "Yes." When asked Individual # 2 was i during breakfast, D dining room table a asked if that was th to eat her meal, DS supposed to sit dow and she (Individual dining room table. than I did. I wasn't was important to er seated at the table "This is her home a to eat her meal and On 11/28/18 at 6:00 staff member) # 1, Group Home) was i finding. No further informati References: (1) Refers to a group by a limited mental adaptive behaviors schedules and routi Intellectual disability 18 and may result finautism or cerebral p	age 37 Ing Individual # 2 her breakfast ont of Individual # 2 without a seated at the table. D. p.m., an interview was P (direct support professional) if she had fed Individual # 2 her at morning, DSP # 1 stated, diff she was aware of where consitioned in the dining room is P # 1 stated, "Between the individual # 2 her at the living room." When it proper way for Individual # 2 her at the I could have done a lot better thinking." When asked why it is the proper way for her is to make her comfortable." D. p.m. ASM (administrative program manager of (Name of made aware of the above on was provided prior to exit. D. of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. To originates before the age of comphysical causes, such as ealsy, or from nonphysical k of stimulation and adult	W 4	83		

		HAND HUMAN SERVICES E & MEDICAID SERVICES			RINTED: 12/06/2018 FORM APPROVED			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
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BURKE			9332 BURKE ROAD BURKE, VA 22015					
(X4) ID PREFIX TAG	EACH DEFICIENC	Y MUST BE PRECEDED BY FILL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHflactsheets/ViewFactSheet.aspx?csid=100 (2) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineptus.gov/epitepsy.html. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.		W 483					