PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

DELAKTIN	COD MEDICARE &	MEDICAID SERVICES			AB NO. 0938-0391
		MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION (X3	OMPLETED
STATEMENT OF DEFICIENCIES (X1) PROVIDE AND PLAN OF CORRECTION IDENTIFE		IDENTIFICATION NUMBER:			COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PR	OVIDER OR SUPPLIER		S'	TREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PRO	SVIDEN ON OUT FEET		5	604 ROSS DRIVE	
ROSS DRIV	Æ		F	REDERICKSBURG, VA 22407	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments		E 000		
	An unannounced F	mergency Preparedness			
	survey was conduct	ed 5/21/19 through 5/23/19.			
	The facility was in c	ompliance with 42 CFR Part			
	483.73, Requirement	nt for Intermediate Care		WIII	6/3/19
	Facilities for Person	s with Intellectual Disabilities.		U agreetive eation will be accomplish	ned
W 000	INITIAL COMMENT	S	W 000	for individual #1:	neu-
(2) 12 (3) (3) (3) (4)				Facility staff will ensure the quarterly rev	views
	An unannounced a	nnual Medicaid survey for		for individual #1 accurately reflect the	
		acilities for Persons with		number of successful trials and progress	for
		ies (ICF/ID) was conducted		each outcome.	
	5/21/19 through 5/2	3/19. The facility was not in		Assurance that other residents are protec	ted
	compliance with 42	CFR Part 483 Requirements		from the possibility of the deficiency:	
	for Intermediate Ca	re Facilities for the		The facility staff will ensure the quarterly	v
		ed. The Life Safety Code		reviews for each individual accurately re	flect
	survey report will fo	flow.		the number of successful trials and progr	ress
				for each outcome.	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		four bed facility was four at the		Measures to be put into place or systemi	c
	time of the survey.	The survey sample consisted		changes to be made to ensure that the	
		idual reviews, (Individuals #1		deficient practice will not recur:	
101.444	and #2).		W/ 11	Facility staff will ensure that each month	nly
VV 111	CLIENT RECORDS CFR(s): 483.410(c)		••••	review is double checked for accuracy for	or
	CFN(3). 403.410(0)	(1)		each individual to ensure that the progre	SS
	The facility must de	evelop and maintain a		calculations in each quarterly review is a	an
	recordkeeping syst	em that documents the client's		accurate representation of what progress	has
	health care, active	treatment, social information,		been made toward outcomes.	
1	and protection of th			How the facility plans to monitor its	
				performance to make sure that solutions	are
				sustained:	
		s not met as evidenced by:		The Program supervisor or designee wil	1
		erviews and clinical record		review each quarterly for each individua	al to
		mined that the facility staff		ensure that they are accurate and	
100 - 10		clinical record was accurate		representative of what progress has been	1
		iduals in the survey sample,		made toward outcomes for each individual	ual.
	Individual # 1.			Date of Completion:	

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

The facility staff failed to accurately calculate the

DD Residental Cooperator

6/3/19

(X6) DATE

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

ROSS DRIVE  FREDERICKSBL  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROPERTY (FACE)	(X3) DATE SURVEY COMPLETED  05/23/2019  ITY, STATE, ZIP CODE  RG, VA 22407  VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
ROSS DRIVE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  W 111 Continued From page 1  number of successful trials and accurately document the progress on Individual # 1's second quarter PCP (person-centered plan) review.	RG, VA 22407  VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE  CONTRIBUTION DATE
ROSS DRIVE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  W 111 Continued From page 1  number of successful trials and accurately document the progress on Individual # 1's second quarter PCP (person-centered plan) review.	RG, VA 22407  VIDER'S PLAN OF CORRECTION (X5)  CORRECTIVE ACTION SHOULD BE  EFERENCED TO THE APPROPRIATE  (X5)  COMPLETION  DATE
W 111 Continued From page 1  number of successful trials and accurately document the progress on Individual # 1's second quarter PCP (person-centered plan) review.	CORRECTIVE ACTION SHOULD BE COMPLETION EFERENCED TO THE APPROPRIATE DATE
number of successful trials and accurately document the progress on Individual # 1's second quarter PCP (person-centered plan) review.	
Individual # 1 was a 39 year-old male, with diagnoses that included but were not limited to: profound intellectual disability (1), and autistic disorder (2).  Individual # 1's PCP (Person Centered Plan) dated 10/29/2018 through 10/28/2019 documented, "Outcomes Important To/or #: 6. (Individual # 1) takes his medications." Under the heading "List the actions/supports needed" it documented, "With no more than two verbal prompts, (Individual # 1) goes to the med (medication) room to take his medications in the morning and evening at (Name of Group Home). Success will be measured when he completes this task with the supports as outlined daily, for 6 (six) consecutive months." Under the heading "Describe how this will be provided based on individual preferences and location where program strategy can be found" it documented, "(Individual # 1) takes medications daily, he will often go to the medication room at the incorrect times for his medications but is willing to come at the appropriate times when verbally prompted, at times it takes two prompts. If it takes more than two prompts for (Individual # 1) to come to the	

his medications at (Name of Group Home) with no more than two verbal prompts A "+" (plus

DEPARTM	IENI OF HEALIN	AND HUMAN SERVICES					O. 0938-039
TATEMENT O	F DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G065	B. WING			05	3/23/2019
NAME OF PROVIDER OR SUPPLIER  ROSS DRIVE			5604 ROSS DRIVI	S, CITY, STATE, ZIP CODE E BURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF CORRECTIVE ACTION SHO S-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 111	Continued From p	age 2	w	111			
	sign) is recorded the indicated level	or meeting outcome criteria per of support."					
	dated "May 6, 20" Under "Describe pit documented, "(I medications at so shows a willingne when asked if he (Individual # 1) re applesauce and tafterwards.	er PCP review for Individual # 1 19" documented, "Outcome # 6." progress toward each outcome" individual # 1) receives his heduled times and typically ss to receive his medications is ready to take them. ceives his medications whole, in ypically enjoys a cup of after yidual # 1) very rarely requires by verbal prompts to see if he is ications. (Individual # 1) has 178 times with 2 (two) mpts. Although he continues to (Individual # 1) has shown he chieving this goal, and staff will offer encouragement and praise pleting this outcome." Under tumented, "Regression."					
	Individual # 1 dat April 30, 2019 do (two times) daily takes his medica verbal prompts, ( (medication) room moming and eve	P Outcome Data Collection" for sed November 1, 2018 through cumented, "Outcome # 6. 2x Important To: (Individual # 1) tions. With no more than two Individual # 1) goes to the med m to take his medications in the ning at (Name of Group Home).					
	this task 5 (five) recorded for mee indicated level of recorded for requ	measured when he completes days in a row. A "+" (plus sign) is eting outcome criteria per the support." A "-" (minus sign) is uiring a higher level of support." If the data collection sheets dated					

November 1, 2018 through April 30, 2019 revealed Individual # 1 was successfully met the

		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT O	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED
		49G065		TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/20/2010
NAME OF PROVIDER OR SUPPLIER  ROSS DRIVE		56	604 ROSS DRIVE REDERICKSBURG, VA 22407		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
W 111	criteria for outcomopportunities indicoutcome with 100 consecutive monitorial consecutive monitorial consecutive monitorial consecutive monitorial consecutive monitorial conducted with Consecutive monitorial completing the stated, "Yes." With process for completing the stated, "Yes." With process for completing the stated, "Yes." With process for completing the stated, "Osmalle in the results of the results of the stated for six of Individual #1's November 1, 20's second quarter #1 was asked if calculated the nuaccurately docur stated no. When progress was mastated, "It was more compared it to the accurate."	ne # 6 362 time out of 362 cating that Individual # 1 met the 1% (percent) accuracy for six ths.  130 p.m., an interview was 15M (other staff member) # 1, 16d Intellectual Disabilities Then asked if he was responsible 16 equarterly reviews, OSM # 1 16hen asked to describe the 16leting the quarterly reviews, 1"I use the data collection each 16 it to the previous month, and 16 numbers are increasing or 17 re are some outcomes that are	W 111		
	(administrative s	staff member) # 1, ICF re facility) supervisor, was made			

No further information was provided prior to exit.

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

PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER  ROSS DRIVE		56	REET ADDRESS, CITY, STATE, ZIP CODE 04 ROSS DRIVE REDERICKSBURG, VA 22407	
PREELY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE
by a limited mental adaptive behaviors schedules and rour Intellectual disabilities and may result autism or cerebral causes, such as la responsiveness. The from the website: https://www.report.ctSheet.aspx?csid (2) A neurological that begins early in throughout a personacts and interacts and learns. This in the website: https://www.nlm.nirumdisorder.html.  W 127 PROTECTION OF CFR(s): 483.420(a)  The facility must early in the facility early in the fa	up of disorders characterized capacity and difficulty with such as managing money, tines, or social interactions. It originates before the age of from physical causes, such as palsy, or from nonphysical ck of stimulation and adult this information was obtained children with the children was obtained and developmental disorder in childhood and lasts on's life. It affects how a person with others, communicates, information was obtained from the communicates was obtained from the communicates of the comm	W 111	W127  How corrective action will be accomplished for individual #1:  Facility staff have been re-trained since this inc policies prohibiting mistreatment for Individual ensure he is free from abuse.  Assurance that other residents are protected from the possibility of the deficiency:  Facility staff have retaken the Human Rights training which specifies the right of all individuals to be free from abuse.  Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:  QIDP and ICF Management will monitor facility staff adherence to Human Rights policies to ensure compliance in the facility. How the facility plans to monitor its performance to make sure that solutions are sustained:  Resident's Human Rights will be reviewed at mandatory staff meetings at least annually. ICF Management will monitor and document various shift checks to ensure that individuals' Human Rights are being protected.  Date of Completion: 6/3/19	6/3/19 ident on 1#1 to

Facility ID: VAICFMR63

CENTERS	FOR MEDICARE	& MEDICAID SERVICES					MB NO. 0938-039 (3) DATE SURVEY
ATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRI	UCTION		COMPLETED
		49G065	B. WING _				05/23/2019
NAME OF PROVIDER OR SUPPLIER				5604 ROSS		CODE	
ROSS DRI	VE			FREDERI	ICKSBURG, VA 22407		
(X4) ID PREFIX TAG	FACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	COMPLETION DATE
W 127	Continued From pa	age 5	W 1	27			
	The facility staff es	scorted Individual # 1 into his the bedroom door closed ual # 1 from leaving his room.					
	The findings include	de:					
	diagnoses that incorprofound intellectudisorder (2).  The facility's "Beh Individual # 1 date "(Individual # 1) ewhich is unpredict thay can not deterwhich may cause impulsiveness and factors, staff should be engages in the being in his room whim to his room whim to his room when to the base indoor swing, every staff should be the staff should be staff should be the staff should be should be staff should be sta	a 39 year-old male, with cluded but were not limited to: all disability (1), and autistic avior Support Plan" for ed 05/28/2018 documented, whibits aggressive behavior, table. In addition, staff report rmine any precipitating factors his behavior. Given this d the lack of clear causal all continue to redirect him when ese behaviors. Since he prefers a staff should continue to redirect when he is exhibiting aggressive when he is exhibiting aggressive fition, (Individual # 1) enjoys ment [with staff] to play on the ery effort should be made to ptive behavior with time in the					
	(residential county) 10/31/2019 docu Description of the were walking in the further. He went up to the door are this wasn't his he became aggregation.	ent Report" completed by RC selor) # 3 for Individual # 1 dated mented, "Provide a Detailed e Incident: (Individual # 1) and I he driveway and he wanted to go to the house next door and went he dried to get in. I told him that buse and that we had to leave. ressive and head butted me in my shoulder."					

"Supervisor Comments:" dated 11/1/18,

PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

CENTERS	OR MEDICARE	& MEDICAID SERVICES				JIVIB 140. 0930-0301
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ROCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING			05/23/2019
NAME OF PROV	IDER OR SUPPLIER			5604 ROS	DDRESS, CITY, STATE, ZIP CODE S DRIVE SICKSBURG, VA 22407	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE	

### W 127 Continued From page 6

completed and signed by ASM (administrative staff member) # 1, ICF (Intermediate Care Facility) supervisor it documented, "(Individual # 1) had a very hard day yesterday starting in the morning. When he returned home he was still very upset. Staff attempted to calm him down by offering some of his favorite items. (RC# 3) offered to take him for a walk. He became upset and [sic] headbutted her in the face and shoulder. Her nose was a little swollen in the spot and (RN [registered nurse] # 1), made her an ice pack to use. I checked in on her this morning and she reported that her nose is sore, but nothing major. (Individual # 1) was able to sit and eat dinner with no issue and continue on with his normal evening routine." Further review of the facility "Incident Report" revealed a "Human Rights Investigation. Allegation of Human Rights Violation: Seclusion" for "(Individual # 1) stapled to the facility's "Incident Report."

The facility's "Human Rights Investigation" with a completion date of 11/05/2018, documented in part the following: "Complaint: An incident report was received on October 31st, 2018 which reported the following: ... ICF (intermediate care facility) Manager reviewed video footage and reported the following: Prior to providing (Individual # 1) his breakfast [sic] decided to remove (Individual # 1's) top shirt (long sleeve orange shirt) and keep his undershirt on while he ate breakfast. This was done to prevent (Individual # 1's) shirt from becoming dirty while he was eating. After (RC # 4) removed (Individual # 1's) shirt, she tossed it to (RC # 1) who was sitting in the living room. (Individual # 1) then got angry and ran over to (RC # 1) and started to grab on her wrists. According to (RC # 5) they, (staff) tried to redirect (Individual # 1's)

W 127

PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PROVIDER OR SUPPLIER  ROSS DRIVE		560	EET ADDRESS, CITY, STATE, ZIP CODE 4 ROSS DRIVE EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
W 127	(RC #1's) wrists. ((and went into the kand pulling on (RC returned to the livir (RC # 1) again unt to his room. (RC # did go in his room came back out, rar slapped (RC # 5) in her to fall over. (R shirt back on him, still aggressive and # 4, RC # 5 and RC back into his room doing so, (Individual (RC # 1 and RC# 4 (Individual # 1's) room with him. (R of (Individual # 1's) room with him. (R of (Individual # 1's) behind her with (In standing outside (Individual # 1's) behind her with (In standing outside (Individual # 1's) behind her with (In standing outside (Individual # 1's) door shut member) # 3, utilization video footage from the morning of Oct documented in pa # 1's) door knob for before the video for # 3, utilization review sface interview at (A November 5th ,20 was present during the standard pulling the standar	then but he kept grabbing on Individual # 1) finally stopped ditchen and began grabbing # 4's) arm. (Individual # 1) and groom and started to grab it all three staff redirected him # 5) stated that (Individual # 1) for a few seconds until he in down the hallway and in the right arm which caused C # 4) put (Individual # 1) was it [sic] continue to hit staff. (RC C # 1) guided (Individual # 1) for a second time. While al # 1) continued to hit and pull (4) while (RC # 5) opened from door. While in the room, rempted to pull (RC # 1) into his C # 1) was able to make it out to room and closed the door individual # 1's) door (RC # 1). " Under "OSM (other staff station review specialist, viewed in (Name of Group Home) from tober 31st, 2018" it tr.," (RC # 1) holds (Individual proproximately three minutes sortage turns off." Under "OSM ew specialist, completed a face to Address in Name of City) on 18 at 2:00pm with staff who gethe event time: (Name of RC and in part: "She stated she	W 127		

was able to close the door [with (OSM (other staff member) # 3, utilization review specialist and

PRINTED: 05/31/2019

	The second secon	& MEDICAID SERVICES	(V6) 1117	IDI E OO	NSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		NSTRUCTION	COMPLETED
		49G065	B. WING_			05/23/2019
NAME OF PROVIDER OR SUPPLIER				STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
				5604	ROSS DRIVE	
ROSS DRIVE				FRE	DERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION ATE DATE
W 127	Continued From p	nage 8	W	127		
** 12.	ACCOUNT OF THE PROPERTY OF THE		•			
		on review specialist,) in the outside of the door. As she				
		door she said she placed her				
		knob and began speaking to				
		rough the door. When asked				
	how long her han	d was on the door knob, she				
		and was on the door knob for				
		o minutes. When asked what				
		he removed her hand from the				
		RC# 1] stated that she walked				
		dual # 1) came out when he was				
		s room. When asked if anyone vidual # 1) while he was in his				
		d no. When asked when did				
		ome out of his room, she stated				
		5) informed him, that it was time				
	Michael Academy and Court Manager Court Court Court Court	n. (RC # 1) also reported that he				
		the time. When asked if				
	(Individual # 1) ha	as a Positive Behavior Plan and				
		r is in the plan, (RC # 1) stated				
		1) did have a plan and holding				
		his plan. She was asked if				
	-	ied to open the door during the				
		hand on the door knob and she neard him slamming and banging				
		which is common when he is				
		asked whether or not she is				
		aff previously standing in front of				
7 - 4		door or holding the door knob in				
		ted yes, we do that as a last				
		does not harm himself or others.				
		d that they (staff) don't know				
		w to handle (Individual # 1). She				
		was familiar with (Individual #				
		access to his plan and she				
		does have access to the plan,				
	but is not familia	with it." Further review of the				

facility "Human Rights Investigation" revealed the facility's (Name of Service Board) Standards Of

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R WING 05/23/2019 49G065 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5604 ROSS DRIVE **ROSS DRIVE** FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 127 Continued From page 9 W 127 Conduct Violation" for (RC # 1) stapled to the "Human Rights Investigation." The facility's (Name of Service Board) Standards Of Conduct Violation" for (RC # 1) signed by RC # 1 and ASM # 1 on 11/28/18 documented, "EMPLOYEE NAME: (Name of RC # 1). VIOLATION: Code of Ethics policy and Human Rights Violation. VIOLATION DATE: 10/31/18. PLACE OF VIOLATION: (Name of Group Home). MAJOR OFFENSE." On 05/21/19 at 3:07 p.m., an interview was conducted with RC # 1. When asked to describe the incident on 10/31/19, with Individual # 1, RC # 1 stated, "(Individual # 1) was upset because his shirt was taken off while he was eating because he had food on it. He became aggressive, head butted a staff and grabbed my shirt and tried to head butt me. We got is shirt back on him and he went back to eat. He went towards his room, staff followed and he started to hit and push. I took him toward his room but he went toward another room but got him to his room and he turned to grab me and pull me in. Verbally I told him no and I closed the door and I held it closed. He was yelling, I could hear him and he was slamming his closet doors." When asked how long she held the door closed RC # 1 sated, "Two to three minutes." When asked if she implemented Individual # 1's behavior plan RC # 1 stated, "No." When asked if she secluded Individual # 1 by holding his door closed while Individual # 1 was inside his room, RC # 1 stated, "Yes." When asked what could have happened to Individual # 1 while being secluded in his room

RC # 1 stated, "He could have hurt himself and it was a violation of his rights." When asked if seclusion was a form of abuse, RC # 1 stated,

		& MEDICAID SERVICES	(X2) MI II TIPI E	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING_		COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSS DRI	VE		F	REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
W 127	Continued From p	age 10	W 127		
	"Yes."				
	conducted with AS member) # 1, ICF supervisor. When Individual # 1 was ASM # 1 stated, "video. When there the video to compasked why RC # 1 room, ASM # 1 stoption and she was individuals and (Ir asked if seclusion stated, "Yes."	OO p.m., an interview was SM (administrative staff (intermediate care facility) a asked how she found out that a being secluded in his room, I found out when I reviewed there is a major incident I review elete the incident report." When I secluded Individual # 1 in his ated, "She felt it was her only anted to keep staff, other individual # 1) safe." When I was a form of abuse, ASM # 1			
	Abuse and Negle Neglect includes this list. Any of the investigation; all obs. Abuse: any act or other person reindividual, that was performed knowing and that caused the second	cy "Client Protection Section 2-3: ct" documented, "9. Abuse and the following but is not limited to nese events will lead to an of these are prohibited: t or failure to act by an employee esponsible for the care of an as performed or was failed to be ngly, recklessly, or intentionally, or might have caused physical or rm, injury or death to a person."			
	On 05/22/19 at a (administrative st was made aware	pproximately 3:00 p.m. ASM taff member) # 1, ICF supervisor, of the findings.			
	No further inform	nation was provided prior to exit.			
	References: (1) Refers to a giby a limited men	roup of disorders characterized tal capacity and difficulty with			

adaptive behaviors such as managing money,

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

PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	49G065	B. WING		05/23/2019	
OVIDER OR SUPPLIER		56	604 ROSS DRIVE		
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
schedules and rout Intellectual disabilit 18 and may result autism or cerebral causes, such as lar responsiveness. T from the website: https://www.report.ctSheet.aspx?csid= (2) A neurological at that begins early in throughout a personacts and interacts and learns. This in the website: https://www.nlm.nii	ines, or social interactions.  y originates before the age of from physical causes, such as palsy, or from nonphysical ck of stimulation and adult his information was obtained  nih.gov/NIHfactsheets/ViewFa =100  and developmental disorder i childhood and lasts on's life. It affects how a person with others, communicates, information was obtained from	W 127	for individual #1: Facility staff will ensure the safety of individual #1 by suspending any alleg member during an investigation into a allegation of abuse.  Assurance that other residents are protected from the possibility of the deficiency: Facility staff will ensure the safety of individuals by suspending any alleged	ed staff ny all I staff	
STAFF TREATMEI CFR(s): 483.420(d) The facility must provide the investigation of the safety of individual to the safety of individual to the safety of individual to the safety sample, incomparing an investigation for the facility staff facility staff facility and investigation of the facility staff facility staff facility staff facility and investigation of the facility staff facility staff facility and investigation of the facility staff facility staff facility and investigation of the facility staff facility	revent further potential abuse tion is in progress.  is not met as evidenced by: erviews and clinical record document review, it was a facility staff failed to ensure duals during an abuse are of two individuals in the dividual # 1.  illed to suspend a staff member ation of an allegation of abuse al # 1.	W 155	allegation of abuse.  Measures to be put into place or syste changes to be made to ensure that the deficient practice will not recur:  The Director of Compliance and Hum Rights will monitor facility staff to ensuspension of any alleged staff membeduring an investigation into any allege abuse.  How the facility plans to monitor its performance to make sure that solutionare sustained:  The DD Residential Coordinator, or designee, will monitor to ensure this suspension process is followed throughour any alleged staff member during a sustained:	mic  nan sure the er ation of	
	CORRECTION  OVIDER OR SUPPLIER  SUMMARY (EACH DEFICIENT REGULATORY OF CONTINUED FROM PROPERTY OF CONTINUED FROM PROPERY OF CONTINUED FROM PROPERTY OF CONTINUED FROM PROPERTY OF CONTIN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11 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 neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspect rumdisorder.html. STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)  The facility must prevent further potential abuse while the investigation is in progress.  This STANDARD is not met as evidenced by: Based on staff interviews and clinical record review and facility document review, it was determined that the facility staff failed to ensure the safety of individuals during an abuse investigation for one of two individuals in the survey sample, Individual # 1.  The facility staff failed to suspend a staff member during an investigation of an allegation of abuse regarding Individual # 1.	OVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  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 neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspect rumdisorder.html. STAFF TREATMENT OF CLIENTS  CFR(s): 483.420(d)(3)  The facility must prevent further potential abuse while the investigation is in progress.  This STANDARD is not met as evidenced by: Based on staff interviews and clinical record review and facility document review, it was determined that the facility staff failed to ensure the safety of individuals during an abuse investigation for one of two individuals in the survey sample, Individual # 1.  The facility staff failed to suspend a staff member during an investigation of an allegation of abuse regarding Individual # 1.	OVIDER OR SUPPLIER  ### SUMMARY STATEMENT OF DEFICIENCIES    SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREPER   PROPRIES R.A.W. OF CORRECTION SHOULD CHOOSE-REFERENCED TO THE APPROPRE DEFICIENCY    Continued From page 11   W 127   W 127    Continued From page 11   W 127    Continued From page 11   W 127   W 127    Continued From page 11   W 127    W 127   W 127    W 127   W 127   W 127    W 128   W 129   W 129    W 129   W 129   W 129    W 120   W 127   W 129   W 129    W 120   W 127   W 129   W 129    W 127   W 129   W 129   W 129    W 127   W 129   W 129   W 129    W 129   W 129   W 129   W 129    W 129   W 129   W 129   W 129    W 120   W 127   W 129   W 129    W 120   W 127   W 129   W 129    W 121   W 127   W 129   W 129    W 127   W 129   W 129   W 129    W 128   W 129   W 129   W 129    W 129   W 129   W 129   W 129    W 129   W 129   W 129   W 129    W 120   W 127   W 129   W 129    W 121   W 127   W 129   W 129    W 127   W 129   W 129   W 129    W 127   W 129	

PRINTED: 05/31/2019

	G111110001011	& MEDICAID SERVICES			(X3) DATE SURVEY
TATEMENT OF D ND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PROV	IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
				5604 ROSS DRIVE	
ROSS DRIVE				FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
W 155 C	ontinued From	page 12	W 15	5	
d	iagnoses that in	s a 39 year-old male, with cluded but were not limited to: tual disability (1), and autistic			
ir "( v ti ti fi th	ndividual # 1 dat (Individual # 1) e which is unpredict ney can not dete which may cause mpulsiveness are actors, staff sho be engages in the	havior Support Plan" for ted 05/28/2018 documented, exhibits aggressive behavior, ctable. In addition, staff report ermine any precipitating factors to his behavior. Given this and the lack of clear causal and continue to redirect him when these behaviors. Since he prefers to, staff should continue to redirect			
t g ii	ehavior. In add joing to the base ndoor swing, ev	when he is exhibiting aggressive dition, (Individual # 1) enjoys ement [with staff] to play on the very effort should be made to aptive behavior with time in the			
)   	residential countil (0/31/2019 doct 10/31/2019	dent Report" completed by RC ncilor) # 3 for Individual # 1 dated umented, "Provide a Detailed he Incident: (Individual # 1) and I the driveway and he wanted to go at to the house next door and went and tried to get in. I told him that ouse and that we had to leave. ressive and head butted me in a my shoulder." Under mments:" dated 11/1/18,			

Facility] supervisor it documented, "(Individual # 1) had a very hard day yesterday starting in the morning. When he returned home he was still

OCNICO	COP MEDICARE	& MEDICAID SERVICES	THE REAL PROPERTY.		OMB NO. 0938-0391
TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PROVIDER OR SUPPLIER  ROSS DRIVE		560	REET ADDRESS, CITY, STATE, ZIP CODE 14 ROSS DRIVE EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
W 155	offering some of the offered to take his and [sic] headbut Her nose was a light [registered nurse] use. I checked in reported that her (Individual # 1) who issue and con routine." Further Report revealed Allegation of Hum	attempted to calm him down by his favorite items. (RC# 3) m for a walk. He became upset ted her in the face and shoulder. Ittle swollen in the spot and (RN I I # 1), made her an ice pack to non her this morning and she nose is sore, but nothing major. The sable to sit and eat dinner with tinue on with his normal evening review of the facility's "Incident a "Human Rights Investigation. In an Rights Violation: Seclusion"	W 155		
	completion date part the following was received on reported the following reported the following the	man Rights Investigation" with a of 11/05/2018, documented in g: "Complaint: An incident report October 31st, 2018 which owing: ICF (intermediate care reviewed video footage and owing: Prior to providing his breakfast [sic] decided to hal # 1's) top shirt (long sleeved keep his undershirt on while he his was done to prevent shirt from becoming dirty while After (RC # 4) removed shirt, she tossed it to (RC # 1) in the living room. (Individual # 1) and ran over to (RC # 1) and on her wrists. According to (RC # ied to redirect (Individual # 1's) kitchen but he kept grabbing on . (Individual # 1) finally stopped			

and went into the kitchen and began grabbing and pulling on (RC # 4's) arm. (Individual # 1)

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		E & MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED	
		49G065	B. WING			05/23/2019
NAME OF PRO	VIDER OR SUPPLIER			5604	ET ADDRESS, CITY, STATE, ZIP CODE ROSS DRIVE DERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
r		page 14 ving room and started to grab	w	155		

to his room. (RC # 5) stated that (Individual # 1) did go in his room for a few seconds until he came back out, ran down the hallway and slapped (RC # 5) in the right arm which caused her to fall over. (RC # 4) put (Individual # 1's) shirt back on him, however (Individual # 1) was still aggressive and [sic] continue to hit staff. (RC #4, RC #5 and RC #1) guided (Individual #1) back into his room for a second time. While doing so, (Individual # 1) continued to hit and pull (RC # 1 and RC# 4) while (RC # 5) opened (Individual # 1's) room door. While in the room, (Individual # 1) attempted to pull (RC # 1) into his room with him. (RC # 1) was able to make it out of (Individual # 1's) room and closed the door behind her with (Individual # 1) inside. While standing outside (Individual # 1's) door (RC # 1) held the door shut." Under "OSM (other staff member) # 3, utilization review specialist and OSM # 4, utilization review specialist, viewed video footage from (Name of Group Home) from the morning of October 31st, 2018" it documented in part," ... (RC # 1) holds (Individual # 1's) door knob for approximately three minutes before the video footage turns off." Under "OSM #3, utilization review specialist and OSM #4, utilization review specialist, completed a face to face interview at (Address in Name of City) on November 5th ,2018 at 2:00pm with staff who was present during the event time: (Name of RC # 1)" it documented in part: " ... She stated she was able to close the door [with (OSM (other staff member) # 3, utilization review specialist and OSM # 4, utilization review specialist,) in the room] and stood outside of the door. As she stood outside the door she said she placed her hand on the door knob and began speaking to

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			_0	MB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		49G065	B. WNG			05/23/2019
NAME OF P	ROVIDER OR SUPPLIER		54	TREET ADDRESS, CITY, STATE, ZIP C 504 ROSS DRIVE REDERICKSBURG, VA 22407	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 155	how long her hand water hand approximately two in happened after she door knob, she [RC away and (Individual ready to leave his rochecked on (Individual room she reported in (Individual # 1) com that when (RC # 5) for his medication, appeared fine at the (Individual # 1) the door is not in his (Individual # 1) tried time she had her has responded no, I heat his closet doors whit agitated. When ask aware of other staff (Individual # 1's) do the past, she stated resort so that he do She also reported the what to do or how to was asked if she wat is not familiar with facility "Human Right facility's (Name of States).	ge 15  ugh the door. When asked was on the door knob, she was on the door knob for ninutes. When asked what removed her hand from the #1] stated that she walked with #1 came out when he was som. When asked if anyone wal #1 while he was in his no. When asked when did the out of his room, she stated informed him, that it was time (RC #1) also reported that he was time. When asked if a Positive Behavior Plan and with the plan, (RC #1) stated did have a plan and holding a plan. She was asked if to open the door during the wind on the door knob and she with the standard previously standing in front of or or holding the door knob in yes, we do that as a last they (staff) don't know on handle (Individual #1). She was familiar with (Individual #1) cass to his plan and she was have access to the plan, with it." Further review of the entire Investigation" revealed the dervice Board) Standards Of for (RC #1) stapled to the	W 155			

"Human Rights Investigation."

The facility's (Name of Service Board) Standards

PRINTED: 05/31/2019

		AND HUMAN SERVICES			OMB NO. 0938-0391
STATEMENT C	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PE	ROVIDER OR SUPPLIER		560	REET ADDRESS, CITY, STATE, ZIP CODE 04 ROSS DRIVE REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
W 155	# 1 and ASM # 1 "EMPLOYEE NAI VIOLATION: Cod Rights Violation. PLACE OF VIOL MAJOR OFFENS Suspension" it do (non-applicable).  Review of the face # 1 revealed RC Home) on: 10/31, 11/03/18 from 5:0 from 1:00 p.m. to from 11:00 p.m. to from 11:00 p.m. to from 11:00 p.m. to from 100 p.m. to from 11:00 p.m. to from 11:0	tion" for (RC # 1) signed by RC on 11/28/18 documented, ME: (Name of RC # 1). e of Ethics policy and Human VIOLATION DATE: 10/31/18. ATION: (Name of Group Home). E." Under "Effective Dates of cumented, "N/A  illity's "Time Card Report" for RC # 1 worked at (Name of Group /18 from 12:00 a.m. to 9:00 a.m., 100 a.m. to 3:00 p.m., 11/04/18 11:00 p.m. and on 11/05/19	W 155		

1 stated, "No." When asked if she secluded Individual # 1 by hold his door closed while Individual # 1 was inside his room RC # 1 stated,

PRINTED: 05/31/2019 FORM APPROVED

		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5604 ROSS DRIVE  FREDERICKSBURG, VA 22407		DE
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION DE APPROPRIATE DATE
	Individual # 1 whill RC # 1 stated, "He was a violation of seclusion was a fe "Yes."  On 05/22/19 at 2: conducted with Asmember) # 1, ICF supervisor. When Individual # 1 was ASM # 1 stated, "video. When there the video to compasked why RC # room ASM # 1 stated, "room asked if seclusion stated, "Yes." When the wideo to compasked if seclusion and she was individuals and (lift asked if seclusion stated, "Yes." When the wideo to compasked if seclusion and she was individuals and (lift asked if seclusion stated, "Yes." When the work individuals and (lift asked if seclusion stated, "No." When the work individuals and (lift asked if seclusion stated, "Yes." When the work individuals and the work of your protect the abuse investigation work. Once even (quality assurance proof, videos or security of the work	age 17  ed what could have happened to e being secluded in his room e could have hurt himself and it his rights." When asked if orm of abuse RC # 1 stated,  00 p.m., an interview was SM (administrative staff (intermediate care facility) a sked how she found out that being secluded in his room I found out when I reviewed the re is a major incident I review bete the incident report." When I secluded Individual # 1 in his sted, "She felt it was her only anted to keep staff, other andividual # 1) safe." When I was a form of abuse ASM # 1 hen asked if RC # 1 was go the abuse investigation ASM # Men asked the question "How e other individuals during an on?" ASM # 1 stated, "It is not by to prevent staff from coming to yothing is handed in to QA e) which would include any taff concerns, I'm out of it and e investigation process."  pproximately 2:20 p.m., a ew was conducted with OSM over) # 2, QA director. When was suspended during the abuse M # 2 stated, "No." When asked	W 155		

just what it was but not abuse." When asked if she considered seclusion a form of abuse OSM #

PRINTED: 05/31/2019

		AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  49G065		IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/23/2019	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
ROSS DR	IVE			REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION ATE DATE	
W 155	whether or not a significant during an abuse in "It's a team appropriate and QA and there on who gets the in read a section of Protection Section documented, "An abuse, neglect or removed from confesults of the invehow they protected of Group Home) 2 stated, "I under The facility's policity 2-3: Abuse and New protected of Group Home) 2 stated, "I under The facility's policity 2-3: Abuse and New protected of Group Home) 2 stated, "I under The facility's policity 2-3: Abuse and New protected of Group Home) abuse, neglect or be removed from the ID (Intellectual Coordinator, the Coordinator, the covering supervision of the above. The to (Name of Communication of Communication abuse) and the covering supervision of the above. The to (Name of Communication of Communication abuse) and the covering supervision of the above.	When asked who determines staff member is suspended investigation OSM # 2 stated, ach. The team includes the ort director, the residential essistant residential coordinator is a discussion and it depends information first." OSM #2 was the facility's policy "Client or 2-3: Abuse and Neglect" that by [sic] empolyees suspected of exploitation will be immediately intact with any residents pending estigation" OSM # 2 was asked and the other individuals at (Name during the investigation. OSM #	W 155			

Executive Director. The Executive Director will name additional staff to investigate further per Rules and regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department

of Behavioral Health and Developmental

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

PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT O	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PR	ROVIDER OR SUPPLIER		56	REET ADDRESS, CITY, STATE, ZIP CO 04 ROSS DRIVE REDERICKSBURG, VA 22407	ODE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
W 155	Continued From pa	age 19	W 155		
	Services."				
		proximately 3:00 p.m. ASM  ff member) # 1, ICF supervisor,  of the findings.			
	No further informati	tion was provided prior to exit.			
	by a limited menta adaptive behaviors schedules and rou Intellectual disabili 18 and may result autism or cerebral causes, such as la responsiveness. I from the website:	up of disorders characterized I capacity and difficulty with s such as managing money, tines, or social interactions. ty originates before the age of from physical causes, such as palsy, or from nonphysical ack of stimulation and adult This information was obtained .nih.gov/NiHfactsheets/ViewFa			
W 159	that begins early in throughout a perso acts and interacts and learns. This in the website: https://www.nlm.ni rumdisorder.html.	and developmental disorder in childhood and lasts on's life. It affects how a person with others, communicates, information was obtained from the gov/medlineplus/autismspect	W 159		
	Each client's active integrated, coording qualified intellecture. This STANDARD	e treatment program must be nated and monitored by a al disability professional. is not met as evidenced by: tial program record reviews,			

PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

		DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE S COMPL	
			49G065	B. WING_	_		05/2	23/2019
NAME	OF PRO	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
2000		-			560	04 ROSS DRIVE		
KUSS	DRIV	-			FR	REDERICKSBURG, VA 22407		
(X4) PREI	FIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	4	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
	1							6/3/19
W	159	Continued From p	age 20	W 1	59	W159		0/3/19
			rd review, facility document			How corrective action will be accomp	lished	
			terview, it was determined that			for individual #1:		
			ed Intellectual Disabilities			The QIDP will ensure the quarterly re		
			d to coordinate and monitor the			for individual #1 accurately reflect the	è	
			treatment programs for two of			condition of each outcome.		
			the survey sample, Individuals #			Assurance that other residents are pro		r:
		1 and # 2.				from the possibility of the deficiency:		
		1 The OIDP faile	d to ensure Individual # 1's			The QIDP will ensure the quarterly	0	
			view was accurate.			reviews for each individual accurately	reflect	
		second quarter re	view was accurate.			the condition of each outcome.	•	
		2 The QIDP faile	ed to ensure Individual # 2's			Measures to be put into place or syste		
			anal protocol was implemented.			changes to be made to ensure that the		
		•				deficient practice will not recur:		
	i	The findings inclu	de:			The QIDP will ensure that each mont		
						review is double checked for accuracy		
		1. The QIDP faile	ed to ensure Individual # 1's			each individual to ensure that the pro-		
		second quarter re	view was accurate.			calculations in each quarterly review		
						accurate representation of what progr	ess has	
			a 39 year-old male, with			been made toward outcomes.		
			cluded but were not limited to:			How the facility plans to monitor its		
			ual disability (1), and autistic			performance to make sure that solution	ins are	
		disorder (2).				sustained:	:11	
		Individual # 1'e Do	CP (Person Centered Plan)			The Program supervisor, or designee,		
			through 10/28/2019			review each quarterly for each individ	lual to	
			tcomes Important To/or #: 6.			ensure that they are accurate and representative of what progress has b	aan	
			kes his medications." Under the			made toward outcomes for each indiv		
			actions/supports needed" it			Date of Completion:	iduai.	
			th no more than two verbal			6/3/19		
			ual # 1) goes to the med			0/3/17		
			n to take his medications in the					
			ning at (Name of Group Home).					
			neasured when he completes					
			supports as outlined daily, for 6					
			months." Under the heading:					
	- 1	"Describe how thi	s will be provided based on					

individual preferences and location where program strategy can be found" it documented,

		& MEDICAID SERVICES			NO. 0938-0391
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	CONSTRUCTION	OATE SURVEY COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PE	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
2000 000	· ·			04 ROSS DRIVE	
ROSS DRI	VE		FR	REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W 159	often go to the metimes for his med the appropriate til times it takes two two prompts for (I med (medication) record a "-" (minusheet Success (Individual # 1) is med room daily, ihis medications a no more than two sign) is recorded the indicated level the indicated level The second quardated "May 6, 20 Under "Describe it documented," (medications at so shows a willingne when asked if he (Individual # 1) reapplesauce and afterwards. (Indimore than 2 (two ready for his medications at so shows a willingne when asked if he (Individual # 1) reapplesauce and afterwards. (Indimore than 2 (two ready for his medications at so shows a willingne when successful unsuccessful attrever in this goal [sic] capable of a work with him to as he nears com	akes medications daily, he will edication room at the incorrect ications but is willing to come at mes when verbally prompted, at prompts. If it takes more than Individual # 1) to come to the room at the appropriate time is sign ) on the data collection will be measured when successful [sic] going to the in the morning and evening for at (Name of Group Home) with a verbal prompts A "+" (plus for meeting outcome criteria per	W 159	How corrective action will be accomplished for Individual #2:  The QIDP will ensure the implementation of the active treatment outcome involving eating and nutritional protocol in accordance with the PCP (Person Centered Plan) for Individual #2.  Assurance that other residents are protected from the possibility of the deficiency:  The QIDP will ensure the implementation of the active treatment outcomes for each individual in accordance with their PCP (Person Centered Plan).  Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:  The QIDP will continue to monitor and ensure implementation of the active treatment outcomes as described in each individual's PCP.  How the facility plans to monitor its performance to make sure that solutions are sustained:  The program supervisor and assistant manager will monitor to ensure implementation of the active treatment outcomes as described in each individual PCP.  Date of Completion:  6/3/19	the

The facility's "PCP Outcome Data Collection" for Individual # 1 dated November 1, 2018 through April 30, 2019 documented, "Outcome # 6. 2x

STATEMENT OF DEFICIENCIES NOD PLAN OF CORRECTION  (X1) PROVIDER OR SUPPLIER  ROSS DRIVE    A BUILDING			& MEDICAID SERVICES	1	I S CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
ROSS DRIVE    CALL   DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION				W,			
ROSS DRIVE    KAN ID   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   PROFICE PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION AC			49G065	B. WING		05/23/2019	
ROSS DRIVE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH OFFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH OFFICIENCY OR LSC IDENTIFYING INFORMATION)  W 159  Continued From page 22  (two times) daily. Important To: (Individual # 1) takes his medications. With no more than two verbal prompts, (Individual # 1) goes to the med (medication) room to take his medications in the morning and evening at (Name of Group Home). Success will be measured when he completes this task 5 (five) days in a row. 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 data collection sheets dated November 1, 2018 through April 30, 2019 revealed Individual # 1 was successfully met the criteria for outcome # 6, 362 time out of 362 opportunities indication that Individual # 1 met the outcome with 100% (percent) accuracy for six consecutive months.	NAME OF P	ROVIDER OR SUPPLIER					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 159  Continued From page 22  (two times) daily. Important To: (Individual # 1) takes his medications. With no more than two verbal prompts, (Individual # 1) goes to the med (medication) room to take his medications in the morning and evening at (Name of Group Home). Success will be measured when he completes this task 5 (five) days in a row. 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 data collection sheets dated November 1, 2018 through April 30, 2019 revealed Individual # 1 was successfully met the criteria for outcome # 6, 362 time out of 362 opportunities indication that Individual # 1 met the outcome with 100% (percent) accuracy for six consecutive months.	ROSS DRIVE						
(two times) daily. Important To: (Individual # 1) takes his medications. With no more than two verbal prompts, (Individual # 1) goes to the med (medication) room to take his medications in the morning and evening at (Name of Group Home). Success will be measured when he completes this task 5 (five) days in a row. 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 data collection sheets dated November 1, 2018 through April 30, 2019 revealed Individual # 1 was successfully met the criteria for outcome # 6, 362 time out of 362 opportunities indication that Individual # 1 met the outcome with 100% (percent) accuracy for six consecutive months.	PREFIX	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP	OULD BE COMPLETION	
takes his medications. With no more than two verbal prompts, (Individual # 1) goes to the med (medication) room to take his medications in the morning and evening at (Name of Group Home). Success will be measured when he completes this task 5 (five) days in a row. 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 data collection sheets dated November 1, 2018 through April 30, 2019 revealed Individual # 1 was successfully met the criteria for outcome # 6, 362 time out of 362 opportunities indication that Individual # 1 met the outcome with 100% (percent) accuracy for six consecutive months.	W 159		ATTENDED TO A STATE OF THE STAT	W 15	59		
On 05/22/19 at 2:30 p.m., an interview was		takes his medicat verbal prompts, (I (medication) room morning and ever Success will be medicated for medicated level of recorded for requirements of November 1, 201 revealed Individual criteria for outcome opportunities indicated with 100 consecutive months.	cions. With no more than two individual #1) goes to the med in to take his medications in the ining at (Name of Group Home). The ineasured when he completes days in a row. A "+" (plus sign) is ting outcome criteria per the support." A "-" (minus sign) is iring a higher level of support." The data collection sheets dated 8 through April 30, 2019 at #1 was successfully met the ine #6, 362 time out of 362 cation that Individual #1 met the 10% (percent) accuracy for six ths.				

# 1 was asked if the quarterly review accurately calculated the number of successful trails and accurately document the progress OSM # 1

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 6 5604 ROSS DRIVE FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
W 159	progress was mark stated, "It was mark compared it to the accurate."  On 05/22/19 at application (administrative stated was made aware of the following stated was also with the following stated was sta	sked why Individual # 1's ked as "Regression" OSM # 1 ked as regression because I last quarter but it's no  proximately 3:00 p.m. ASM ff member) # 1, ICF supervisor, of the findings.  tion was provided prior to exit.  up of disorders characterized I capacity and difficulty with s such as managing money, tines, or social interactions. ty originates before the age of from physical causes, such as palsy, or from nonphysical ick of stimulation and adult This information was obtained  .nih.gov/NIHfactsheets/ViewFa	W1	59	
	rumdisorder.html.  2. The QIDP failed	d to ensure Individual # 2's nal protocol was implemented.			

Individual # 2 was a 44 year-old male with diagnoses that included but were not limited to:

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		& MEDICAID SERVICES				OMB NO. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G065	B. WING			05/23/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	STATE, ZIP CODE		
ROSS DRI	VE			5604 ROSS DRIVE FREDERICKSBURG,	VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		
W 159	An observation of 9:20 a.m., at (Nan conducted. Individual with staff men #2. RC #2 assist a cup of coffee by a flavored creame hand-over-hand at coffee. After the operated the cup hard plastic cup. Fhand-over-hand at took sips of coffee Individual #1's PC dated 12/29/2018 documented, "Gos prescribed eating #2) uses a nosey for proper chin tuc Responsible Partn (Name of Day Pro	disability (1), bipolar disorder deLange Syndrome (3).  Individual # 2 on 05/22/19 at the of Day Program) was dual # 2 was observed seated in the kitchen at the day program of the kitchen at the day program of the control of the limited and the limited at the day program of the limited at the limited at limited and limited at	W	159			
	Group Home) "Eat	ing Precaution Plan" for imented, "Equipment: Suction					
	Assessment" for Ir documented, "Rec	on and Swallowing/Eating ndividual # 2 dated 12/6/2018 commendations: 4. Use nosey o allow for chin tuck position					

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			OMB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
49G065	B. WNG		05/23/2019
	56	504 ROSS DRIVE	
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE COMPLETION
ucted with RC # 2 at (Name of the asked what adaptive al # 2 uses when eating and ated, "He uses a divided plate When asked if she provided individual # 2 when he drank stated, "No." When asked if all be used for all liquids RC # p.m., an interview was sim (other staff member) # 1, resence of ASM (administrative the ICF [intermediate care OSM #1 was asked the P. OSM # 1 stated, "It's person the individual where they are at the em toward independence in DSM # 1 was informed of the day program of Individual # 2 with his nosey cup. OSM # 1 is a lot of collaboration with the gers/staff day support staff and ans while developing PCPs. #2 were made aware of this tion was provided prior to exit.	W 159		
	(X1) PROVIDER/SUPPLIER/CLIA	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  49G065  B. WING  STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  R LSC IDENTIFYING INFORMATION)  W 159  ID PREFIX TAG  W 159  W 15	MEDICAID SERVICES  (X1) PROVIDERSUPPLICATION NUMBER:  49G065  49G065  8 WING  STREET ADDRESS, CITY, STATE, ZIP CODE  5604 ROSS DRIVE FREDERICKSBURG, VA 22407  FREDERICKSBURG, VA 22407  PROVIDERS PLAN OF CORRE  TAG  PROVIDERS PLAN OF CORRE  RESC IDENTIFYING INFORMATION)  TAG  W 159  W 159

causes, such as lack of stimulation and adult responsiveness. This information was obtained

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES		Ç	OMB NO. 0938-0391
TATEMENT O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	E CONSTRUCTION (2	(X3) DATE SURVEY COMPLETED
		49G065	B. WING	The same of the same of the	05/23/2019
NAME OF PE	ROVIDER OR SUPPLIER		56	STREET ADDRESS, CITY, STATE, ZIP CODE 604 ROSS DRIVE FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
W 159	Continued From pa	age 26	W 159		
1	from the website: https://www.report.r ctSheet.aspx?csid=	.nih.gov/NIHfactsheets/ViewFa =100			
	mood, energy, active carry out day-to-day obtained from the we https://www.nimh.ni order/index.shtml.  (3) A developmental parts of the body. If growth before and at that is usually sever abnormalities involved distinctive facial feat obtained from the we https://ghr.nlm.nih.ge-syndrome.  PROGRAM IMPLEM CFR(s): 483.440(d).  As soon as the interformulated a client's each client must reconstructed the control of the control	al disorder that affects many It is characterized by slow after birth, intellectual disability ere to profound, skeletal ving the arms and hands, and atures) This information was website: gov/condition/cornelia-de-lang  MENTATION (1) erdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number	W 249	W 249  How corrective action will be accomplish for individual #1:  The QIDP will coordinate and monitor the ensure the quarterly reviews for individual #1 accurately reflect the condition of each outcome.  Assurance that other residents are protected from the possibility of the deficiency:  The QIDP will coordinate and monitor the ensure the quarterly reviews for each individual accurately reflect the condition of each outcome.  Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:  The QIDP will coordinate and monitor the ensure that each monthly review is double checked for accuracy for each individual ensure that the progress calculations in equarterly review is an accurate representation of what progress has been made toward outcomes.  How the facility plans to monitor its	to  ceted to  to  ble al to each
	objectives identified plan.  This STANDARD is	upport the achievement of the d in the individual program s not met as evidenced by:		performance to make sure that solutions sustained:  The Program supervisor, or designee, wi review each quarterly for each individual ensure that they are accurate and representative of what progress has been made toward outcomes for each individu	rill al to

day program record review, facility document

review and staff interview, it was determined that

6/3/19

Date of Completion:

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 05/23/2019 496065 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5604 ROSS DRIVE ROSS DRIVE FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 6/3/19 W 249 Continued From page 27 W 249 W 249 How corrective action will be the QIDP (Qualified Intellectual Disabilities accomplished for Individual #2: Professional) failed to coordinate and monitor the The OIDP will coordinate and monitor to individuals' active treatment programs for two of two individuals in the survey sample, Individuals # ensure the implementation of the active 1 and # 2. treatment outcome involving eating and nutritional protocol in accordance 1. The QIDP failed to ensure Individual # 1's with the PCP (Person Centered Plan) for second quarter review was accurate. Individual #2. Assurance that other residents are 2. The QIDP failed to ensure Individual # 2's protected from the possibility of the eating and nutritional protocol was implemented. deficiency: The QIDP will coordinate and monitor to The findings include: ensure the implementation of the active treatment outcomes for each individual in The QIDP failed to ensure Individual # 1's accordance with their PCP (Person second quarter review was accurate. Centered Plan). Measures to be put into place or systemic Individual # 1 was a 39 year-old male, with changes to be made to ensure that the diagnoses that included but were not limited to: profound intellectual disability (1), and autistic deficient practice will not recur: The QIDP will continue to coordinate and disorder (2). monitor to ensure implementation of the Individual # 1's PCP (Person Centered Plan) active treatment outcomes as described in dated 10/29/2018 through 10/28/2019 each individual's PCP. documented, "Outcomes Important To/or #: 6. How the facility plans to monitor its (Individual # 1) takes his medications." Under the performance to make sure that solutions heading "List the actions/supports needed" it are sustained: documented, "With no more than two verbal The program supervisor and prompts, (Individual # 1) goes to the med assistant manager will monitor to ensure (medication) room to take his medications in the the implementation of the active treatment morning and evening at (Name of Group Home). outcomes as described in each individual's Success will be measured when he completes PCP. this task with the supports as outlined daily, for 6 Date of Completion: (six) consecutive months." Under the heading: 6/3/19 "Describe how this will be provided based on individual preferences and location where

program strategy can be found" it documented, "(Individual # 1) takes medications daily, he will often go to the medication room at the incorrect

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		AND HUMAN SERVICES			OMB NO. 0938-0391
CENTERS	FOR MEDICARE	& MEDICAID SERVICES	1	TO CONTRICTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CLE CONSTRUCTION	COMPLETED
		49G065	B. WING		05/23/2019
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5604 ROSS DRIVE FREDERICKSBURG, VA 22407	DDE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
W 249	times for his media the appropriate tin times it takes two two prompts for (In med (medication) record a "-" (minus sheet Success of (Individual # 1) is med room daily, in his medications at no more than two sign) is recorded to the indicated leve  The second quart dated "May 6, 20" Under "Describe it documented, "(I medications at so shows a willingne when asked if he (Individual # 1) re applesauce and to afterwards. (Indiv more than 2 (two) ready for his med been successful unsuccessful atte excel in this goal [sic] capable of at work with him to as he nears comp	cations but is willing to come at these when verbally prompted, at prompts. If it takes more than individual # 1) to come to the room at the appropriate time is sign ) on the data collection will be measured when successful [sic] going to the in the morning and evening for to to the total prompts A "+" (plus for meeting outcome criteria per	W 2-	49	

The facility's "PCP Outcome Data Collection" for Individual # 1 dated November 1, 2018 through April 30, 2019 documented, "Outcome # 6. 2x (two times) daily. Important To: (Individual # 1) takes his medications. With no more than two

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INTERENT OF DEFICIENCIES NOP FLAN OF CORRECTION  NOP FLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  ROSS DRIVE  PAGE  SUMMARY STATEMENT OF DEFICIENCIES FREDERICKSBURG, VA 22407  PREFIX FREDERICKSBURG, VA 22407  FREDERICKSBU	DEPARTIV	ENI OF TILALITY	A MEDICAID SERVICES					J. 0930-0391
STREET ADDRESS, CITY, STATE, ZIP CODE 5604 ROSS DRIVE  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG  W 249  Continued From page 29  verbal prompts, (individual # 1) goes to the med (medication) room to take his medications in the morning and evening at (Name of Group Home). Success will be measured when he completes this task 5 (five) days in a row. A ** (plus sign) is recorded for requiring a higher level of support. Further review of the data collection sheets dated November 1, 2018 through April 30, 2019 revealed Individual # 1 mes the outcome with 100% (percent) accuracy for six consecutive months.  On 05/22/19 at 2:30 p.m., an interview was conducted with OSM (other staff member) # 1, the CIDP (Qualified Intellectual Disabilities Professional). When asked if he was responsible for completing the quaretry reviews, OSM # 1 stated, "Ves." When asked to describe the process for completing the puaretry reviews. OSM # 1 stated, "I use the data collection each month, compare it to the previous month, and determine if the numbers are increasing or decreasing. There are some outcomes that are measured for six months.  On 05/22/19 at 2:30 p.m., an interview was conducted with OSM # 1, the QIDP. After review of Individual # 1's data collection sheets dated November 1, 2018 through April 30, 2019 and the second quarter PCP review dated 05/06/1, OSM # 1 was asked if the quaretry reviews accurately	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:							
ROSS DRIVE    SUMMARY STATEMENT OF DEFICIENCIES   PROPERTY   PROPERY   PROPERTY   PROPERTY   PROPERTY   PROPERTY   PROPERTY   PROPER			B. WING			05	/23/2019	
ROSS DRIVE  ROSS DRIVE  ROSS DRIVE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION)  W 249  Continued From page 29  verbal prompts, (individual # 1) goes to the med (medication) room to take his medications in the morning and evening at (Name of Group Home). Success will be measured when he completes this task 5 (five) days in a row. A "" (plus sign) is recorded for meeting outcome criteria per the indicated level of support." A "" (plus sign) is recorded for requiring a higher level of support." Further review of the data collection sheets dated November 1, 2015 through April 30, 2019 revealed Individual # 1 mas successfully met the criteria for outcome # 6, 362 time out of 3622 opportunities indication that Individual # 1 met the outcome with 100% (percent) accuracy for six consecutive months.  On 05/22/19 at 2:30 p.m., an interview was conducted with OSM (other staff member) # 1, the OIDP (Qualified Intellectual Disabilities Professional). When asked if he was responsible for completing the quarenty reviews. OSM # 1 stated, "Yes." When asked to describe the process for completing the unarenty reviews. OSM # 1 stated, "I use the data collection each month, compare it to the previous month, and determine if the numbers are increasing or decreasing. There are some outcomes that are measured for six months.  On 05/22/19 at 2:30 p.m., an interview was conducted with OSM # 1, the QIDP. After review of Individual # 1's data collection sheets dated November 1, 2013 through April 30, 2019 and the second quarter PCP review dated 05/06/1, OSM # 1 was asked if the quaretery review accurately			490000		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	^	
PREDERICKSBURG, VA 22407  (A4) ID PRETRY (EACH OPERCIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)  W 249 Continued From page 29 verbal prompts, (Individual # 1) goes to the med (medication) room to take his medications in the morning and evening at (Name of Group Home). Success will be measured when the completes this task 5 (five) days in a row. A *+** (plus sign) is recorded for requiring a higher level of support.** Further review of the data collection sheets dated November 1, 2018 through April 30, 2019 revealed Individual # 1 ms successfully met the criteria for outcome # 6, 362 time out of 362 opportunities indication that Individual # 1 met the outcome with 100% (percent) accuracy for six consecutive months.  On 05/22/19 at 2:30 p.m., an interview was conducted with OSM (other staff member) # 1, the QIDP (Qualified Intellectual Disabilities Professional). When asked to describe the process for completing the quarterly reviews, OSM # 1 stated, "vis.* When asked to describe the process for completing the quarterly reviews, OSM # 1 stated, "vis.* When asked to describe the process for completing the quarterly reviews, OSM # 1 stated, "it use the data collection each month, compare it to the previous month, and determine if the numbers are increasing or decreasing. There are some outcomes that are measured for six months.  On 05/22/19 at 2:30 p.m., an interview was conducted with OSM # 1, the QIDP. After review of Individual # 1 is data collection sheets dated November 1, 2018 through April 30, 2019 and the second quarter PCP review dated 05/08/1, OSM # 1 was asked if the quarterly review accurately	NAME OF PR	OVIDER OR SUPPLIER						
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calculated the number of successful trails and								
accurately document the progress OSM # 1								

stated no. When asked why Individual # 1's progress was marked as "Regression" OSM # 1

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CENTERS	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G065	B. WING			05/23/2019
ROSS DRI	OVIDER OR SUPPLIER			5604	ROSS DRIVE DERICKSBURG, VA 22407	
					THE COME SECURITY AND ASSESSMENT OF THE SECURITY OF THE SECURI	MAI (ME)
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
W 249	Continued From p	age 30	w	249		
	stated, "It was ma	rked as regression because I last quarter but it's no				
		proximately 3:00 p.m. ASM  of the findings.				
	No further informa	tion was provided prior to exit.				
	by a limited menta adaptive behavior schedules and rou Intellectual disabil 18 and may result autism or cerebral causes, such as la responsiveness. from the website: https://www.reportSheet.aspx?csic(2) A neurological that begins early inthroughout a persuacts and interacts and learns. This is the website:	oup of disorders characterized all capacity and difficulty with a such as managing money, attines, or social interactions. It originates before the age of from physical causes, such as palsy, or from nonphysical ack of stimulation and adult. This information was obtained and developmental disorder in childhood and lasts on's life. It affects how a person with others, communicates, information was obtained from the gov/medlineplus/autismspect				
	eating and nutritio Individual # 2 was diagnoses that inc	d to ensure Individual # 2's nal protocol was implemented. a 44 year-old male with luded but were not limited to: disability (1), bipolar disorder				

(2), and Cornelia deLange Syndrome (3).

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CENTERS	FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	Town the Town	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
(X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		49G065	B. WNG		05/23/2019
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5604 ROSS DRIVE	
ROSS DRIV	<b>VE</b>			FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	FACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE
W 249	Continued From p	page 31	W 24	9	
	9:20 a.m., at (Nar conducted. Indivinis wheelchair, in site with staff mei # 2. RC # 2 assis a cup of coffee by a flavored cream hand-over-hand coffee. After the presented the cu hard plastic cup. hand-over-hand took sips of coffee Individual # 1's F dated 12/29/201 documented, "Giprescribed eating # 2) uses a nose for proper chin to Responsible Par (Name of Day Pi The (Name of Day Pi The (Name of Day Fi The (Name of Day F	essistance while Individual # 2 the until he drank it all.  PCP (Person Centered Plan) 8 through 12/28/2019 total 7 Protocol. I follow my total and nutritional plan. (Individual try cup when drinking which allows tuck position. How often? Daily. ther: (Name of Group Home) and trogram)."  ay Program) and (Name of teating Precaution Plan" for tocumented, "Equipment: Suction			
4 1 1		ation and Swallowing/Eating			

when drinking."

documented, "Recommendations: 4. Use nosey cup for all liquids to allow for chin tuck position

On 05/22/19 at approximately 9:20 a.m., an interview was conducted with RC # 2 at (Name of Day Program). When asked what adaptive

PRINTED: 05/31/2019

DEPARTM	MENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				OMB NO. 0938-0391	
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G065	B. WING_			05/23/2019	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5604 ROSS DRIVE  FREDERICKSBURG, VA 22407				
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES EIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	(FACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD I FERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
W 249	drinking, RC # 2 and a nosey cup the nosey cup for his coffee, RC # the nosey cup sl 2 stated, "Yes."	page 32 dual # 2 uses when eating and stated, "He uses a divided plate ." When asked if she provided or Individual # 2 when he drank 2 stated, "No." When asked if mould be used for all liquids RC # 31 p.m., an interview was	wa	49			

conducted with OSM (other staff men the QIDP in the presence of ASM (administrative staff member) #1, the ICF [intermediate care facility] supervisor. OSM #1 was asked the purpose of the PCP. OSM # 1 stated, "It's person centered to meet the individual where they are at while promoting them toward independence in different areas." OSM # 1 was informed of the observation at the day program of Individual # 2 not being provided with his nosey cup. OSM # 1 stated he conducts a lot of collaboration with the group home managers/staff day support staff and Individuals' guardians while developing PCPs. ASM #1 and OSM #2 were made aware of this concern.

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

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

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The same of the sa	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION CO	05/23/2019
NAME OF PROVIDER OR SUPPLIER			560	EET ADDRESS, CITY, STATE, ZIP CODE 4 ROSS DRIVE EDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	/EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL. R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	mood, energy, activ		W 249		
W 436	obtained from the whttps://www.nimh.norder/index.shtml.  (3) A developmenta parts of the body. growth before and that is usually seven abnormalities involdistinctive facial ferobtained from the https://ghr.nlm.nih.e-syndrome.  SPACE AND EQUICTER(s): 483.470(growth than the syndrome is the facility must fer and teach clients to choices about the hearing and other and other devices.	vebsite: iih.gov/health/topics/bipolar-dis  al disorder that affects many It is characterized by slow after birth, intellectual disability ere to profound, skeletal lving the arms and hands, and atures) This information was website: gov/condition/cornelia-de-lang  IPMENT (a)(2)  urnish, maintain in good repair, to use and to make informed use of dentures, eyeglasses, communications aids, braces,	W 436	W436  How corrective action will be accomplished for individual #2: Facility staff will ensure they provide adaptive equipment (nosey cup) for use by individual #2 when he is drinking his coffe or other liquids in accordance with his eath and nutritional plan.  Assurance that other residents are protected from the possibility of the deficiency: Facility staff will ensure they provide all individuals with adaptive equipment for unas described in each individual's ISP.  Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur: The QIDP will coordinate and monitor to ensure that needed adaptive equipment for each individual is available and implement by facility staff for each individual.	e ng <u>d</u> se
	Based on observed inical record reverse facility staff failed for one of two individual #2.	is not met as evidenced by: ation, staff interviews and iew, it was determined that the to provide adaptive equipment ividuals in the survey sample,		How the facility plans to monitor its performance to make sure that solutions as sustained:  The Program supervisor, or designee, will monitor to ensure that needed adaptive equipment for each individual is available and implemented by facility staff for each individual.  Date of Completion:  6/3/19	

DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391
CENTERS	FOR MEDICARE	& MEDICAID SERVICES		OIL C CONSTRUCTION	(X3) DATE SURVEY
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		49G065	B. WING _		05/23/2019
		4,000		STREET ADDRESS, CITY, STATE, ZIP C	CODE
NAME OF PR	OVIDER OR SUPPLIER			6604 ROSS DRIVE	
ROSS DRI	VE			FREDERICKSBURG, VA 22407	
			ID	PROVIDER'S PLAN OF	CORRECTION (X5)
(X4) ID PREFIX TAG	/EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	TACH CORRECTIVE AC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
W 436	Continued From p	nage 34	W	436	
11 400		en he was drinking his coffee.			
	The findings inclu	de:			
	Individual # 2 was	s a 44 year-old male with			
	diagnoses that in	cluded but were not limited to:			
	severe intellectua	Il disability (1), bipolar disorder			
	(2), and Cornelia	deLange Syndrome (3).			
		f Individual # 2 on 05/22/19 at			
	9:20 a.m., at (Na	me of Day Program) was			
	conducted. Indiv	idual # 2 was observed seated in			
	his wheelchair, in	the kitchen at the day program			
	site with staff me	mber RC (residential councilor) sted Individual # 2 with preparing			
	#2. RC #2 assi	y allowing Individual # 2 to select			
	a flavored cream	er from a choice of two, and			
		assistance with stirring the			
	coffee After the	coffee was prepared RC # 2			
	presented the cu	p of coffee in a regular standard			
	hard plastic cup.	RC #2 provided			
	hand-over-hand	assistance while Individual # 2			
		e until he drank it all.			
		PCP (Person Centered Plan)			
		8 through 12/28/2019			
		oal 7 Protocol. I follow my			
		g and nutritional plan. (Individual			
		ey cup when drinking which allows			
		uck position. How often? Daily.			
	(Name of Day P	tner: (Name of Group Home) and rogram)."			
	The (Name of D	ay Program) and (Name of			
7. 7. 7. 7.		ating Precaution Plan" for			
		cumented "Equipment Suction			

divided plate, nosey cup."

The "Communication and Swallowing/Eating

### PRINTED: 05/31/2019 **FORM APPROVED** DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 05/23/2019 B. WING 49G065 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5604 ROSS DRIVE FREDERICKSBURG, VA 22407 ROSS DRIVE PROVIDER'S PLAN OF CORRECTION ID SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG W 436 W 436 Continued From page 35 Assessment" for Individual # 2 dated 12/6/2018 documented, "Recommendations: 4. Use nosey cup for all liquids to allow for chin tuck position when drinking." On 05/22/19 at approximately 9:20 a.m., an interview was conducted with RC # 2 at (Name of Day Program). When asked what adaptive equipment Individual # 2 uses when eating and drinking, RC # 2 stated, "He uses a divided plate and a nosey cup." When asked if she provided the nosey cup for Individual # 2 when he drank his coffee, RC # 2 stated, "No." When asked if the nosey cup should be used for all liquids RC # 2 stated, "Yes." On 05/22/19 at approximately 3:00 p.m. ASM (administrative staff member) # 1, ICF (Intermediate Care Facility) supervisor, 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/ViewFa

ctSheet.aspx?csid=100

(2) A brain disorder that causes unusual shifts in

PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED 05/23/2019
		496065	STF 560	4 ROSS DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROXIMATION OF THE APPROX	ULD BE COMPLETION
IDENTIFICATION NUMBER:  49065  NAME OF PROVIDER OR SUPPLIER  ROSS DRIVE    (A4) ID   SUMMARY STATEMENT OF DEFICIENCIES   FREDERICKSBURG, VA 22407					
W 440	(3) A development parts of the body. growth before and that is usually sev abnormalities invodistinctive facial fe obtained from the https://ghr.nlm.nih e-syndrome.	tal disorder that affects many It is characterized by slow I after birth, intellectual disability ere to profound, skeletal siving the arms and hands, and eatures). This information was website: I.gov/condition/comelia-de-lang	W 440	How corrective action will be acceptable a	ntion drills at ersonnel. e protected
	This STANDARD Based on facility interview, it was of	is not met as evidenced by: document review and staff determined that the facility failed		All ICF facilities will conduct ev drills at least quarterly for each s personnel.  Measures to be put into place or changes to be made to ensure that deficient practice will not recur:  The program supervisor will more ensure that facility staff conduct	systemic at the nitor to evacuation
	Review of the factorial dated 05/2018 that an evacuation 11:00 p.m. to 7:0 and September 2 and March 2019.	cility's "Emergency Drill Forms" rough 04/2019 failed to evidence on drill was conducted on the 0 a.m. shift between July 2018 2018 and between January 2019		personnel.  How the facility plans to monito performance to make sure that so sustained:  The Director of Compliance and Rights, or designee, will review that evacuation drills are conduct quarterly for each shift of person Date of Completion:	olutions are  Human to ensure eted at least

PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

TATEMENT O	F DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  49G065	(X2) MULT A. BUILDII B. WING		(X3) DATE SURVE COMPLETED 05/23/20	
NAME OF PROVIDER OR SUPPLIER  ROSS DRIVE			STREET ADDRESS, CITY, STATE, ZIP C 5604 ROSS DRIVE FREDERICKSBURG, VA 22407	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ARADA ACCEDENCED TO	TION SHOULD BE COM THE APPROPRIATE	(X5) IPLETION DATE
W 440	(Intermediate Care to provide evidence the 11:00 p.m. to 2018 and Septem 2019 and March 2019 and March 2019 and twas not conducte shift between July On 05/22/19 at ap (administrative stawas made aware	off member) # 1, ICF a Facility) supervisor was asked be of the fire drills conducted on a 7:00 a.m. shift between July ber 2018 and between January a 19. a 5 p.m., ASM # 1 stated they beate the evacuation drill for a 11:00 p.m. to 7:00 a.m. a 2018 and September 2018. b 2018 and September 2018. b 3 proximately 3:00 p.m. ASM aff member) # 1, ICF supervisor,	W	440		