STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G073	A. BUILDING _____ B. WING _____	03/21/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/19/19 through 03/21/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency	E 022	E 022 1. Policy and procedures will be revised to include a description of the facility's means to shelter in place for patients, staff, and volunteers who remain in the facility during an emergency. 2. The policy and procedure for all ICF programs will likewise be revised to include a description of the facility's means to shelter in place for patients, staff, and volunteers who remain in the facility during an emergency. 3. The program manager will review the policy annually and make any needed revisions to ensure that the description of the facility's means to shelter in place for patients, staff, and volunteers who remain in the facility during an emergency is still accurate. 4. Any time changes to policy and procedures are proposed by the program manager, he or she will forward the document to the DD Residential Coordinator or designee for final review to ensure that the description of the facility's means to shelter in place for patients, staff, and volunteers who remain in the facility during an emergency is recorded accurately in the plan. 5. Date of completion will be by 4/30/19.	4/30/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: DD Residential Coordinator | (X6) DATE: 4/1/19

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

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E 022	Continued From page 1 preparedness plan. The facility staff failed to develop policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. The findings include: On 03/20/19 at 1:00 p.m., a review of the facility's emergency preparedness plan and interview was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager. Review of the facility's emergency preparedness plan failed to evidence policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. ASM # 1 stated, "We don't have it." On 03/21/19 at 10:30 a.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings. No further information was provided prior to exit.	E 022		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 026	E 026 1. Policy and procedures will be revised to include a description of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. 2. The policy and procedure for all ICF programs will likewise be revised to include a description of the facility's role in providing care and treatment at alternate	4/30/19

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E 026	Continued From page 2 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that the policies and procedures in the emergency plan describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. The findings include: On 03/20/19 at 1:00 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager. Review of the facility's emergency	E 026	care sites under an 1135 waiver. 3. The program manager will review the policy annually and make any needed revisions to ensure that the description of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver is still accurate. 4. Any time changes to policy and procedures are proposed by the program manager, he or she will forward the document to the DD Residential Coordinator or designee for final review to ensure that the description of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver is recorded accurately in the plan. 5. Date of completion will be by 4/30/19.	4/30/19

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E 026	Continued From page 3 preparedness plan failed to evidence documentation that the policies and procedures in the emergency plan describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. ASM # 1 stated, "We don't have it." On 03/21/19 at 10:30 a.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager was made aware of the findings No further information was provided prior to exit.	E 026		
W 000	INITIAL COMMENTS An unannounced annual Medicaid ICF/IDD Health Care Certification survey was conducted 03/19/19 through 03/21/19. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Mentally Retarded. The Life Safety Code survey report will follow. The census in this four bed facility was four at the time of the survey. The survey sample consisted of three current Individual reviews (Individuals #1, #2 and #3).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff	W 111	W111 How corrective action will be accomplished for individual #1: Facility staff will 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 facility staff will 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: Facility staff will ensure that each monthly review is double checked for accuracy for each individual to ensure that the progress calculations in each quarterly review is an accurate representation of what progress has been made toward outcomes. How the facility plans to monitor its performance to make sure that solutions are sustained: The Program supervisor or designee will review each quarterly for each individual to ensure that they are accurate and representative of what progress has been made toward outcomes for each individual. Date of Completion: 4/1/19	4/1/19

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W 111	Continued From page 4 failed to ensure the clinical record was accurate for two of three individuals in the survey sample, Individuals # 1 and # 2. 1. The facility staff failed to ensure the quarterly review for Individual # 1's PCP (person-centered-plan) was accurate. 2. The facility staff failed to ensure the quarterly review for Individual # 2's PCP (person-centered-plan) was accurate. The findings include: 1. The facility staff failed to ensure the quarterly review for Individual # 1's PCP (person-centered-plan) was accurate. Individual # 1 was a 60 year old male, who was admitted to (Name of Group Home) on 01/20/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), seizures (2), gastroesophageal reflux disease (3), hypertension (4) and cardiomyopathy (5). The (person-centered plan) for individual # 1 dated "Start: 2/21/2018. End: 2/20/2019" documented, "2b. (Individual # 1) brushes his teeth twice daily, 8a. (Individual # 1) chooses items that he wants to purchase. (Individual # 1) is offered visual and 2 (two) verbal prompts to choose between two items that he would like to purchase; success is measured when he chooses an item 3 (three) months in a row." The quarterly review for (Individual # 1) dated "February 27, 2019" was reviewed. The quarterly review documented, "Desired Outcome: 2b. Important for: (Individual# 1) brushes his teeth	W 111	W111 How corrective action will be accomplished for individual #2: Facility staff will ensure the quarterly reviews for individual #2 accurately reflect the condition of each outcome. Assurance that other residents are protected from the possibility of the deficiency: The facility staff will 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: Facility staff will ensure that each monthly review is double checked for accuracy for each individual to ensure that the progress calculations in each quarterly review is an accurate representation of what progress has been made toward outcomes. How the facility plans to monitor its performance to make sure that solutions are sustained: The Program supervisor or designee will review each quarterly for each individual to ensure that they are accurate and representative of what progress has been made toward outcomes for each individual. Date of Completion: 4/1/19	4/1/19

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W 111	Continued From page 5	W 111		

twice a day." Under 'Describe progress toward each outcome" it documented, "During this quarter, (Individual # 1) has been successful with this goal 124 times and unsuccessful 60 times" for a total of 184 opportunities. Under "Condition", it documented "Met." Under "Desired Outcome: 8a. Important To: (Individual #1) chooses items that he wants to purchase." Under "Condition", it documented "Met."

The data collection sheets for Individual # 1 dated 11/21/18 through 02/20/19 revealed the PCP outcome 2b, tooth brushing contained 182 opportunities for implementation and the PCP outcome 8a, choosing an item to purchase, was not met for three month in a row.

On 03/20/19 at 3:00 p.m., an interview and review of Individual # 1's quarterly review dated "February 27, 2019", PCP dated 2/21/2018 through2/20/2019 and the data collection sheets dated 11/21/18 through 02/20/19 was conducted with OSM (other staff member) # 1, the QIDP (Qualified Intellectual Disabilities Professional). When asked if the documentation on the quarterly review for Individual # 1's PCP outcome 2b of 184 opportunities was correct, OSM # 1 stated, "No." When asked if the coding of Individual # 1's PCP outcome 8a was coded correctly as being met, OSM # 1 stated, no." When asked how the quarterly reviews were developed, OSM # 1 stated, "They are based on my monthly reviews."

On 03/21/19 at 10:05 a.m., an interview was conducted with ASM # 1, ICF (intermediate care facility) manager. When asked who was responsible for ensuring the QIDP's quarterly reviews were accurate, ASM # 1 stated, "It's done

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W 111	Continued From page 6 by (Name of ASM # 3)." On 03/21/19 at 10:15 a.m., an interview was conducted with ASM # 3, the assistant residential coordinator. When asked about ensuring the accuracy the QIDP's quarterly reviews, ASM # 3 stated, "I make sure they are done. I don't check them for accuracy that is left up to the responsibility of the QIDP." On 03/21/19 at 10:30 a.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager, was made aware of the findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) Stomach contents to leak back, or reflux, into	W 111		

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W 111	Continued From page 7 the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Disease in which the heart muscle becomes weakened, stretched, or has another structural problem. It often occurs when the heart cannot pump or function well. Most people with cardiomyopathy have heart failure. This information was obtained from the website: https://medlineplus.gov/ency/article/001105.htm. 2. The facility staff failed to ensure the quarterly review for Individual # 2's PCP (person-centered-plan) was accurate. Individual # 1 was a 54 year old male, who was admitted to (Name of Group Home) on 01/18/16. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), and osteopenia (2). The (person-centered plan) for individual # 1 dated "Start: 10/01/2018. End: 9/30/2019" documented, "3. Twice daily, at home, and once daily at Day Support, (Individual # 2) grasps his toothbrush in his right hand and participates in brushing his teeth for 3-5 seconds. Success is measured when (Individual # 2) completes this task with support as outlined, daily, for 6 (six) consecutive months; 4. With no more than two verbal prompts, (Individual # 2) opens his mouth to take his medications. Success is measured when he completes this task twice a day.	W 111		

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W 111	Continued From page 8 Responsible partner: (Name of Group Home and Name of Day Support Program)." The quarterly review for (Individual # 2) dated "January 8, 2019" was reviewed. The quarterly review documented, "Desired Outcome: 3. I participate in brushing my teeth for 3-5 seconds out of a 2 (two)-minute total process." Under 'Describe progress toward each outcome" it documented, "During this past quarter, (Individual # 2) has been successful 86 times and unsuccessful 158 times" for a total of 244 opportunities. Under "Desired Outcome: 4.I take my medications as prescribed." Under 'Describe progress toward each outcome" it documented, "During this past quarter, (Individual # 2) has been successful 238 times and unsuccessful 4 times" for a total of 242 opportunities. The data collection sheets for Individual # 2 dated 10/01/18 through 12/31/18 revealed the PCP outcome 3, tooth brushing contained 250 opportunities for implementation and the PCP outcome 4, taking medication, contained 250 opportunities for implementation. On 03/20/19 at 3:00 p.m., an interview and review of Individual # 2's quarterly review dated "January 8, 2019", PCP dated 10/01/2018 through 9/30/2019 and the data collection sheets dated 10/01/18 through 12/31/18 was conducted with OSM (other staff member) # 1, the QIDP (Qualified Intellectual Disabilities Professional). When asked if the documentation on the quarterly review for Individual # 2's PCP outcome 3 of 244 opportunities was correct, OSM # 1 stated, "No." When asked if the coding of Individual # 1's PCP outcome 4 of 242 opportunities was correct, OSM # 1 stated, no."	W 111		

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W 111	Continued From page 9 When asked how the quarterly reviews were developed, OSM # 1 stated, "They are based on my monthly reviews." On 03/21/19 at 10:05 a.m., an interview was conducted with ASM # 1, ICF (intermediate care facility) manager. When asked who was responsible for ensuring the QIDP's quarterly reviews were accurate, ASM # 1 stated, "It's done by (Name of ASM # 3)." On 03/21/19 at 10:15 a.m., an interview was conducted with ASM # 3, the assistant residential coordinator. When asked about ensuring the accuracy the QIDP's quarterly reviews, ASM # 3 stated, "I make sure they are done. I don't check them for accuracy that is left up to the responsibility of the QIDP." On 03/21/19 at 10:30 a.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager, was made aware of the findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100.	W 111		

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W 111	Continued From page 10 (2) A term to define bone density that is not normal but also not as low as osteoporosis. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmed/21234807.	W 111		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to report an allegation of abuse immediately to the administrator or to other officials in accordance with State law through established procedures for one of three individuals in the survey sample, Individual # 1. The facility staff failed to ensure an allegation of abuse for Individual # 1 was reported immediately. On 8/12/18, Residential Counselor RC #2 informed (RC) # 3 of an allegation of sexual abuse by RC #5 towards Individual #1. RC #2 failed to report the allegation and RC #3 did not report the allegation of abuse to ASM [administrative staff member) # 1, the ICF (intermediate care facility) manager until 08/1318. The findings include:	W 153	W153 How corrective action will be accomplished for Individual #1: Facility staff will immediately report any allegations of abuse and/or mistreatment for Individual #1. Assurance that other residents are protected from the possibility of the deficiency: Facility staff will be required to review the Mandated Reporter policy and sign a statement that they understand the content. Facility staff will immediately report any allegations of abuse and/or mistreatment for all ICF residents. Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur: QIDP and ICF Management will monitor facility staff adherence to Human Rights policies and Mandated Reporter requirements to ensure compliance in the facility. How the facility plans to monitor its performance to make sure that solutions are sustained: Resident's Human Rights and Mandated Reporter requirements will be reviewed at mandatory staff meetings at least annually. ICF Management will conduct monthly 1:1 supervision meetings with each staff to ensure that there are no unreported allegations or concerns. Date of Completion: 4/30/19	4/30/19

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W 153	Continued From page 11 Individual # 1 was a 60 year old male, who was admitted to (Name of Group Home) on 01/20/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), seizures (2), gastroesophageal reflux disease (3), hypertension (4) and cardiomyopathy (5). The facility "Incident Report" dated 08/19/18 for Individual # 1documented, "Date of Discovery: 8/13/18. Originator/Witness of the accident (this is the person who reported or witnessed the incident initially) (RC [residential counselor] # 3) - Reported the accusation." Under "Type of Incident" it documented, "Sexual Assault." Under "Provide a Detailed Description of the Incident (What happened?)" it documented, "(RC # 3) asked to speak with the ICF (intermediate care facility) Manager about something that she was told by fellow staff (RC # 2). (RC # 3) stated that (RC # 2) told her that when (RC # 5) works with (Individual # 1) and supports him in the shower, he (RC # 5) locks the door to the bathroom and that she (RC # 2) hears (Individual # 1) vocalize in an unusual manner. (RC # 3) reports that (RC # 2) believes from this that (Individual # 1) is being touched inappropriately by (RC # 5). (RC # 3) stated that she was told this on Sunday 8/12/18 and it made her feel uncomfortable. Consequently, when (RC # 3) worked with (RC # 5) this morning she did not hear anything unusual coming from the bathroom. (RC # 3) asked her co-worker (RC # 4) about this accusation, since (RC # 2) had also spoken to her about it and she works with (RC # 5) most mornings. (RC # 4) stopped (RC # 3) from speaking and asked "Did (RC # 2) tell you this?" (RC # 3) confirmed with a "yes." (RC # 4) mentioned that she never heard anything abnormal about (Individual # 1's) shower in the morning or the interaction that (RC # 5) and	W 153		

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W 153	Continued From page 12 (Individual # 1) have. (RC # 3) stated that (RC # 4) was planning to tell ASM (administrative staff member) # 1, ICF manager, this morning of (RC # 2's) allegations against (RC # 5). (RC # 3) asked (RC # 2) why she didn't report this information to (ASM [administrative staff member] # 1) already. (RC # 3) reports that (RC # 2) believed that because the allegation couldn't be possibly confirmed on camera, it would be hard to prove. (RC # 3) stated that she was puzzled about the allegation because (RC # 5) and (RC # 2) don't work together in the program." Review of the facility's "Human Rights Investigation" for Individual # 1 dated 08/15/18 revealed a complete investigation. On 03/19/19 at approximately 1:50 p.m., ASM # 1, ICF manager was asked by this surveyor to interview RC # 2, RC # 3, RC # 4 and RC # 5. ASM # 1 stated, "(RC # 2) is on vacation, (RC # 3) is on suspension, (RC # 4 and # 5) have been terminated." When asked to define what was meant by 'immediate' when referring to reporting abuse or neglect ASM # 1 stated, "It means the minute they hear about or witness it." When asked about the time frame of RC # 3 and RC # 2 reporting the allegation of abuse to her, ASM # 1 stated, "I was informed on 08/1318 from (RC # 3), she knew about the allegation on 08/12/18 and reported it to me the following day, 08/13/18." When asked if (RC # 2) reported the allegation timely ASM # 1 stated, "No." The facility's policy "Client Protection. Section2-3: Abuse and Neglect" documented, "8. Any employee who witnesses any behavior prohibited by (Name of Community Service Board's) Human Rights Plan is required to	W 153		

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W 153	Continued From page 13	W 153		

complete an incident report and immediately inform the supervisor and (Name of Community Service Board's) Human Rights Advocate in accordance with (Name of Community Service Board's) Code of Ethics and Corporate Compliance Plan. Failure to do so violates (Name of Community Service Board's) Human Rights Plan and Corporate Responsibility Resolution."

On 03/20/19 at 4:35 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager, was made aware of the findings.

No further information was provided prior to exit.

References:

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

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

(3) Stomach contents to leak back, or reflux, into

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W 153	Continued From page 14 the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Disease in which the heart muscle becomes weakened, stretched, or has another structural problem. It often occurs when the heart cannot pump or function well. Most people with cardiomyopathy have heart failure. This information was obtained from the website: https://medlineplus.gov/ency/article/001105.htm.	W 153		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate and monitor the active treatment program for one of three individuals in the survey sample, Individuals # 1. The QIDP (Qualified Intellectual Disabilities Professional) failed to ensure Individual # 1's active treatment program for sensory stimulation was implemented according to the PCP (person-centered-plan). The findings include:	W 159	W 159 How corrective action will be accomplished for Individual #1: The QIDP will ensure the implementation of the active treatment outcome involving sensory stimulation in accordance with the PCP (Person Centered Plan) for Individual #1. 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 the implementation of the active treatment outcomes as described in each individual's PCP. Date of Completion: 4/1/19	4/1/19

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W 159	Continued From page 15 Individual # 1 was a 60 year old male, who was admitted to (Name of Group Home) on 01/20/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), seizures (2), gastroesophageal reflux disease (3), hypertension (4) and cardiomyopathy (5). The (person-centered plan) for individual # 1 dated "Start: 2/21/2018. End: 2/20/2019" documented, "3b. (Individual # 1) utilizes his sensory box. With supervision and verbal prompting, (Individual # 1) utilizes his sensory box for 5 (five) minutes 3 (three) times a week. Success is measured when he completes this with the support as outlined for 4 (four) weeks in a row." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...daily he is offered the sensory box which contains various sensory items to include books, beanbags, and items of various textures that (Individual # 1) can 'tap' or have different tactile perceptions from ..." The (Name of Group Home's) data collection sheet dated 11/1/2018 for Individual # 1 documented, "With supervision and verbal prompting, (Individual # 1) utilizes his sensory box for 5 (five) minutes 3 (three) times a week. A "+" is recorded for meeting outcome criteria per the indicated level of support. A "-" is recorded for requiring a higher level of support." Further review of the data collection sheet revealed a blank on 11/27/18. On 03/20/19 at 3:00 p.m., an interview was conducted with OSM (other staff member) # 1, the QIDP (Qualified Intellectual Disabilities Professional). After reviewing the PCP and data collection sheet for Individual # 1, OSM # 1 was	W 159		

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W 159	Continued From page 16 asked how often the active treatment program for sensory stimulation should be implemented. OSM # 1 stated, "Every day." When asked to explain the blank on the data collection sheet for 11/27/18, OSM # 1 stated, "If it isn't documented it wasn't done." When asked to describe the responsibilities of the QIDP, OSM # 1 stated, " To make sure the PCP is written correctly, in that it is building skills, make sure staff are caring out the active treatment, review the data collection at the home at least two times a month and at the day support on a weekly basis." On 03/20/19 at 4:35 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager, was made aware of the findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.ht	W 159		

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W 159	Continued From page 17 ml. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Disease in which the heart muscle becomes weakened, stretched, or has another structural problem. It often occurs when the heart cannot pump or function well. Most people with cardiomyopathy have heart failure. This information was obtained from the website: https://medlineplus.gov/ency/article/001105.htm.	W 159		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to implement the active treatment program for one of three individuals in the survey sample,	W 249	W 249 How corrective action will be accomplished for Individual #1: Facility staff will implement the active treatment outcome involving sensory stimulation for Individual #1. Assurance that other residents are protected from the possibility of the deficiency: Facility staff will implement the active treatment outcomes from the PCP's for each individual. 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 the implementation of the active treatment outcomes as described in each individual's PCP. Date of Completion: 4/1/19	4/1/19

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W 249	Continued From page 18 Individuals # 1. The facility staff failed to implement Individual # 1's PCP (person-centered plan) outcomes/goals of sensory stimulation. The findings include: Individual # 1 was a 60 year old male, who was admitted to (Name of Group Home) on 01/20/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (1), seizures (2), gastroesophageal reflux disease (3), hypertension (4) and cardiomyopathy (5). The (person-centered plan) for individual # 1 dated "Start: 2/21/2018. End: 2/20/2019" documented, "3b. (Individual # 1) utilizes his sensory box. With supervision and verbal prompting, (Individual # 1) utilizes his sensory box for 5 (five) minutes 3 (three) times a week. Success is measured when he completes this with the support as outlined for 4 (four) weeks in a row." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...daily he is offered the sensory box which contains various sensory items to include books, beanbags, and items of various textures that (Individual # 1) can 'tap' or have different tactile perceptions from ..." The (Name of Group Home's) data collection sheet dated 11/1/2018 for Individual # 1 documented, "With supervision and verbal prompting, (Individual # 1) utilizes his sensory box for 5 (five) minutes 3 (three) times a week. A "+" is recorded for meeting outcome criteria per the indicated level of support. A "-" is recorded for requiring a higher level of support." Further	W 249		

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W 249	Continued From page 19 review of the data collection sheet revealed a blank on 11/27/18. On 03/20/19 at 3:00 p.m., an interview was conducted with OSM (other staff member) # 1, the QIDP (Qualified Intellectual Disabilities Professional). After reviewing the PCP and data collection sheet for Individual # 1, OSM # 1 was asked how often the active treatment program for sensory stimulation should be implemented. OSM # 1 stated, "Every day." When asked to explain the blank on the data collection sheet for 11/27/18, OSM # 1 stated, "If it isn't documented it wasn't done." On 03/20/19 at 4:35 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager, was made aware of the findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100. (2) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the	W 249		

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W 249	Continued From page 20 website: https://www.nlm.nih.gov/medlineplus/seizures.html. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Disease in which the heart muscle becomes weakened, stretched, or has another structural problem. It often occurs when the heart cannot pump or function well. Most people with cardiomyopathy have heart failure. This information was obtained from the website: https://medlineplus.gov/ency/article/001105.htm.	W 249		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and staff interviews it was determined that the facility staff failed to follow infection control practices for one of three individuals in the survey sample, Individual # 3 and during the medication administration observation. 1. The facility staff failed to store Individual # 3's	W 455	W455 1. How corrective action will be accomplished : Facility staff will store Individual # 3's C-PAP mask and tubing in a sanitary manner. Assurance that other residents are protected from the possibility of the deficiency: Facility staff will store C-PAP masks and tubing in a sanitary manner for each resident that utilizes this equipment. Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur: Sanitary storage practices will be reviewed and discussed at the next mandatory staff meeting. Staff will sign off on their understanding of these practices on a training time record. How the facility plans to monitor its performance to make sure that solutions are sustained: ICF Management will intermittently observe facility staff to ensure that they are storing C-PAP masks and tubing in accordance with sanitary storage practices. Date of Completion: 4/30/19	4/30/19

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W 455	Continued From page 21 C-PAP (1) mask and tubing in a sanitary manner. 2. The facility staff failed to change gloves during the medication administration observation. The findings include: 1. The facility staff failed to store Individual # 3's C-PAP (1) mask and tubing in a sanitary manner. Individual # 3 was a 63-year-old female, who was admitted to (Name of Group Home) on 01/11/16. Diagnoses in the clinical record included but were not limited to: severe intellectual disability (2), seizures (3), and gastroesophageal reflux disease (4). On 03/19/19 at 11:35 a.m., an observation of Individual # 3's bedroom revealed a C-PAP machine, tubing and mask sitting on top of the bedside table. Further observation of the C-PAP mask and tubing revealed the tubing disconnected from the mask, the tubing and mask uncovered. On 03/19/19 at 4:30 p.m., an observation of Individual # 3's bedroom revealed a C-PAP machine, tubing and mask sitting on top of the bedside table. Further observation of the C-PAP mask and tubing revealed the tubing disconnected from the mask, the tubing and mask uncovered. On 03/20/19 at 7:30 a.m., an observation of Individual # 3's bedroom revealed a C-PAP machine, tubing and mask sitting on top of the bedside table. Further observation of the C-PAP mask and tubing revealed the tubing disconnected from the mask, the tubing and	W 455	W455 2. How corrective action will be accomplished : Facility staff will change their gloves between each task per standard infection control precautions during medication administration. Assurance that other residents are protected from the possibility of the deficiency: Facility staff will change their gloves between each task per standard infection control precautions during medication administration every time for each resident. Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur: All facility staff will read the RACSB Infection Control Policy again and will sign a statement of understanding of the information therein. The Infection Control Policy will be reviewed and discussed at the next mandatory staff meeting. How the facility plans to monitor its performance to make sure that solutions are sustained: ICF Management will intermittently observe facility staff to ensure that they are changing gloves per standard infection control precautions when preparing meals for individuals. Date of Completion: 4/30/19	4/30/19

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W 455	Continued From page 22 mask uncovered. On 03/20/19 at 10:30 p.m., an observation of Individual # 3's bedroom revealed a C-PAP machine, tubing and mask sitting on top of the bedside table. Further observation of the C-PAP mask and tubing revealed the tubing disconnected from the mask, the tubing hanging over the hand sanitizer dispenser mounted on the wall above the bedside table with the end in contact with the wall, uncovered and the mask sitting on top of the bedside table uncovered. The facility's "Standing Orders" for Individual # 3 dated "2/28/19" documented, "C-PAP - use/settings/care per Sleep Medicine MD (medical doctor)." The TAR (treatment administration record) for Individual # 3 dated 03/2-19 documented, "Apply CPAP at Bedtime. 8 PM (8:00 p.m.). Clean tubing weekly with baby shampoo (C-PAP) 8AM (8:00 a.m.). Wipe down C-PAP mask daily with baby wipe. 8AM." Review of the TAR revealed Individual # 3 received the C-PAP every evening at bedtime and the mask was wiped down every morning at 8:00 a.m., from 03/01/19 through 03/20/19. Further review of the TAR revealed the C-PAP tubing was cleaned with baby shampoo weekly from 03/01/19 through 03/20/19. On 03/20/19 at 12:40 p.m., an interview was conducted with RN (registered nurse) # 1. When asked about the storage of Individual # 3's C-PAP mask and tubing, RN # 1 stated, "There is a cleaning schedule, it is kept at the bedside after its cleaned and is set out to dry." When asked if the C-PAP tubing and mask remained in sanitary condition if it was cleaned in the morning and left uncovered on the bedside table throughout the	W 455		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 23 day until Individual # 3 used it in the evening, RN # 1 stated, "It should be stored in a way so it remains sanitary after it is cleaned." On 03/20/19 at 4:35 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager, was made aware of the findings. No further information was provided prior to exit. References: (1) Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. (2) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100. (3) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website:	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G073	A. BUILDING _____ B. WING _____	03/21/2019

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W 455	Continued From page 24 https://www.nlm.nih.gov/medlineplus/seizures.html. (4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. 2. The facility staff failed to change gloves during the medication administration observation. On 03/19/19 at 4:20 p.m., the medication administration observation was conducted at (Name of Group Home). RC (residential counselor) # 1 was observed in the (Name of Group Home)'s medication room preparing to dispense and administer medications. RC # 1 washed her hands and put on a clean pair of plastic gloves, opened the door, went out of the medication room, re-entered with keys, opened the closet inside the medication room, which contained the Individual's medications. The closet contained multiple shelves with plastic boxes on them, one for each Individual that contained the Individual's medications. RC # 1 removed a plastic box containing medications and placed it on the counter in the medication room, opened a three-ring binder containing the MARs (medication administration records) and the physician's orders, turned the pages comparing the medication to the orders and the MAR while wearing the same gloves. Keeping the same gloves on, RC # 1 removed a bottle of Miralax (1), removed the measuring cap, wiped out the inside of the cap with her gloved finger, poured an amount of Miralax into the measuring cap to the 17 grams mark on the inside of the cap then poured the Miralax from the measuring cap	W 455		

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W 455	Continued From page 25 into a drinking cup. RC #1 then opened the medication room door, went into the kitchen, opened the refrigerator, removed a container of thickened prune juice, poured some into the cup with the Miralax, replaced the juice back in the refrigerator, and closed the door. RC #1 went back to the medication room, opened the door, entered the room, and placed the cup of prune juice on the counter. RC # 1 then removed her gloves, washed her hands and put on a clean pair of plastic gloves. RC # 1 then opened the medication room door, and went to the kitchen. RC #1 opened the refrigerator, removed a container of juice, and then place the container back into the refrigerator, went back to the medication room, opened the door and went inside. RC # 1 removed a clear, small plastic medication cup from a stack of them on the counter, turned it over placing her gloved finger on the inside of the medication cup. RC # 1 opened a three-ring binder containing the MARs (medication administration records) and the physician's orders turned the pages comparing the medication to the orders and the MAR while wearing the same gloves. RC # 1 then opened the bubble pack of medications, which contained seven and attempted to pour them into the medication cup. Observation of this action revealed that the medication cup tipped over and RC # 1 placed her gloved finger inside the cup to place it upright, and then poured the tablets into the medication cup. RC # 1 then placed the medication cup on the counter next to the cup of prune juice. RC # 1 then removed her gloves, washed her hands and put on a clean pair of plastic gloves, opened the door to the medication closet, removed a plastic box of medications for the next Individual, opened a	W 455		

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W 455	Continued From page 26 container of powdered fiber mix, measured two teaspoons of the powdered fiber mix and pour it into a drinking cup. While still wearing the plastic gloves RC # 1 picked up the cup with the powdered fiber mix, opened the medication room door, went to the kitchen, opened the refrigerator, and removed a container of juice, poured into the cup with the fiber mix. RC #1then went to a kitchen cabinet, opened it and removed a cup, and filled it approximately one-third of the way with water from the kitchen sink and went back to the medication room. RC # 1 was observed outside the medication room, placing the cup of fiber mix and juice in one hand and placing the cup of water in the same hand, but held it by placing two of her gloved fingers inside the cup of water to hold it while she opened the medication room door with the other hand. At approximately 5:20 p.m., RC # 1 was observed administering the Miralax, tablets and the cup of water to the three different individuals. Further observation revealed that one Individuals consumed all of the Miralax, another consumed all of the tablets and the other Individual consumed the water. On 03/19/19 at 5:25 p.m., an interview was conducted with RC # 1. When asked to describe the purpose of wearing gloves RC # 1 stated, "To make sure there is no cross contamination." RC # 1 further stated, "I should have changed gloves and kept my fingers on the outsides of the cups. I wasn't aware my fingers were inside the cups." On 03/20/19 at 12:35 p.m., an interview was conducted with RN (registered nurse) # 1. When asked to describe the purpose of wearing gloves RN # 1 stated, "To prevent any contamination	W 455		

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W 455	Continued From page 27 between the patient, staff or the environment especially when applying a topical or eye drops." When informed of the observations of RC # 1 during the medication administration observation on 03/19/19 RN # 1 stated that RC # 1's fingers should not have been placed inside the cups and that the gloves should have been changed. On 03/20/19 at 4:35 p.m., ASM (administrative staff member) # 1, ICF (intermediate care facility) manager, was made aware of the findings. No further information was provided prior to exit.	W 455		

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

March 28, 2019

Mr. S. Curtis, Director
Wolfe Street Icf Id
815 Wolfe Street
Fredericksburg, VA 22401

RE: Wolfe Street Icf Id
Fredericksburg, Virginia
ICF/ID: 49G073

Dear Mr. Curtis:

An unannounced Medicaid survey, ending March 21, 2019 was conducted, by the VDH Office of Licensure and Certification staff. All references to regulatory requirements are found in Title 42, Code of Federal Regulations

Survey Results and Plan of Correction

Enclosed is the CMS-2567, Statement of Deficiencies, for the Fundamental Health Survey. This document contains a listing of the deficiencies found at the time of this inspection. [Any deficiencies found as a result of a Life Safety Code inspection will be mailed separately from the office of the State Fire Marshall.]

You are required to file a plan for correcting these deficiencies. Your statements shall reflect the specific detailed actions you will take to correct deficiencies, prevent a recurrence of the deficiencies, and measures implemented to maintain compliance. You must also give the specific calendar date on which correction for each deficiency is expected to be completed. The response "Corrected" is not an acceptable response. That kind of response does not fulfill the requirement to provide information on preventing recurrence or maintaining compliance. The response "will train staff" is not an acceptable response unless specific information is given on the plan for frequency and methods to evaluate results.

Correction/completion dates must be within forty-five (45) days from the day of the inspection. If you have been cited for physical plant or Life Safety Code deficiencies that will require more than 45 days to correct and you intend to request an exception, you must provide a specific reason for the request and the expected completion date.

After signing and dating your Plan of Correction, retain one copy of the Report for your files and return the original to this office within ten (10) calendar days from receiving the report. You will be notified if your Plan of Correction is not acceptable.

Failure to return your Plan of Correction within the time frame specified above can result in a loss of Medicaid reimbursement.

A copy of the completed form (CMS-2567) will be kept on file in this office and will be available for public review. This Division is required to make copies of this report available to other Federal and State regulatory or reimbursement agencies upon request.

Survey Response Form

The LTC Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at:
"http://www.vdh.virginia.gov/content/uploads/sites/96/2019/02/LTC-facility-survey-response-form.pdf"
We will appreciate your participation.

If you have any questions, please call me at (804) 367-2100.

Sincerely,

Wietske G. Weigel-Delano, LTC Supervisor
Division of Long Term Care Services

Enclosures

cc: Bertha Ventura, Department of Medical Assistance Services (Sent Electronically)
Susan Elmore, Department of Behavioral Health and Developmental Services