PRINTED: 09/11/2020 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		49G037	B. WING _			09/02/2020
NAME OF PE	ROVIDER OR SUPPLIER SON ICF			STREET ADDRESS, CITY, STATE, ZIP CO 807 NORTH JACKSON ARLINGTON, VA 22201	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	D 4.T.E.
E 000	Initial Comments		E0	00		
W 000	survey was conducte facility was in complia 483.73, 483.475, Cor		W 0	00		
	Intermediate Care Fa Intellectual Disabilitie on 09/02/20. The fac with 42 CFR Part 483 Intermediate Care Fa	nual Medicaid survey for cilities for Individuals with s (ICF/IID) was conducted cility was not in compliance B Requirements for cilities for the Intellectually afety Code survey report will				
W 111	time of the survey. T of three current indivi #1, # 2 and #3). CLIENT RECORDS CFR(s): 483.410(c)(1	•	W 1	11		
		n that documents the client's eatment, social information,				
	Based on staff interv review, it was determ failed to maintain an	not met as evidenced by: iew and clinical record ined that the facility staff accurate clinical record for ils in the survey sample,				
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(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.

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

Terell Jones

Event ID: R01R11

Facility ID: VAICFMR36

Clinical Director

9/15/2020

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49G037	B. WING		09/	02/2020
NAME OF P	ROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 111	1a. The facility staff faimplementation Indivicentered plan] for consheets. 1b. The facility staff faimplementation Indivicentered plan] for soon new sign on the data The findings include: 1a. The facility staff faimplementation Indivicentered plan] for consheets. Individual # 1 was a 3 admitted to [Name of diagnoses that included profound intellectual of the conversation of the would like meetings once a week consecutive months to Activities & Instruction asked if she would like meeting. 2. When enconversation, she will hand and to give frequil provide [Individual and to give frequil provide [I	ailed to document dual #1's PCP [person numunication on the data failed to clarify the frequency th brushing outcome. Ided to document dual # 3's PCP [person cialization and learning a sheets. Ided to document dual #1's PCP [person numunication on the data for the dual #1's PCP [person numunication on the data for the dest were not limited to: disability [1]. Ided 10/01/2019 through the disability [1]. Ided 10/01/2019 through the disability [1]. Ided 10/01/2019 through the disability [1] in the limited to rise her uent eye contact. 3. Staff I # 1] pictures of activities, Observe her eye contact	W 111	 The Program Manager will retrain proportion of the documenting appropriately on individual #1's communication goal via collection form. The Program Manager manager will and amend the ISP for individual #1 to the frequency of implementation. The Program Manager will retrain proportion of the frequency of implementation. The Program Manager will retrain proportion of the program Manager will retrain proportion of the program Manager will retrain proportion of the program Manager will review a individuals' ISP goals to ensure the frequenciaritied. The QIDP and Program Manager with the ISP goals and data collection on a way basis and train staff as needed. The Clinical Director will complete Quarterly Audits and review the ISP goals and collection for accuracy. 	update clarify rogram ridual ning a cogram sheets Il quency is	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ISTRUCTION	(X3) DATE	SURVEY PLETED
		49G037	B. WING _			09	/02/2020
NAME OF P	ROVIDER OR SUPPLIER		,	807 N	STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 111	Continued From page	e 2	W	111			
	at particular pictures, turning her head awa Frequency: Weekly.'						
	for June 1, 2020 thro documented, "Desire Initials] will attend an meetings." Review o revealed plus signs [-2020 through August Under "Frequency/Du" "Frequency: Daily." On 9/02/2020 at appointerview was conducted staff member] #1, prowas asked to review collection sheets from August 31, 2020 hou house meetings. What discrepancy in the free implementation of the that was collected As meeting were only continued as the continued of the continue	d Outcome: [Individual # 1's d participate in weekly house f the data collection sheets +] and "Os" from June 1, 31, 2020 on each day. uration/time" it documented, coximately 11:05 p.m., an eted with ASM [administrative ogram manager. ASM # 1 Individual # 1's data in June 1, 2020 through se meetings and the PCP for en asked about the					
	[administrative staff n manager, ASM # 2, c	oroximately 11:05 a.m. ASM nember] # 1, program dinical director, and LPN rse] # 1 were made aware of					
	No further information	n was provided prior to exit.					
		of disorders characterized apacity and difficulty with					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		49G037	B. WING _		09/02/2020
NAME OF PR	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201	1 03/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
W 111	schedules and routing Intellectual disability 18 and may result from autism or cerebral procauses, such as lack responsiveness. The from the website:	such as managing money, nes, or social interactions. originates before the age of om physical causes, such as alsy, or from nonphysical cof stimulation and adult is information was obtained ith.gov/NIHfactsheets/ViewFa	W 1	11	
	of Individual # 1's too Individual #1's PCP 09/20/2020 docume [Individual #1] will pa 7 out of 7 days per will plan year. Support / [Individual #] will be her teeth. 2. Using I [Individual #] will col toothpaste. 3. Once the proper items, sh and over to the sink. assistance, [Individual appropriate amount toothbrush. 5. She will the toothbrush in he [Individual #]stand in encourage her to loo hand over hand assibrush her teeth. 8. encouraged to hold 9. With support from the cup to her mouth	failed to clarify the frequency of the brushing outcome. dated 10/01/2019 through inted:, "Desired Outcome: articipate in daily hygiene task week during the 2019-2020 Activities & Instructions: 1. Inotified that it is time to brush hand over hand assistance, ect her toothbrush and Individual #] has collected e will walk into the bathroom 4. Using hand over hand al #] will squeeze an of toothpaste onto her will be assisted in securing a hand. 6. Staff will have a front of the sink and ok in the mirror. 7. Using stance, [Individual #] will be ther cup and fill it with water. staff, [Individual #] will bring a and rinse her mouth out. Individual #] for brushing her			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	. ,	ATE SURVEY DMPLETED
		49G037	B. WING _	· · · · · · · · · · · · · · · · · · ·		09/02/2020
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 111	teeth. Type: Skill Bu Annually." Review of Individual for July 1, 2020 throu documented, "Desire Further review of the tooth brush outcome implemented 62 of 1 "Frequency/Duration "Frequency: Daily." On 9/02/2020 at app interview was condustaff member] #1, prowas asked to review collection sheets fror August 31, 2020 for tooth brushing. Who discrepancy regarding on the data sheets a that it should have be implementation. On 09/02/2020 at app [administrative staff imanager, ASM # 2, 0 [licensed practical nuthe findings. No further information.	#1's data collection sheets ugh August 31, 2020 ed Outcome: Hygiene." data collection sheets the revealed it was 24 opportunities. Under /time" it documented, roximately 11:05 a.m., an cted with ASM [administrative ogram manager. ASM # 1 Individual # 1's data m July 1, 2020 through tooth brushing and PCP for en asked about the ng the frequency documented nd the PCP, ASM # 1 stated een clarified for daily proximately 11:05 a.m. ASM member] # 1, program clinical director, and LPN urse] # 1 were made aware of In was provided prior to exit. iiled to document ridual # 3's PCP [person cialization and learning a	W 1	11		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION IG	, ,	E SURVEY MPLETED
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NAME OF PI	ROVIDER OR SUPPLIER SON ICF	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 111	admitted to [Name o diagnoses that include severe intellectual diagnoses that include include a communicate with week (100%) during Support Activities & will make eye contact looking to communicate will wave upon her in the severe people hand. 4. [Individual social interaction (e. space, etc.). 5. Staff each time she engage interaction. Frequer "Desired Outcome: [expressive signs and communicate. Suppersonation of the severe signs and communicate signs and communicate. Suppersonation of the severe signs and communicate signs and communic	32 year old female, who was f Group Home] with ded but were not limited to: sability [1] and low iron. dated 09/01/2019 through nted:, Individual #3] will socialize ith others, 7 out of 7 days per the 2019-2020 plan year. Instructions: 1. [Individual # 3] of with whomever she is eate with. 2. [Individual #3] nitial approach. 3. [Individual by waving or extending her #3] will engage in appropriate g. not invading personal f will praise [Individual #3] ges in appropriate social ncy: Daily." Individual #3] will use d learn new signs to port Activities & Instructions: I use signs she is familiar needs and wants. 2. Farn news signs each week. The replicate signs demonstrated document the signs she is ess notes. 5. Staff will sign as she participates in this goal.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G037	B. WING		09/02/2020
NAME OF P	ROVIDER OR SUPPLIER	•	8	TREET ADDRESS, CITY, STATE, ZIP CODE 07 NORTH JACKSON ARLINGTON, VA 22201	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
W 111	Continued From pa	nge 6	W 111		
	for June 1, 2020 th documented, "Desi Communication" [le review of the data of blanks on 06/18/20 On 9/01/2020 at apinterview was cond staff member] #1, previewing Individual from June 1, 2020 PCP outcomes for new sign. ASM #1 were implemented on the data sheets. On 09/02/2020 at a [administrative staff manager, ASM #2 [licensed practical in the findings.	earning a new sign]. Further collection sheet revealed through 06/21/20. Approximately 11:05 a.m., an ucted with ASM [administrative program manager. After all # 3's data collection sheets through June 30,2020 for the communication and learning a lastated that the programs but staff forgot to document it approximately 11:45 a.m. ASM f member] # 1, program and clinical director, and LPN nurse] # 1 were made aware of			
	References: [1] Refers to a grouby a limited mental adaptive behaviors schedules and rout Intellectual disabilit 18 and may result autism or cerebral causes, such as lacresponsiveness. Tfrom the website:	ion was provided prior to exit. up of disorders characterized capacity and difficulty with such as managing money, 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			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		SURVEY PLETED
		49G037	B. WING _			09	/02/2020
NAME OF PR	ROVIDER OR SUPPLIER	1		80	TREET ADDRESS, CITY, STATE, ZIP CODE 07 NORTH JACKSON RLINGTON, VA 22201	, 33	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	nNI	(X5)
PREFIX TAG	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE RIATE	COMPLETION DATE
W 159	integrated, coordina qualified intellectual This STANDARD is Based on record review and staff into the QIDP [Qualified Professional] failed the individuals' activathree of three individuals # 1, # 2 1a. The QIDP [qual professional] failed active treatment for implemented according centered plan]. 1b. The QIDP failed the implementation communication on the implemented according to the implementation. 3. The QIDP failed the implementation.	treatment program must be ated and monitored by a I disability professional. It is not met as evidenced by: eviews, facility document erview, it was determined that I Intellectual Disabilities coordinated and monitored we treatment programs for duals in the survey sample, and # 3. Ilified intellectual disabilities to ensure Individual #1's communication was ding to the PCP [person It to maintain documentation of Individual #1's PCP for the data sheets. It to clarify the frequency of the brushing outcome. It o ensure Individual #2's communication was ding to the PCP [person It o ensure Individual #2's communication was ding to the PCP [person It o maintain documentation of Individual #3's PCP for	W 1		1. The Program Manager will retrain staff on how to implement individual active treatment for communication pISP. 2. The Program manager will retrain staff on how to accurately document implementation of individual #1's PC communication via the data collection. 3. The Program Manager will update amend the ISP to clarify the frequence individual #1's tooth brushing outcon. 4. The Program Manager will retrain staff during the staff meeting how to implement individual #2's active treat communication program per the ISP. 5. The Program Manager will retrain staff during the staff meeting how to implement and document individual for socialization and learning a new sthe data collection sheets. 6. The Program Manager will retrain staff how to properly implement all in ISP goals and how to properly documindividuals' ISP goals. 7. The Program Manager will review individual's ISP goals to ensure the fris specified. 8. The Program Manager and QIDP	#1's per the program the P for n sheets. and y of ne. program tment program timent program dividuals nent all program and program dividuals nent all program and program and program and program nent all program and program and program and program nent all program and pro	10/2/2020
		arning a new sign on the data			monitor the implementation and docu of the ISP on a weekly basis.		
FORM CMS 256	The findings include 7(02-99) Previous Versions C		211		9. The CD will audit the program on quarterly basis to ensure the individuate implemented and documented acc	al's goals	et Page 8 of 35

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		49G037	B. WING _			09/	02/2020
NAME OF PE	ROVIDER OR SUPPLIER			807	REET ADDRESS, CITY, STATE, ZIP CODE 7 NORTH JACKSON RLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 159	professional] failed to active treatment for complemented according to entered plan]. Individual # 1 was a admitted to [Name or diagnoses that include profound intellectual Individual #1's PCP of 09/20/2020 documer "Desired Outcome: [Individual #1] has a during the 2019-2020 Activities & Instruction otified that it is time hand over hand assisted ther toothbrus [Individual #1] has a coulled the toothbrus [Individual #1] has a coulled the toothbrus [Individual #1] has a coulled the sink and over hand assisted in securing 6. Staff will have [Individual #1] will squeeze an a toothpaste onto her thank and encoura 7. Using hand over hand the sink and encoura 7. Using hand over hand water. 9. With supposition will bring the cup to hand the sink and encouraged to water. 9. With supposition will bring the cup to hand the sink and encouraged to water. 9. With supposition will bring the cup to hand the sink and encouraged to water. 9. With supposition out. 10. Staff brushing her teeth. Frequency: Annually	ied intellectual disabilities of ensure Individual #1's communication was ing to the PCP [person] 31 year old female, who was if Group Home] with ded but were not limited to: disability [1]. dated 10/01/2019 through of the feet of 7 days per week of plan year. Support of 8 stance, [Individual #1] will be to brush her teeth. 2. Using of stance, [Individual #1] will he and toothpaste. 3. Once of the proper items, she	W	159			
	Review of Individual for July 1, 2020 throu						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY
		49G037	B. WING _			09/02/2020
NAME OF PI	ROVIDER OR SUPPLIER SON ICF		•	STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 159	Further review of the the tooth brush outdimplemented 62 of "Frequency/Duratio" "Frequency: Daily." On 9/02/2020 at apinterview was condustaff member] #1, pasked if the QIDP wasked if the QIDP wasked if the PCP outcom ASM # 1 stated that After reviewing Individual # 2. ASM # 1 was asked responsibility to maimplementation of the Individual # 2. ASM The [Name of Group QIDP" documented responsible for trainstaff to ensure qualicare." On 09/02/2020 at a [administrative staff manager, ASM # 2, [licensed practical in the findings. No further information References: [1] Refers to a group by a limited mental adaptive behaviors	red Outcome: Hygiene." e data collection sheets for come revealed it was 124 opportunities. Under n/time" it documented, proximately 12:00 p.m., an acted with ASM [administrative rogram manager. When was available for an interview at they were not in the facility. widual # 1's data collection 2020 through August 31,2020 es for tooth brushing ASM # 1 if it was the QIDP's intain consistent the active treatment for	W 1	59		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			TE SURVEY MPLETED
		49G037	B. WING _			9/02/2020
NAME OF P	ROVIDER OR SUPPLIER SON ICF		A BUILDING 49G037 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201 OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION) S before the age of cal causes, such as om nonphysical lation and adult attion was obtained Hfactsheets/ViewFa wind documentation of #1's PCP for heets. ##1's PCP fo	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETION DATE
W 159	18 and may result fautism or cerebral parauses, such as lad responsiveness. The from the website: https://www.report.ictSheet.aspx?csid= 1b. The QIDP failed the implementation communication on fautividual #1's PCF 09/20/2020 docume [Individual #1] will pareetings once a war consecutive months Activities & Instruct asked if she would meeting. 2. When conversation, she whand and to give frowill provide [Individual #1] may at particular picture turning her head aw Frequency: Weekly Review of Individual for June 1, 2020 the documented, "Desi Initials] will attend a meetings." Review revealed plus signs	y originates before the age of from physical causes, such as palsy, or from nonphysical ck of stimulation and adult this information was obtained with a such as a suc	W 1	59		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION IG	1, ,	ATE SURVEY OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 159	"Frequency: Daily." On 9/02/2020 at ap interview was cond staff member] #1, pasked if the QIDP v ASM # 1 stated tha After reviewing Indi sheets from June 1 2020 house meeting meetings ASM # 1 responsibility to ma data collection for leyes. On 09/02/2020 at a [administrative staff manager, ASM # 2, [licensed practical refindings.	Duration/time" it documented,	W 1	59		
	Individual # 1's toot Individual #1's PCF 09/20/2020 docume [Individual #1] will p 7 out of 7 days per	d to clarify the frequency of the brushing outcome. If dated 10/01/2019 through the ented:, "Desired Outcome: participate in daily hygiene task week during the 2019-2020				
	[Individual #] will be her teeth. 2. Using [Individual #] will co toothpaste. 3. Onc the proper items, sl	Activities & Instructions: 1. e notified that it is time to brush hand over hand assistance, illect her toothbrush and e Individual #] has collected ne will walk into the bathroom c. 4. Using hand over hand				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
W 159	toothbrush. 5. She we the toothbrush in her [Individual #]stand in encourage her to loo hand over hand assis brush her teeth. 8. Tencouraged to hold high with support from the cup to her mouth 10. Staff will praise [I teeth. Type: Skill Bur Annually." Review of Individual for July 1, 2020 throu documented, "Desire Further review of the tooth brush outcome implemented 62 of 12 "Frequency/Duration." Frequency: Daily." On 9/02/2020 at apprinterview was conducted if the QIDP was ASM # 1 stated that the After reviewing Indivisheets from June 1, 2020 house meetings ASM # 1 was responsibility to main and the data collection 1 stated yes. On 09/02/2020 at apprinterview and the data collection 1 stated yes.	al #] will squeeze an of toothpaste onto her will be assisted in securing hand. 6. Staff will have front of the sink and in the mirror. 7. Using stance, [Individual #] will hen [Individual #] will be er cup and fill it with water. staff, [Individual #] will bring and rinse her mouth out. Individual #] for brushing her lding. Frequency: #1's data collection sheets the hand state of the state	W 1			

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NAME OF PI	ROVIDER OR SUPPLIER SON ICF		•	80	TREET ADDRESS, CITY, STATE, ZIP CODE 07 NORTH JACKSON .RLINGTON, VA 22201	,	
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W 159	[licensed practical null the findings.	e 13 linical director, and LPN rse] # 1 were made aware of n was provided prior to exit.	W	159			
	active treatment for complemented according centered plan]. Individual # 2 was a 4 admitted to [Name of	ng to the PCP [person If year old female, who was Group Home] with ed but were not limited to: sability [1] and					
	02/28/2021 documen "Desired Outcome: [In communication board express her wants an communicate with stawith the use of alterna (i.e., picture cards). So Instructions: 1. Staff v 2] to utilize her commit to her while she is in call [Individual #2's] n with her while having hand and greet [Individual #3. Staff will start with questions for [Individual will add pictures to the [Individual #2] to poin successful completion	ndividual #2] will use her I 100% of the time to d needs and to iff while she is in the house ative communication options					

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMF	SURVEY
		49G037	B. WING _			09/	02/2020
NAME OF PROVIDER OR S	SUPPLIER			80	TREET ADDRESS, CITY, STATE, ZIP CODE D7 NORTH JACKSON RLINGTON, VA 22201	,	
	CH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
demonstra Skill Build Review of for June 1 document will use he time to ex communio with the u (i.e., pictu further do and on 06 collection offered)." On 9/02/2 interview staff mem asked if th ASM # 1 st After reviews sheet on 0 outcomes if it was th consistent for Individ On 09/02/2 [administra manager, [licensed the finding	Individual, 2020 throed, "Desire er commun press her with state of altern re cards) Toumented to /07/20. Fursheets door 020 at appwas conduction and with the community of the QIDP was tated that the end of the QIDP's resident of the community	e vith [Individual #2]. Type: ency: Daily." #2's data collection sheets ugh June 30, 2020 and Outcome: [Individual #2] iteation board 100% of the wants and needs and to aff while she is in the house ative communication options. The data collection sheet the letter "O" on 06/06/20 arther review of the data attemented "Key O- other (not roximately 12:00 p.m., an otted with ASM [administrative orgam manager. When as available for an interview they were not in the facility. Item and on 06/07/20 for the PCP anication ASM # 1 was asked desponsibility to maintain the tation of the active treatment attempt of the active treatment of the active treatment attempt of the active treatment attempt of the active treatment of the active treatment attempt of the active treatment attempt of the active treatment of the active treatment attempt of the active treatment of the active treatment of the active treatment attempt of the active treatment of the active treatment of the active treatment attempt of the active treatment of the active t	W	1159			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		49G037	B. WING _			09/02/2020
NAME OF PI	ROVIDER OR SUPPLIER SON ICF			STREET ADDRESS, CITY, STATE, ZIP COE 807 NORTH JACKSON ARLINGTON, VA 22201	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	· ·		(X5) COMPLETION DATE
W 159	schedules and routi Intellectual disability 18 and may result fr autism or cerebral p causes, such as lac responsiveness. Tr from the website: https://www.report.r ctSheet.aspx?csid= [2] A mental condition contact with reality [problems [depression was obtained from the	such as managing money, nes, or social interactions. or originates before the age of comphysical causes, such as alsy, or from nonphysical k of stimulation and adult his information was obtained with gov/NIHfactsheets/ViewFa 100 on that causes both a loss of psychosis] and mood on or mania]. This information he website:	W 1	59		
	3. The QIDP failed to the implementation socialization and least sheets. Individual # 3 was a admitted to [Name of diagnoses that inclusevere intellectual of the company	o maintain documentation of Individual #3's PCP for arning a new sign on the data 32 year old female, who was of Group Home] with ded but were not limited to: isability [1] and low iron. dated 09/01/2019 through inted:, [Individual #3] will socialize with others, 7 out of 7 days per of the 2019-2020 plan year. Instructions: 1. [Individual # 3] oct with whomever she is cate with. 2. [Individual #3] initial approach. 3. [Individual				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			ATE SURVEY OMPLETED
	49G037	B. WING			09/02/2020
			STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
#3] will greet people hand. 4. [Individual social interaction (e space, etc.). 5. Sta each time she engainteraction. Freque "Desired Outcome: expressive signs an communicate. Suppl. [Individual # 3] will to express her [Individual #3] will learning in her prog "good job" each time Frequency: Daily." Review of Individual for June 1, 2020 ther documented, "Desir Communication." Feollection sheet revethrough 06/21/20. Review of Individual for June 1, 2020 ther documented, "Desir Communication" [learning in her prog "good job" each time Frequency: Daily." Review of Individual for June 1, 2020 ther documented, "Desir Communication" [learning in her prog "good job" each time Frequency: Daily." On 9/02/2020 at application of the data communication of the data commu	by waving or extending her #3] will engage in appropriate .g. not invading personal ff will praise [Individual #3] ges in appropriate social ncy: Daily." [Individual #3] will use delearn new signs to port Activities & Instructions: Ill use signs she is familiar needs and wants. 2. Farn news signs each week. I replicate signs demonstrated I document the signs she is ress notes. 5. Staff will sign the she participates in this goal. I #3's data collection sheets ough June 21, 2020 feed Outcome: Further review of the data feeled blanks on 06/18/20 I #3's data collection sheets ough June 21, 2020 feed Outcome: Further review of the data feeled blanks on 06/18/20 I #3's data collection sheets ough June 21, 2020 feed Outcome: Further review of the data feeled blanks on 06/18/20 For each of the data feeled blanks on 06/18/20. For each of the data feeled blanks on 06/18/20. For each of the data feeled blanks on 06/21/20. For each of the data feeled blanks on 06/21/20.	W 18	59		
-	Continued From page #3] will greet people hand. 4. [Individual social interaction (e space, etc.). 5. State each time she engal interaction. Freque "Desired Outcome: expressive signs and communicate. Suppl. [Individual #3] will be a communication." Frequency: Daily." Review of Individual for June 1, 2020 threst documented, "Desir Communication." Frequency of Individual for June 1, 2020 threst documented, "Desir Communication" [Itereview of the data communication" [Itereview of the data communication" [Itereview of the data communication of t	A9G037 ROVIDER OR SUPPLIER SON ICF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 #3] will greet people by waving or extending her hand. 4. [Individual #3] will engage in appropriate social interaction (e.g. not invading personal space, etc.). 5. Staff will praise [Individual #3] each time she engages in appropriate social interaction. Frequency: Daily." "Desired Outcome: [Individual #3] will use expressive signs and learn new signs to communicate. Support Activities & Instructions: 1. [Individual # 3] will use signs she is familiar with to express her needs and wants. 2. [Individual #3] will learn news signs each week. 3. [Individual #3] will replicate signs demonstrated by staff. 4. Staff will document the signs she is learning in her progress notes. 5. Staff will sign "good job" each time she participates in this goal. Frequency: Daily." Review of Individual #3's data collection sheets for June 1, 2020 through June 21, 2020 documented, "Desired Outcome: Communication." Further review of the data collection sheet revealed blanks on 06/18/20	A BUILDIN 49G037 ROVIDER OR SUPPLIER SON ICF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 #3] will greet people by waving or extending her hand. 4. [Individual #3] will engage in appropriate social interaction (e.g. not invading personal space, etc.). 5. Staff will praise [Individual #3] each time she engages in appropriate social interaction. Frequency: Daily." "Desired Outcome: [Individual #3] will use expressive signs and learn new signs to communicate. Support Activities & Instructions: 1. [Individual #3] will es signs she is familiar with to express her needs and wants. 2. [Individual #3] will replicate signs demonstrated by staff. 4. Staff will document the signs she is learning in her progress notes. 5. Staff will sign "good job" each time she participates in this goal. Frequency: Daily." Review of Individual #3's data collection sheets for June 1, 2020 through June 21, 2020 documented, "Desired Outcome: Communication." Further review of the data collection sheet revealed blanks on 06/18/20 through 06/21/20. Review of Individual #3's data collection sheets for June 1, 2020 through June 21, 2020 documented, "Desired Outcome: Communication" [learning a new sign]. Further review of the data collection sheet revealed blanks on 06/18/20 through 06/21/20. On 9/02/2020 at approximately 12:00 p.m., an interview was conducted with ASM [administrative staff member] #1, program manager. When asked if the QIDP was available for an interview ASM # 1 stated that they were not in the facility.	ROVIDER OR SUPPLIER SON ICF SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY PULL [REGULATORY OR LSC IDENTIFYING INFORMATION] Continued From page 16 #3] will greet people by waving or extending her hand. 4. [Individual #3] will engage in appropriate social interaction (e.g. not invading personal space, etc.). 5. Staff will praise [Individual #3] will each time she engages in appropriate social interaction. Frequency: Daily." "Desired Outcome: [Individual #3] will use expressive signs and learn new signs to communicate. Support Activities & Instructions: 1. [Individual #3] will learn news signs each week. 3. [Individual #3] will learn news signs each week. 3. [Individual #3] will replicate signs demonstrated by staff. 4. Staff will document the signs she is learning in her progress notes. 5. Staff will sign "good job" each time she participates in this goal. Frequency: Daily." Review of Individual #3's data collection sheets for June 1, 2020 through June 21, 2020 documented, "Desired Outcome: Communication." Further review of the data collection sheet revealed blanks on 06/18/20 through 06/21/20. Review of Individual #3's data collection sheets for June 1, 2020 through June 21, 2020 documented, "Desired Outcome: Communication" [learning a new sign]. Further review of the data collection sheet revealed blanks on 06/18/20 through 06/21/20. On 9/02/2020 at approximately 12:00 p.m., an interview was conducted with ASM [administrative staff member] #1, program manager. When asked if the QIDP was available for an interview ASM # 1 stated that they were not in the facility.	A BUILDING 496037 B. WINKS SON ICF SUMMARY STATEMENT OF DEPICIENCES (ECAN DEFOCENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 16 Continued From page 17 Continued From page 18 A BUILDING Continued From page 19 Conti

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		49G037	B. WING _	·····		09/02/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APPLICATION CONTROL OF	IOULD BE	(X5) COMPLETION DATE
W 159	sheet on 06/18/20 thr outcomes for socializ sign ASM # 1 was as responsibility to main data collection for Indives. On 09/02/2020 at app [administrative staff in manager, ASM # 2, collicensed practical nutthe findings. No further information References: [1] Refers to a group	rough 06/21/20 for the PCP ation and learning a new ked if it was the QIDP's tain accurate and complete lividual # 3. ASM # 1 stated croximately 11:45 a.m. ASM nember] # 1, program linical director, and LPN rse] # 1 were made aware of a was provided prior to exit.	W	59		
W 249	adaptive behaviors si schedules and routine Intellectual disability of 18 and may result fro autism or cerebral pa causes, such as lack responsiveness. This from the website: https://www.report.nifctSheet.aspx?csid=1PROGRAM IMPLEM CFR(s): 483.440(d)(1) As soon as the interd formulated a client's i each client must receit reatment program conterventions and seriand frequency to sup	ENTATION) isciplinary team has ndividual program plan, ive a continuous active	W 2	249		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE S COMPL	
		49G037	B. WING _			09/0	02/2020
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)	I	(X5) COMPLETION DATE
W 249	Based on staff intervand clinical record rethe residential staff fawas receiving service [Person Centered Plaindividuals in the survand # 2 1. The facility staff fai #1's PCP [person cerbrushing. 2. The facility staff fai #2's PCP for community PCP in the findings include: 1. The facility staff fai #2's PCP [person cerbrushing. Individual # 1 was a 3 admitted to [Name of diagnoses that include profound intellectual for the findividual #1's PCP of 09/20/2020 documents.	not met as evidenced by: iew facility document review view, it was determined that alled to ensure an Individual es consistent with the PCP an] for two of three vey sample, Individuals # 1 led to implement Individual antered plan] for tooth led to implement Individual antered plan] for tooth at year old female, who was Group Home] with ed but were not limited to: disability [1]. lated 10/01/2019 through ted:,	W 2	staff on the imple PCP for tooth by 2. The Program staff on the imple PCP for commu. 3. The Program staff how to imple goals. 4. The Program implementing the weekly basis. 5. The CD will	Manager will train pro lementation of individu rushing. Manager will train pro lementation of individu	al #1's gram al #2's gram ISP the staff s on a	10/2/2020
	in daily hygiene task during the 2019-2020 Activities & Instruction notified that it is time	ndividual #1] will participate 7 out of 7 days per week 9 plan year. Support ns: 1. [Individual #1] will be to brush her teeth. 2. Using stance, [Individual #1] will					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		TE SURVEY MPLETED
		49G037	B. WING _			09/02/2020
NAME OF PI	ROVIDER OR SUPPLIER SON ICF		•	STREET ADDRESS, CITY, STATE, ZIP (807 NORTH JACKSON ARLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO) DEFICIENCY	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 249	collect her toothbrush [Individual #1] has co will walk into the bath 4. Using hand over ha #1] will squeeze an a toothpaste onto her to assisted in securing t 6. Staff will have [Indithe sink and encourar 7. Using hand over ha #1] will brush her teel will be encouraged to water. 9. With suppo will bring the cup to h mouth out. 10. Staff brushing her teeth. Trequency: Annually Review of Individual for July 1, 2020 throu documented, "Desire Further review of the the tooth brush outco implemented 62 of 12 "Frequency/Duration/"Frequency: Daily." On 9/02/2020 at apprinterview was conducted from July 1, 2020 through the tooth brush outco implemented 62 of 12 "Frequency: Daily." On 9/02/2020 at apprinterview was conducted from July 1, 2020 through the programs should be program be progra	and toothpaste. 3. Once llected the proper items, she room and over to the sink. and assistance, [Individual ppropriate amount of bothbrush. 5. She will be he toothbrush in her hand. vidual #1] stand in front of ge her to look in the mirror. and assistance, [Individual #1] hold her cup and fill it with rt from staff, [Individual #1] hold her cup and fill it with rt from staff, [Individual #1] er mouth and rinse her will praise [Individual #1] for type: Skill Building. "#1's data collection sheets gh August 31, 2020 d Outcome: Hygiene." data collection sheets for me revealed it was each opportunities. Under time" it documented, oximately 12:00 p.m., an atted with ASM [administrative gram manager. After each state of the brushing ASM # 1 stated buld have been implemented	W 2	249		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	(X3) DATE S COMPLI	
		49G037	B. WING _		09/0	2/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201	1 35.0	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	its development. Of fully implemented, support, learning et engagement neces objectives/desired of ISPAll staff work fully engaged in acconsumer." On 09/02/2020 at a [administrative staff manager, ASM # 2 [licensed practical rithe findings. No further information of the findings	the ISP begins at the time of components of the plan are with consumer receiving the nvironment and active sary to reach his or her outcomes as defined in the ing with consumers must be tive treatment with the approximately 11:45 a.m. ASM of member] # 1, program, clinical director, and LPN nurse] # 1 were made aware of ion was provided prior to exit. Approximately 11:45 a.m. ASM of member] # 1, program, clinical director, and LPN nurse] # 1 were made aware of ion was provided prior to exit. Approximately 11:45 a.m. ASM of member] # 1, program, clinical director, and LPN nurse] # 1 were made aware of ion was provided prior to exit. Approximately 11:45 a.m. ASM of member] # 1, program, clinical director, and LPN nurse] # 1 were made aware of ion was provided prior to exit. Approximately 11:45 a.m. ASM of member] # 1, program, clinical director, and LPN nurse] # 1 were made aware of ion was provided prior to exit.	W 2	49		
	#2's PCP for comm					
		a 41 year old female, who was of Group Home] with				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	1, ,	TE SURVEY MPLETED
		49G037	B. WING _		١٠	9/02/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	severe intellectual of schizoaffective disconsisted individual #2's PCF 02/28/2021 docume "Desired Outcome: communication book express her wants are communicate with swith the use of alter (i.e., picture cards). Instructions: 1. Staff 2] to utilize her comit to her while she is call [Individual #2's] with her while having hand and greet [Incommunicate with swill add pictures to [Individual #2] to posuccessful complet will provide praise and demonstrate patien Skill Building. Frequence Review of Individual for June 1, 2020 the documented, "Desir will use her communicate with swith the use of alter (i.e., picture cards) further documented and on 06/07/20. Frequence in the sum of the schizostal sch	dided but were not limited to: disability [1] and order [2]. I dated 03/01/2020 through ented:, [Individual #2] will use her and 100% of the time to and needs and to staff while she is in the house mative communication options Support Activities & ff will encourage [Individual # munication board by bringing is idle in the house. 2. Staff will name and make eye contact and the communication board in dividual #2] with a handshake. The "yes" and "no" answer didual #2] to point to. 4. Staff the board as necessary for bint to. 5. Through each ion of the above steps, staff and encouragement as [sic] ice with [Individual #2]. Type:	W 2	49		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	1, ,	TE SURVEY MPLETED
		49G037	B. WING _			9/02/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201	,	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 249	interview was condistaff member] #1, previewing Individual from June 1, 2020 the PCP outcome for contract the programs on 06/06/20 and on On 09/02/2020 at a [administrative staff manager, ASM # 2, [licensed practical right the findings. No further information References: [1] Refers to a grouply a limited mental adaptive behaviors schedules and routintellectual disability 18 and may result from the website: https://www.report.rctSheet.aspx?csid= [2] A mental condition contact with reality problems [depression was obtained from the website was obtained from the website for the websi	proximately 12:00 p.m., an acted with ASM [administrative rogram manager. After # 2's data collection sheet hrough June 30, 2020 for the emmunication ASM # 1 stated hould have been implemented 06/07/20. pproximately 11:45 a.m. ASM member] # 1, program clinical director, and LPN increal # 1 were made aware of on was provided prior to exit. p of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. It is originates before the age of rom physical causes, such as ealsy, or from nonphysical et of stimulation and adult his information was obtained on that causes both a loss of (psychosis) and mood on or mania]. This information	W 2	49		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		49G037	B. WING		09/	02/2020
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CRIJACK	SUN ICF			ARLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
				1. The Program Manager will retrain	the	10/2/2020
W 369	Continued From page	e 23	W 369	program staff who made the error how	to	
W 369	DRUG ADMINISTRA	TION	W 369	measure the Lactulose medication for		
	CFR(s): 483.460(k)(2			individual #1 correctly per the doctor's	orders.	
	The system for drug that all drugs, includit	administration must assure		2. The Program Manager will retrain a program staff who made the error how measure all individuals' liquid medicate	ot	
	Based on observation facility document reviolatermined that the facility administer medication standards for one of medication administration. 1a. The facility staff of Lactulose [1], Mira	n according to clinical one individuals during the ation observation, Individual neasure the correct amount lax [2] and prior to		 The Program Manager will retrain program staff who made the error how administer individual #1's Fluticasone spray correctly per the doctor's orders. The Program Manager will retrain on the Medication administration Polic focus on measuring individual #1's another individuals' liquid medication coper the doctor's orders. The Program Manager will retrain and the program will retrain and the program Manager will retrain and the program will retrain and the program will retrain and the pr	to nasal all staff cy with a d all rrectly	
		railed to administer the ticasone SPR [spray] [1] to		on how to administer the nasal spray c per the doctor's orders for individual # other individuals who receive nasal sp	orrectly 1 and all	
	The findings include:	neasure the correct amount lax [2] and prior to		6. The Program Manager, Program No QIDP will conduct random quarterly medication administration observation quarterly basis.		
	admitted to [Name of diagnoses that include profound intellectual On 09/02/2020 at appredication administration.	31 year old female, who was Group Home] with ed but were not limited to:				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMF	SURVEY
		49G037	B. WING _			09/	02/2020
NAME OF PI	ROVIDER OR SUPPLIER SON ICF			807 N	EET ADDRESS, CITY, STATE, ZIP CODE NORTH JACKSON INGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
W 369	Lactulose from the mandividual # 1's bedrointo a plastic 30 milliliplaced the cup on a cabinet. Observation in the medication cup. DSP # 1 then remove [polyethylene glycol] a 30 ml plastic medication cabin amount of Miralax in it to be between 15m obtained a cup of wathe cup and mixed it. Individual # 1 was as and DSP # 1 was ob Miralax and Lactulos observation reveal In the medications orall. The POS [physician 08/01/20 To 08/31/20 documented in part, "LACTULOSE SOL [two] tablespoonsful daily (May hold for diconstipation. Date 0 "POLYETHYLENE GSub [substitute] For powdered]. Mix 17 of water or juice and Date: 08/06/2019."	SP # 1 removed a bottle of nedication cabinet in pom, poured the medication iter [ml] medication cup and shelf above the medication of the amount of lactulose prevealed 20 ml. The deal of Miralax and poured the cap, obtained cation cup, poured the cand placed it a shelf above et. Observation of the the medication cup revealed all and 20ml. DSP # 1 and 20ml. DSP # 1 and 20ml. DSP # 1 are, poured the Miralax into their bedroom served administering the eto Individual # 1. Further advidual # 1 consumed all of y. For order sheet] dated "From one of the condition o	W	369			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	(X:	3) DATE SURVEY COMPLETED		
		49G037	B. WING _			09/02/2020		
NAME OF PR	ROVIDER OR SUPPLIER SON ICF			STREET ADDRESS, CITY, STATE 807 NORTH JACKSON ARLINGTON, VA 22201	E, ZIP CODE	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE		
W 369	[licensed practical nuthe above observation measured and admir ordered amount of Licensed process of the provider of the review the POS for Nordered amount of the review the POS for Nordered process of the plastic medication of the plastic medication of the plastic medication of the plastic medication of the plastic mif they accurately measuring the correct took the cap off the body to the 17 gram mark LPN # 1 further state used for measuring the correct took the plastic measuring the plastic measured measuring the plastic	cted with DSP # 1 and LPN arse] # 1. When informed of an, DSP # 1 was asked if he aistered the physician actulose. DSP # 1 stated no. The above observation and Airalax DSP # 1 was asked to the mark for 17 grams on the tip they used to measure the	W	369				
	No further informatio	n was provided prior to exit.						
		used to treat constipation.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G037	B. WING		09/02/2020		
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 807 NORTH JACKSON ARLINGTON, VA 22201		•		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION		
W 369	https://medlineplustml [2] Used to treat or information was obhttps://medlineplustml. [3] Refers to a grouby a limited mental adaptive behaviors schedules and rour Intellectual disabilitia and may result autism or cerebral causes, such as la responsiveness. Trom the website:	age 26 as obtained from the website:gov/druginfo/meds/a682338.h ccasional constipation. This stained from the website:gov/druginfo/meds/a603032.h up of disorders characterized capacity and difficulty with such as managing money, tines, or social interactions. ty originates before the age of from physical causes, such as palsy, or from nonphysical ck of stimulation and adult this information was obtained nih.gov/NIHfactsheets/ViewFa	W 36	9			
	doses of nasal spranostril for Individual On 09/02/2020 at a medication administ conducted with DS # 1. At 7:07 a.m., of plastic gloves, u medication cabinet removed a box coropened the MAR a administration recoadministration recoadministration recoadministration reco	ff failed to administer two ay, Fluticasone [1] into each al # 1. approximately 7:00 a.m., the stration observation was P [direct support professional] DSP # 1, while wearing a pair nlocked and opened the in Individual # 1's bedroom, ntaining a bottle of nasal spray, nd TAR [medication					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		` ′	TE SURVEY MPLETED				
		49G037	B. WING		ا ا	9/02/2020	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201	'		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 369	was siting by themse sprays for the nasal Individual # 1, remove hands and then place the box. The POS [physician 08/01/20 To 08/31/20 documented in part, MCG [microgram]. It nostril twice a daily. On 09/02/20 at approinterview was conducted [licensed practical numany sprays they accorded in Individual # 1's nostril." After review Individual # 1's nasal Individual # 1 should each nostril. LPN # physician's order for and agreed that the spray in each nostril. On 09/02/2020 at approinterview in each nostril. On 09/02/2020 at approinterview in each nostril. No further information in the findings. No further information in the findings.	area where Individual # 1 elves, administered two spray into each nostril of yed their gloves, washed their ed the nasal spray back into order sheet] dated "From 0" for Individual # 1 "Fluticasone SPR [spray] 50 Use 1 [one] sprays in each Date 07/10/2019." oximately 8:02 a.m., an cted with DSP # 1 and LPN urse] # 1. When asked how dministered into each of els DSP # 1 stated, "Two in ving the physician's order for Il spray DSP # 1 stated that Il have received one sprays in 1 was asked to view the Individual # 1's nasal spray order said to administer one	W 36	59			

NAME OF PROVIDER OR SUPPLIER	49G037	B. WING			
NAME OF DROVIDER OF SLIPBLIED		D. WING _		09/	02/2020
CRI JACKSON ICF			STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFIDERICIENCY)	BE	(X5) COMPLETION DATE
W 369 Continued From page 28 dust, or pets). Prescription used to relieve symptoms of such as sneezing and runn are not caused by allergies obtained from the website: https://medlineplus.gov/dru tml. W 381 DRUG STORAGE AND RE CFR(s): 483.460(I)(1)	of nonallergic rhinitis y or stuffy nose which . This information was ginfo/meds/a695002.h	W 36	 The Program staff who made the refailing to close and lock the medication in individual #1's bedroom when leavarea, will be retrained on ensuring the close and locks individual #1's medicabinet and all other individuals' medicabinet. The Program Manager will retrain staff on ensuring during medication administration they are closing and lomedication cabinet for individual #1 	on cabinet ing the staff ation ication program	10/2/2020
The facility must store drug conditions of security. This STANDARD is not me Based on observation facil and staff interview it was de facility staff failed to secure of one individuals during the administration observation, 1. The facility staff failed to medication cabinet in Indivi when they left the room una The findings include: 1. The facility staff failed to medication cabinet in Indivi when they left the room una Individual # 1 was a 31 year admitted to [Name of Group diagnoses that included but profound intellectual disabilion of 09/02/2020 at approximation administration of the security.	et as evidenced by: lity document review etermined that the medications for one e medication Individual #1. close and lock the idual # 1's bedroom attended. close and lock the idual # 1's bedroom attended. ar old female, who was be Home] with t were not limited to: lity [1].		other individuals they support when oneed to leave the area. 3. The Program Manager, Program Nor QIDP will complete quarterly mediadministration observations verifying not leaving the medication cabinets unwhen or if they need to leave the area. 4. The CD will monitor the quarterly medication administration observation completed by the PM, Nurse, and/or and a support of the program of the pr	furse, and/ ication staff are nlocked	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		49G037	B. WING				09/02/2020	
NAME OF P	ROVIDER OR SUPPLIER SON ICF			807 NOR	ADDRESS, CITY, STATE, ZIP CODE RTH JACKSON GTON, VA 22201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 381	# 1. At 7:07 a.m., D 1's bedroom, unlock cabinet that containe medications. Observations of the Individual # 1 watime. At approximate the bedroom to retrice Observations of the Individual #1's bedrood drawer containing th tablet and pills was I approximately 7:20 a bedroom to obtain a Observations of the Individual #1's bedrood drawer containing th tablet and pills was I approximately 7:30 a bedroom again to obto Observations of the Individual #1's bedrood drawer containing th tablet and pills was I approximately 7:30 a bedroom again to ob Observations of the Individual #1's bedrood drawer containing th tablet and pills was I On 09/02/20 at approximately approximately Con 09/02/20 at approximately interview was conducted licensed practical not the above observation describe the procedured medication cabinet u that when leaving the should be put inside locked. When asked nurse] # 1 to describ leaving the medication stated that all medication stated that all medications	[direct support professional] SP # 1 entered Individual # and opened a two drawer ed Individual # 1's vation of the bedroom reveal as not in their bedroom at the ely 7:16 a.m., DSP # 1 left eve a pen from another room. medication cabinet in from reveal that the top e blister/bubble packs of eft open and unlocked. At a.m., DSP # 1 left the cup from the kitchen area. medication cabinet in from reveal that the top e blister/bubble packs of eft open and unlocked. At a.m., DSP # 1 left the otal a.m., DSP # 1 left the betain a straw from the kitchen. medication cabinet in from reveal that the top e blister/bubble packs of eft open and unlocked. Matter of the betain a straw from the kitchen. Medication cabinet in from reveal that the top e blister/bubble packs of eft open and unlocked. Matter of the bedroom reveal At a.m., DSP # 1 left the otal a straw from the kitchen. Medication cabinet in from reveal that the top e blister/bubble packs of eft open and unlocked. Matter of the bedroom reveal At a.m., DSP # 1 left the otal a straw from the kitchen. Matter of the bedroom reveal At a.m., DSP # 1 left the otal a straw from the kitchen. Matter of the bedroom reveal At a.m., DSP # 1 left the otal a.m., DSP # 1 left th	W	381				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		49G037	B. WING _		09	/02/2020	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201	,	, 33/3_23	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 381	documented in part, Medication" The Nurs Aide/Technician is remedication storage punlocked medication On 09/02/2020 at apple [administrative staff remanager, ASM # 2, or [licensed practical nutthe findings. No further information References: [1] Refers to a group by a limited mental cadaptive behaviors and routin Intellectual disability 18 and may result from autism or cerebral particulatism or cerebral particulation of the comparticulation of the compa	3.4 Medication Management" 3.4.7 Inventory of se or Medication sponsible for the following rocedures: F. Never leave unattended." proximately 11:45 a.m. ASM nember] # 1, program clinical director, and LPN rse] # 1 were made aware of n was provided prior to exit. of disorders characterized apacity and difficulty with uch as managing money, es, or social interactions. originates before the age of m physical causes, such as alsy, or from nonphysical of stimulation and adult is information was obtained in.gov/NIHfactsheets/ViewFa 00 .S) I evacuation drills at least	W 3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		49G037	B. WING		,	09/02/2020	
NAME OF P	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP COD 807 NORTH JACKSON ARLINGTON, VA 22201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 455	The finding include: Review of the facility 03/2018 through 08/2 fire drills were condup.m. shift between Ja 2020. Further review of the dated between January were all conducted of and 11:00 p.m. to 9:00. On 09/02/2020 at apinterview was conducted above AS forms and acknowled not conducted quarted On 09/02/2020 at apinterview was conducted quarted On 09/02/2020 at apinterview and acknowled not conducted quarted On 09/02/2020 at apinterview was conducted on 09/02/2020 at apinterview was conducted quarted On 09/02/2020 at apinterview was conducted quarted On 09/02/2020 at apinterview was conducted on 09/	is "Fire Drill Form [s]" dated 2020 failed to evidence that cted on the 6:00 a.m. to 2:00 anuary 2020 and March forms revealed that fire drills ary 2020 and March 2020 in the 3:00 p.m. to 11:00 p.m. 20 a.m. shifts. proximately 11:05 a.m., an cted with ASM [administrative ogram manager. When ing fire drills on the shifts and SM # 1 reviewed the fire drill diged that the fire drills were carly for each shift. proximately 11:45 a.m. ASM inember] # 1, program slinical director, and LPN irse] # 1 were made aware of in was provided prior to exit. OL) tive program for the and investigation of infection	W 44			10/2/2020	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49G037	B. WING		09/	02/2020
NAME OF P	ROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
W 455	This STANDARD is r Based on observation was determined that the follow infection control individuals in the mediobservation, Individual The facility staff failed while administering a to Individual # 1. The findings include: The facility staff failed while administering a to Individual # 1. Individual # 1 was a 3 admitted to [Name of diagnoses that include profound intellectual of On 09/02/2020 at app medication administrate conducted with DSP [# 1. At 7:07 a.m., DS of plastic gloves, unlo medication cabinet in removed a box contai opened the MAR and administration record administration record correct form, took the went into the kitchen is was siting by themsel sprays for the nasal s Individual # 1, remove	not met as evidenced by: ns and staff interviews it he facility staff failed to il practices for one of one lication administration all # 1. It to wear a pair of gloves Fluticasone SPR [spray] [1] It year old female, who was Group Home] with ed but were not limited to: disability [2]. In oximately 7:00 a.m., the ation observation was direct support professional] P # 1, while wearing a pair cked and opened the Individual # 1's bedroom, ning a bottle of nasal spray, TAR [medication	W 455	 The Program Manager will create a soutlining the dates and times each mont fire drill should be conducted ensuring a done on the am, pm, and overnight shift quarter. The Program Manager will train progstaff on how to read the schedule and the importance of completing fire drills on alternating shifts (am, pm, overnight) due ach quarter. The Program Manager will review as monitor the fire drill completion on a mbasis ensuring the fire drills are occurring that time and date per the schedule on alternating shifts (am, pm, overnight) for quarter. The CD will audit the program on a quarterly basis ensuring the fire drills are completed on alternating shifts (am, pm overnight) during the quarter. 	th the a drill is each gram e arring and conthly ag at the arr the	10/2/2020

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G037	B. WING			09/	02/2020
NAME OF PI	ROVIDER OR SUPPLIER SON ICF		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 807 NORTH JACKSON ARLINGTON, VA 22201	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 455	Continued From page	33	W	455	5		
	interview was conduct [licensed practical number of the above observation did not change their of the nasal spray to Individual why it was important administering nasal sprevent cross contamn asked to describe the administering the nast DSP # 1 should have administering the nast On 09/02/2020 at app [administrative staff of manager, ASM # 2, collicensed practical number findings. No further information References: [1] Used to relieve synthmatical runny itchy, watery eyes care allergies (caused by a dust, or pets). Prescriused to relieve sympt such as sneezing and are not caused by alle obtained from the well https://medlineplus.gottml.	proximately 11:45 a.m. ASM nember] # 1, program linical director, and LPN rse] # 1 were made aware of a was provided prior to exit. Imptoms of rhinitis such as a stuffy, or itchy nose and used by hay fever or other an allergy to pollen, mold, ption fluticasone is also oms of nonallergic rhinitis a runny or stuffy nose which ergies. This information was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		49G037	B. WING _	······		09/02/2020
NAME OF PI	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP C 807 NORTH JACKSON ARLINGTON, VA 22201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 455	adaptive behaviors s schedules and routin Intellectual disability 18 and may result fro autism or cerebral pacauses, such as lack responsiveness. Thi from the website:	uch as managing money, es, or social interactions. originates before the age of m physical causes, such as alsy, or from nonphysical of stimulation and adult s information was obtained h.gov/NIHfactsheets/ViewFa	W 4	155		