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

PRINTED: 08/03/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIÉS F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILOIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		49G044	B. WING _			07/28/2020
	ROVIDER OR SUPPLIER STREET ICF/MR			STREET ADDRESS, CITY, STATE, 7811 OAK STREET MANASSAS, VA 20111	ZIP CODE	Agraega: eg
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	
E 000	Initial Comments		E 0	00		
	survey was conducted was found to be in su	nergency Preparedness d 07/28/2020. The facility bstantial compliance with 42 quirement for Long-Term				
W 000	INITIAL COMMENTS		W 0	00		
	Intermediate Care Fa Intellectual Disabilities 07/28/20020. The fac with 42 CFR Part 483 Intermediate Care Fa	nual Medicaid survey for cilities for Persons with s (ICF/ID) was conducted on cility was not in compliance Requirements for cilities for the Intellectual afety Code survey report will				
W 159	time of the survey. To of three current Indivi- 1, # 2, and # 3).	bed facility was five at the he survey sample consisted dual reviews (Individuals #	W 18	59		
	Each client's active to integrated, coordinate qualified intellectual d. This STANDARD is r. Based on residential day program record review and staff intervithe QIDP (Qualified In Professional) failed to individuals' active trees	isability professional. not met as evidenced by: program record reviews, eview, facility document view, it was determined that				
	1a. The QIDP [Qualifi	ed Intellectual Disabilities				
AUGRATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E/	C - TITLE		(XÉ) 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.

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER	A: BUILDING_			PLETED
		49G044	B. WING		u.	7/28/2020
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE		72072020
CBLOAK	STREET ICF/MR		7	811 OAK STREET		
CRIGAN	STREET ICPANIK		N	MANASSAS, VA 20111		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	for Individual # 1's PC outcome/goal for med documented in meast 1b. The QIDP [Qualific Professional] failed to [Person-Centered -PI was implemented. 2. The QIDP [Qualific Professional] failed to for Individual # 2's PC outcome/goal for med documented in meast 3. The QIDP [Qualific Professional] failed to for Individual # 3's PC outcome/goal for comdocumented in meast The findings include:	ensure the data collection CP [Person-Centered -Plan] lication management was urable terms. ed Intellectual Disabilities ensure Individual # 1's PCP an] outcome/goal for laundry ed Intellectual Disabilities ensure the data collection CP [Person-Centered -Plan] lication management was urable terms. ed Intellectual Disabilities ensure the data collection CP [Person-Centered -Plan] munication was	W 159	The QIDP will revise Individual # 1 Medication Management" outcor measurable terms to collect appredata The QIDP will revise Individual # 2 "Medication Management" outcor measurable terms to collect appredata The QIDP will revise Individuals # "Communication" outcome into r terms to collect appropriate data. The Program Manager will update to incorporate these changes for individuals The Program Manager will comple process for all the other individual prevent further deficiencies The Program Manager will contin monitor and ensure that all service the individuals are accurately refle	me into opriate I's ome into opriate 3's operiate the PCPs operiate oper	9/9/2020
	Professional] failed to for Individual # 1's PC	ensure the data collection CP [Person-Centered -Plan] dication management was		through the use of weekly operat meetings		
	documented in measu			The Clinical Director will review w supervision with the Program Ma	nager for	
	admitted to [Name of diagnoses that includ	Propersold male, who was Group Home with ed but were not limited to: disability (1) and mood		documentation to support the co of services for each individual's no		
	through 11/30/2020 d	nt PCP dated 12/01/2019 ocumented, "Desired tion Management. Goal#				

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY PLETED
		49G044	B. WING		07/	28/2020
	ROVIDER OR SUPPLIER STREET ICF/MR			STREET ADDRESS, CITY, STATE, ZIP CODE 7811 OAK STREET MANASSAS, VA 20111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORK (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 159	prescribed medication with which to swallow 100% of the time until Activities & Instruction informed when it is tir [Individual # 1] is prorwater. 3) [Individual # medication. 4) [Individual # medication. Frequence of [Name of Onte" for Individual # In: 3:00 pm. [p.m.]. The documented, "8.1 Was completed? Please of participation level: Ye swallow his routine mater." Review of [Name of Onte" for Individual # In: 3:00 pm. [p.m.]. The documented, "8.1 Was completed? Please of participation level: Ye completed? Please of participation level: Ye participation level: Ye completed? Please of participation level: Ye participation level: Ye participation level: Ye participation level: Ye completed? Please of participation level: Ye complet	icipates in administering his n. He get a cup of water, his medication twice daily, 11/30/2020. Support his: 1) [Individual # 1] is ne for his medication. 2) hipted to get a glass of f 1] administers his own dual #1] is praised for taking hency: Daily." Group Home] "Progress 1 dated 06/01/2020 at "Time hime Out 11:00 pm [p.m.] s the support activity escribe barriers and s. He was educated to hedication with a glass of Group Home] "Progress 1 dated 06/02/2020 at "Time hime Out 11:00 pm [p.m.] s the support activity	W	The QIDP will revise Individual # 159 outcomes that addresses "Launthat the outcome accurately ref of Individual #1 and is implement appropriately The Program Manager / QIDP windividuals' outcomes to ensure accurately reflect their needs are implemented as designed within the Program Manager will provide all the staff to review all individuring the next staff meeting. The Manager will provide supervision and ensure that the PCPs accurated individuals needs and are imples appropriately. The QIDP will conduct monthly ensure that all services and need are accurately implemented on QIDP notes. The Clinical Director will review supervision with the Program Midocumentation to support the deservices for each individual.	dry" to ensure flect the needs need will review all that they and that they are in the PCPs. The program on to all staff at they reflect the mented assessments to ds are met and the monthly within lanager the	9/9/2020
	Note" for Individual # In: 3:00 pm. [p.m.]. T documented, "8.1 Wa completed? Please d participation level: Ye	escribe barriers and s. PM [Initials of Individual # ing medication with water.				

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		MEDICAID SERVICES				(FORM AI		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		STRUCTION		(X3) DATE SURVEY COMPLETED		
		49G044	B. WNG_				07/28/	2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP	CODE	011201		
CRI OAK	STREET ICFIMR				AK STREET SSAS, VA 20111				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIAT		(XS) DMPLETION DATE	
W 159	Continued From page	ge 3	W 1	59					
	Note" for Individual a In: 3:00 pm. [p.m.]. documented, "8.1 W completed? Please participation level: Y 1] was given his eve He swallowed his m Review of [Name of Note" for Individual a In: 11:00 pm. [p.m.]. documented, "8.1 W completed? Please participation level: Y 1] was informed that	was given a glass of water.							
	Note" for Individual # In: 3:00 pm. [p.m.], documented, "8.1 W completed? Please participation level: Y	Group Home] "Progress # 1 dated 06/10/2020 at "Time Time Out 11:00 pm [p.m.] /as the support activity describe barriers and es. PM [Initials of Individual # nedication with water."							
	conducted with OSM QIDP. When asked responsibility in rega notes OSM # 1 state to go through to see goals, at staff meetir look at the progress see if they are comp	2 p.m., an interview was 1 [Other staff member] # 1, to describe their and to the individual's progress and that they were responsible if staff are following the ags train them to follow goals, notes on a weekly basis to leted and how they were the accuracy of the note and							

make sure that they are documenting it so it can

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		49G044	B. WING			07/28/2020
	ROVIDER OR SUPPLIER STREET ICF/MR		1	7811 C	T ADDRESS, CITY, STATE, ZIP CODE PAK STREET ASSAS, VA 20111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
111.450				ñ		
VV 159	Continued From page		W	159		
	progress notes descr asked if the data coll outcome for medicati	reviewing Individual # 1's ibed above OSM # 1 was ection for Individual # 1's on management was written to obtain a glass of water.				
	1, program manager	oximately 11:45 p.m., ASM # was made aware of the				
	above findings by tel	ephone.				
	No further information	n was provided prior to exit.				
	ì					
		of disorders characterized apacity and difficulty with				
		uch as managing money,				
		es, or social interactions. originates before the age of				
	18 and may result fro autism or cerebral pa	om physical causes, such as alsy, or from nonphysical				
	•	of stimulation and adult information was obtained				
	https://report.nih.gov/ t.aspx?csid=100.	nihfactsheets/ViewFactShee				
	Professional) failed to	ied Intellectual Disabilities o ensure Individual # 1's PCP lan] outcome/goal for laundry				
	Home] dated 12/01/2 documented, "Desire Independent Living S #1] likes to help out a	nt PCP from {Name of Group 019 through 11/30/2020 d Outcome: # 6: skills. Goal # 6: [Individual around the house. [Individual ing laundry 2 out of 4 times a				

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		MEDICAID SERVICES						APPROVEI 0938-039
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL'	TIPLE CONSTR	UCTION		(X3) DATE SU COMPLE	
		49G044	B. WNG				07/2	8/2020
NAME OF P	ROMDER OR SUPPLIER			STREET AC	DORESS, CITY, STATE, ZIP	CODE	07.72	72020
CRI OAK	STREET ICF/MR		7811 OAK STREET MANASSAS, VA 20111					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
W 159	Continued From pag	e 5	w.	150				
	week (50%) of the tir Activities & Instruction	ne until 11/30/2020. Support ins: 1) [Individual # 1] is	-	133				
		ered hand over hand support						
	_	of individual # 1) is nitiative and do laundry, 4) sed for doing a good job.						
	Note" for Individual # In: 3:00 pm. [p.m.]. I documented, "6.1 Wa completed? Please participation level: Ye	Group Home] "Progress 1 dated 06/02/2020 at "Time Fime Out 11:00 pm [p.m.] as the support activity describe barriers and es. He was prompted to th staff supervision during						
	Note" for Individual # in: 3:00 pm, [p.m.]. 3 documented, "6.1 Wacompleted? Please oparticipation level. Yes	es. With a prompt PM # 1] washed his hands before						
	Note" for Individual # In: 3:00 pm. [p.m.]. 1 documented, "6.1 Wa completed? Please of	es. He was prompted to			er.			
	Review of [Name of (Group Home] "Progress						

Note" for Individual # 1 dated 06/07/2020 at "Time In: 11:00 pm. [p.m.]. Time Out 9:00 am [a.m.] documented, "6.1 Was the support activity

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CENTER	S FUR MEDICARE &	MEDICAID SEKVICES				OMI	<u>B NO_0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CON		(X3) DATE SURVEY COMPLETED	
		49G044	B. WING				07/28/2020
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
CRI OAK	STREET ICF/MR			7811 0	DAK STREET		
				MAN	ASSAS, VA 20111		
(X4) ID PREFIX TAG	(EACH DÉFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	Continued From page 6		w	1591			
	completed? Please of						
		es. PM [Initials of Individual # before eating his breakfast					
	and he put his cup and plate ion the sink after his breakfast."						
	Onders of Name of	Dance II 1 8Dance					
	Review of [Name of Group Home] "Progress Note" for Individual # 1 dated 06/07/2020 at "Time						
	In: 11:00 pm. [p.m.]						
	documented, "6.1 Wa						
	completed? Please of						
	1] watered the garder	s. PM (Initials of Individual #					
	ij watered the garder	THE CHECKFOOL					
		p.m., an interview was					
		[Other staff member] # 1,					
	QIDP. When asked t	d to the individual's progress					
		that they were responsible					
		f staff are following the					
	-	gs train them to follow goals,					
		notes on a weekly basis to eted and how they were					
	•	e accuracy of the note and					
	make sure that they a	are documenting it so it can					
		eviewing Individual # 1's					
	 progress notes descr asked if the goal for land 	ibed above, OSM # 1 was					
	implemented_ OSM #						
		eximately 11:45 p.m., ASM #					
	1, program manager above findings by tele	was made aware of the ephone.					
	No further information	n was provided prior to exit.					
	2. The facility staff fa	iled to document the data					

collection Individual # 2's PCP [Person-Centered

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					FORM APPROVE OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED
		49G044	B. WING_	B. WING			07/29/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DORESS, CITY, STATE, ZII	P CODE	07/28/2020
CRIOAK	STREET ICF/MR			7811 OAK	STREET AS, VA 20111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	
W 159	Continued From pag	e 7	™ W 1:	59			
	-Plan] outcome/goal in measurable terms.	for medication management					
	admitted to [Name of diagnoses that include	71 year-old male, who was Group Home] with led but were not limited to: oility (1) and epilepsy (2).					
	Individual # 2's current PCP dated 02/01/2020 through 11/30/2021 documented, "Desired Outcome: # 6 Medication Management. Goal #						
	medication managem medication with a gla of 2 times offered a d Support Activities: 1) that it is time for him	sires to participate in his nent by swallowing all his ass of water 2 [two] times out lay at 100% until 01/31/2021. [Individual # 2] is reminded to take his medication. 2) as where he will take his					
	medication. 3) [Indivi- his medication. 4) [In- medication with a cup- opens his mouth for s	idual # 2] is prompted to take idividual #2] swallows the poof water. 5) [Individual #2] staff to be sure he swallowed					
	participating appropri Frequency: Daily."	ndividual #2] is praised for ately.					
	Note" for Individual #	Group Home] "Progress 2 dated 06/01/2020 at "Time Time Out 11:00 pm [p.m.]					
	documented, "6.1 Wa completed? Please of	s the support activity					
	[medications] (sic) by helps him."	saying how his meds [sic]					
		Group Home] "Progress 2 dated 06/02/2020 at "Time					

In: 10:00 pm. [p.m.]. Time Out 8:00 am [a.m.] documented, "6.1 Was the support activity

DEPARTMENT OF HEALTH AND HUMAN

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391			
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED			
		49G044	B, WING		07/28/2020			
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 0772012020			
CBLOAK	CTDEET ICEIMD		7811	OAK STREET				
CRIOAR	STREET ICF/MR		MAM	ASSAS, VA 20111				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFE			DBE COMPLETION			
W 159	Continued From page	e 8	W 159					
			,00					
	completed? Please describe barriers and participation level: Yes. Another staff assisted							
	him with his medication this morning."							
	Review of [Name of	Group Home] "Progress						
		2 dated 06/03/2020 at "Time						
		Time Out 11:00 pm [p.m.]						
		as the support activity						
	completed? Please							
	participation level: Yes. He was prompted to mention at least two of his meds and how it helps							
	him to feel better."	or mo mods and now it hops						
		Group Home] "Progress						
		2 dated 06/04/2020 at "Time						
		Time Out 8:00 am [a.m.]						
	completed? Please	as the support activity						
		es. Another staff assisted						
	him with his medicati							
	Review of [Name of (Group Home} "Progress						
		2 dated 06/06/2020 at "Time						
		Fime Out 11:00 pm [p.m.]						
0		as the support activity						
	completed? Please							
		es. [Initials of Individual # 2]						
	was notified by staff to	when it was time for wed his medication with staff						
	· ·	and over hand support to						
		lage, staff prompted him to						
		taff to be sure he has						
	•	nedication and he was						
	praised by staff for de	oing a tremendous job."						
	Review of [Name of (Group Home] "Progress						
		2 dated 06/09/2020 at "Time						

in: 10:00 pm. [p.m.]. Time Out 8:00 am [a.m.] documented, "6.1 Was the support activity

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		STRUCTION		(X3) DATE SURVEY COMPLETED		
		49G044	B. WING				07/28/2020		
NAME OF P	ROVIDER OR SUPPLIER		-	STREE	TADDRESS, CITY, STATE, ZI	P CODE	### ### ### ##########################		
CRI OAK	STREET ICF/MR			7811 O	OAK STREET				
	<u>V</u>		MANASSAS, VA 20111						
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG				OF CORRECTION ACTION SHOULD BE TO THE APPROPRIA ENCY)			
W 159	Continued From pag	e 9	10/	159					
		describe barriers and	VV	159					
		es. [Initals for Indivisual #2]							
		orted by staff with am [a.m.]							
		2 p.m., an interview was [Other staff member] # 1,							
	QIDP. When asked								
	responsibility in rega								
	notes OSM # 1 stated that they were responsible								
		if staff are following the							
		gs train them to follow goals,							
		notes on a weekly basis to leted and how they were							
		e accuracy of the note and							
		are documenting it so it can							
	be measured. After	reviewing Individual # 2's							
		ribed above, OSM # 1 was							
		ection for Individual # 2's							
		ion management was written OSM # 1 stated no.					i		
		oximately 11:45 p.m., ASM #							
	program manager above findings by tel	was made aware of the ephone.							
	No further informatio	n was provided prior to exit							
	Reference								
		of disorders characterized							
	by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions.								
		es, or social interactions. originates before the age of							
		onginates before the age of om physical causes, such as							
		alsy, or from nonphysical							
		of stimulation and adult							

from the website:

responsiveness. This information was obtained

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

	O TOTTIME BIOTUTE O	MILOTO/ NE OLITATOLO			OIND NO. 0330-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
· · · · · · · · · · · · · · · · · · ·		49G044	B. WING	<u> </u>	07/28/2020
NAME OF P	ROVIDER OR SUPPLIER		l l	EET ADDRESS, CITY, STATE, ZIP CODE	
CRI OAK	STREET ICF/MR			1 OAK STREET NASSAS, VA 20111	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D 8E COMPLETION
W 159	Continued From page	e 10	W 159		
		nihfactsheets/ViewFactShee	***************************************		
	recurring seizures. The clusters of nerve cells send out the wrong significant muscle spasm	nat causes people to have he seizures happen when s, or neurons, in the brain ignals. They may have hs or lose consciousness, obtained from the website: ov/epilepsy.html.			
	The facility staff facollection Individual # [Person-Centered-Placommunication in me	an) outcome/goal for			
	Individual # 3 was a 64 year-old female, who was admitted to [Name of Group Home] with diagnoses that included but were not limited to: profound intellectual disability (1) and epilepsy (2).				
	through 07/31/2020 d Outcome: # 2 Commit [Individual #3] uses in communicate her wan to a desired location, indicate specific need leading to specific are or to eat, Monday to I makes it 100% of the Support Activities & Ir 3] uses non-verbal cu- wants and needs. For eat, effectively to other	nts and needs. She will walk purposefully vocalize to destain the purposeful time, until 7/31/2020, and tructions: 1) [Individual # destain the purposeful time, until 7/31/2020, and tructions: 1) [Individual # destain the purposeful time, to go to bed or to destain the purposeful time, pec [Picture Exchange]			

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DAT	E SURVEY	
		49G044	B. WING		0.	7/28/2020	
NAME OF P	PROVIDER OR SUPPLIER	V 2-1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		IZUIZUZU	
CRI OAK	STREET ICF/MR		78 M				
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 159	Continued From page	e 11	W 159			- 7	
	Note" for Individual # In: 3:00 pm. [p.m.]. T documented, "2.1 Wa completed? Please of participation level: Ye was nonverbal and covocalizations and few Review of [Name of ONote" for Individual # AM. [a.m.]. 9:04 AM support activity comp barriers and participa communicates non vevocalizations, gesture Review of [Name of ONote" for Individual # In: 3:00 pm. [p.m.]. 7	es. [Initials of Individual # 3] communicates with v gestures." Group Home] "Progress 3 dated 06/09/2020 at "8:49 documented, "2.1 Was the oleted? Please describe ation level: Yes. She cerbally by giggling, smiling, es, facial expressions." Group Home] "Progress 3 dated 06/11/2020 at "Time Time Out 11:00 pm [p.m.] as the support activity					
	facial and body gesturable wants." Review of [Name of Content for Individual # AM. [a.m.]. 8:21 AM support activity completes and participal communicate her wants and participal communicate her wants and participal communicate section."	Group Home] "Progress 3 dated 06/12/2020 at "8:08 documented, "2.1 Was the oleted? Please describe ation level: Yes to nts and needs by gesturing, alizations, gestures, facial					

On 07/28/20 at 12:02 p.m., an interview was conducted with OSM [Other staff member] # 1,

QIDP. When asked to describe their

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		49G044	B WING		07/28/2020
	ROVIDER OR SUPPLIER		78	REET ADDRESS, CITY, STATE, ZIP CODE 11 OAK STREET ANASSAS, VA 20111	0772872020
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 159	Continued From p	ago 12	14450		
** 100			W 159		
		gard to the individual's progress			
		ated that they were responsible			
		ee if staff are following the			
		tings train them to follow goals, as notes on a weekly basis to			
		npleted and how they were			
		the accuracy of the note and			
		ey are documenting it so it can			
		er reviewing Individual # 3's			
		scribed above OSM # 1 was			
		ollection for Individual # 3's			
	outcome for comm	unication was written in			
	measurable terms	OSM # 1 stated no.			
		proximately 11:45 p.m., ASM #			
		er was made aware of the			
	above findings by	telephone.			
	No further informa	tion was provided prior to exit.			
	Reference:				
	(1) Refers to a gro	up of disorders characterized			
		I capacity and difficulty with			
		s such as managing money,			
	schedules and rou	tines, or social interactions.			
	Intellectual disabili	ty originates before the age of			
		from physical causes, such as			
	autism or cerebral	palsy, or from nonphysical			
		ck of stimulation and adult			
	•	his information was obtained			
	from the website:				
	t.aspx?csid=100.	ov/nihfactsheets/ViewFactShee			
	(2) A brain disorde	r that causes people to have			
		The seizures happen when			
		ells, or neurons, in the brain			
		g signals. They may have			
		sms or lose consciousness			

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

STATEMENT OF DEFICIENCIES (X1) PF		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G044	B. WING		07/28/2020		
	ROVIDER OR SUPPLIER STREET ICF/MR		7	STREET ADDRESS, CITY, STATE, ZIP CODE 1811 OAK STREET MANASSAS, VA 20111			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
W 159	Continued From pag This information was https://medlineplus.g	obtained from the website	W 159				
W 249	PROGRAM IMPLEN CFR(s): 483.440(d)(W 249	W 249 PROGRAM IMPLEMENTATION 483.440 (d)(1)	CFR(s) 9/9/2020		
	formulated a client's each client must rec treatment program of interventions and se and frequency to sup	disciplinary team has individual program plan, eive a continuous active onsisting of needed rvices in sufficient number oport the achievement of the in the individual program		The QIDP will revise individual #1's Por "Independent Living Skills" outcome that it accurately reflects and is imple as per the needs of the Individual. The Program Manager / QIDP will revindividuals outcomes to ensure that accurately implemented as designed PCPs.	to ensure emented riew all they		
	Based on staff inter and facility documen that the facility staff of treatment program for the survey sample, I staff failed to implem (person-centered plate) "Independent Living			The Program Manager will provide the to all the staff to review all individual during the next staff meeting, and will provide supervision to all staff and enthe PCPs are implemented appropriate. The Program Manager will complete audits of Progress Notes to ensure the completed outcomes are accurately response in the pCPs.	s' PCPs il also nsure that tely. weekly at the		
	admitted to [Name o diagnoses that include moderate intellectual	27 year-old male, who was f Group Home] with ded but were not limited to: I disability (1) and mood		the supports in the PCPs. The Clinical Director will review withi supervision with the Program Manage documentation to support the coordiservices for each individual.	er the		
	Home] dated 12/01/2 documented, "Desire	ont PCP from [Name of Group 2019 through 11/30/2020 ad Outcome: # 6: Skills. Goal # 6: [Individual					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OI	MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2.3	TIPLE CON	STRUCTION	(×	3) DATE SURVEY COMPLETED
		49G044	B. WNG				07/28/2020
NAME OF P	ROVIDER OR SUPPLIER	<u>'</u>		STREE	T ADDRESS, CITY, STATE, ZIP CODE	E	
CRI OAK	STREET ICFIMR				ASSAS, VA 20111		
(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 COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	#1] likes to help out a #1] participates in doi week (50%) of the tim Activities & Instruction prompted when it is ti [Individual # 1] is offe to complete tasks. 3) encouraged to take in [Individual #1] is prais Frequency: Daily. Review of [Name of C Note" for Individual # In: 3:00 pm. [p.m.]. T documented, "6.1 Wa completed? Please of participation level: Ye clean up his room wit the shift." Review of [Name of C Note" for Individual # In: 3:00 pm. [p.m.], T documented, "6.1 Wa completed? Please of participation level: Ye [Initials of Individual # eating his breakfast." Review of [Name of C Note" for Individual # In: 3:00 pm. [p.m.], T documented, "6.1 Wa completed? Please of Note" for Individual # In: 3:00 pm. [p.m.]. T documented, "6.1 Wa completed? Please of	round the house. [Individual ng laundry 2 out of 4 times a ne until 11/30/2020. Support ns: 1) [Individual # 1] is me to clean up. 2) red hand over hand support [Individual # 1] is itilitative and do laundry. 4) sed for doing a good job. Group Home] "Progress 1 dated 06/02/2020 at "Time time Out 11:00 pm [p.m.] is the support activity lescribe barriers and s. He was prompted to the staff supervision during for the support activity lescribe barriers and s. With a prompt PM to the support activity lescribe barriers and s. With a prompt PM to the support activity lescribe barriers and s. With a prompt PM to the support activity lescribe barriers and s. With a prompt PM to the support activity lescribe barriers and s. With a prompt PM to the support activity lescribe barriers and s. He was prompted to	W	249			

Review of [Name of Group Home] "Progress

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CENTER	RS FOR MEDICARE	MEDICAID SERVICES			OMB NO. 0938-039			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		49G044	B. WING		07/20/2000			
	ROVIDER OR SUPPLIER		7811	EET ADDRESS, CITY, STATE, ZIP CODE OAK STREET NASSAS, VA 20111	07/28/2020			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						
W 249	Note" for Individual In: 11:00 pm. [p.m.], documented, "6.1 W completed? Please participation level: Y 1] washed his hands and he put his cup a breakfast." Review of [Name of Note" for Individual In: 11:00 pm. [p.m.], documented, "6.1 W completed? Please participation level: Y 1] watered the garder On 07/28/20 at 11:4	# 1 dated 06/07/2020 at "Time Time Out 9:00 am [a.m.] //as the support activity describe barriers and //es. PM [Initials of Individual # //s before eating his breakfast and plate ion the sink after his Group Home] "Progress # 1 dated 06/07/2020 at "Time Time Out 9:00 am [a.m.] ///as the support activity describe barriers and //es. PM [Initials of Individual # //en in the afternoon."	W 249					
	member] # 1, progra Individual # 1's prog ASM # 1 was asked independent living s implemented accord ASM # 1 stated, "Do laundry." When ask program was implen stated no. The facility's policy " documented, "ISP In Engagement: Impler the time of its developlan are fully implem receiving support, le active engagement r		50					

ISP."

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

			(X3) DATE SURVEY COMPLETED	
49G044 B. WING		B. WING		07/28/2020
ROVIDER OR SUPPLIER		7811 (ET ADDRESS, CITY, STATE, ZIP CODE DAK STREET ASSAS, VA 20111	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
On 07/28/20 at appro 1, program manager above findings by tel	oximately 11:45 p.m., ASM # was made aware of the ephone.	W 249		
Reference: (1) Refers to a group by a limited mental consideration adaptive behaviors a schedules and routing limited mental consideration and result from the lectual disability 18 and may result from autism or cerebral pacauses, such as lack responsiveness. This from the website: https://report.nih.gov/t.aspx?csid=100. PROGRAM DOCUM CFR(s): 483.440(e)(1) Data relative to accompacified in client indicates.	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 information was obtained (nihfactsheets/ViewFactShee ENTATION)	W 252		
Based on staff intervand facility document that the facility staff fatreatment program for in the survey sample.	iew, clinical record review review it was determined ailed to implement the active r three of three individuals. Individual # 1, # 2 and # 3.	55.		
	Continued From page On 07/28/20 at approduced from page On 07/28/20 at approduced for program manager above findings by teles No further information Reference: (1) Refers to a group by a limited mental cadaptive behaviors a schedules and routin Intellectual disability 18 and may result from autism or cerebral pacauses, such as lack responsiveness. This from the website: https://report.nih.gov/t.aspx?csid=100. PROGRAM DOCUM CFR(s): 483.440(e)(1) Data relative to according program for the survey sample, and facility document that the facility staff fact treatment program for in the survey sample, and facility staff fact.	(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://report.nih.gov/nihfactsheets/ViewFactShee t.aspx?csid=100. PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 8Y FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 On 07/28/20 at approximately 11:45 p.m., ASM # 1, program manager was made aware of the above findings by telephone. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100. PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility staff failed to implement the active treatment program for three of three individuals in the survey sample, Individual # 1, # 2 and # 3. 1. The facility staff failed to document the data	(#ACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 On 07/28/20 at approximately 11:45 p.m., ASM # 1, program manager was made aware of the above findings by telephone. No further information was provided prior to exit. Reference: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactShee t.aspx?csid=100. PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. 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 implement the active treatment program for three of three individuals in the survey sample, Individual # 1, # 2 and # 3. 1. The facility staff failed to document the data

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE S COMPLE	
		49G044	B WING	1	07/2	8/2020
	ROVIDER OR SUPPLIER STREET ICF/MR		7	TREET ADDRESS, CITY, STATE, ZIP CODE 811 OAK STREET	1 0772	0/2020
	SUBULA DI			MANASSAS, VA 20111		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 252	Continued From p	age 17	W 252	W 252 PROGRAM DOCUMENTA CFR(s): 483.440(e)(1)	TION	9/9/2020
		al for medication management	77 202	The QIDP will revise Individual # 1's " Medication Management" outcome i		
		f failed to document the data al # 2's PCP [Person-Centered		measurable terms to collect appropri		
	in measurable term			The QIDP will revise Individual # 2's "Medication Management" outcome measurable terms to collect appropri		
	collection Individua			The QIDP will revise Individuals # 3's		
	(Person-Centered- communication in	Plan] outcome/goal for measurable terms.		"Communication" outcome into mea terms to collect appropriate data.	surable	
	The findings include	le:		The Program Manager will update the	e PCPs to	
	collection Individua	f failed to document the data all # 1's PCP [Person-Centered		incorporate these changes for those individuals		
	-Plan] outcome/go in measurable tern	al for medication management ns.		The Program Manager will complete process for all the other individuals to		
		a 27 year-old male, who was of Group Home] with		further deficiencies		
	diagnoses that inc	luded but were not limited to: ual disability (1) and mood		The Program Manager will continue to monitor and ensure that all service no the individuals are accurately reflected through the use of weekly operations	eeds of	
	through 11/30/202	rrent PCP dated 12/01/2019 0 documented, "Desired		meetings		
	8: [Individual #1] prescribed medica with which to swall	lication Management. Goal # participates in administering his tion. He get a cup of water, low his medication twice daily, until 11/30/2020. Support		The Clinical Director will review within supervision with the Program Manage documentation to support the coordinates for each individual's needs.	er for	
	Activities & Instruction informed when it is	tions: 1) (Individual # 1) is s time for his medication. 2) prompted to get a glass of				- 2

water. 3) [Individual # 1] administers his own medication. 4) [Individual #1] is praised for taking

his medication. Frequency: Daily."

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB I	NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			1, ,	NTE SURVEY
		49G044	B WNG_				07/28/2020
2	ROVIDER OR SUPPLIER			7811 O	TADDRESS, CITY, STATE, ZIP CODE AK STREET SSAS, VA 20111	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 252	Continued From page 18		W 2	!52			1
	Review of [Name of Group Home] "Progress Note" for Individual # 1 dated 06/01/2020 at "Time In: 3:00 pm. [p.m.]. Time Out 11:00 pm [p.m.] documented, "8.1 Was the support activity completed? Please describe barriers and participation level: Yes. He was educated to swallow his routine medication with a glass of water." Review of [Name of Group Home] "Progress Note" for Individual # 1 dated 06/02/2020 at "Time In: 3:00 pm. [p.m.]. Time Out 11:00 pm [p.m.] documented, "8.1 Was the support activity completed? Please describe barriers and participation level: Yes. He was educated to swallow his routine medication with a glass of						
Ŷ	Note" for Individual # In: 3:00 pm. [p.m.]. T documented, "8.1 Wa completed? Please of participation level: Ye	es. PM [Initials of Individual # ning medication with water.					
i	Note" for Individual # In: 3:00 pm. [p.m.]. T documented, "8.1 Wa completed? Please of participation level; Ye	es. PM (Initials of Individual # ning medication with water.					

Review of [Name of Group Home] "Progress Note" for Individual # 1 dated 06/07/2020 at "Time

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	<u> </u>		OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G044	B WING			07/28/2020	
	STREET ICF/MR		STREET ADDRESS, CITY, STATE, ZIP CODE 7811 OAK STREET MANASSAS, VA 20111				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	(XS) COMPLETION E DATE	
M 252	Continued From pa	10					
VV 252	The state of the s		W 252				
]. Time Out 9:00 am [a.m.]					
		Was the support activity e e describe barriers and					
		Yes. PM [Initials of Individual #					
		at it was time for his					
		e was given a glass of water.					
	He took medication						
	Review of [Name of	of Group Home] "Progress					
		# 1 dated 06/10/2020 at "Time					
	In: 3:00 pm. [p.m.].	Time Out 11:00 pm (p.m.)					
		Was the support activity					
		e describe barriers and					
		Yes. PM [Initials of Individual #					
	1] took his evening	medication with water."					
		45 a.m., an interview was					
		M [administrative staff					
		ram manager. After reviewing					
		gress notes described above, d if the data collection for					
		come for medication					
		written in measurable terms to					
		ater. ASM # 1 stated no.					
	On 07/28/20 at app	proximately 11:45 p.m., ASM #					
	4	er was made aware of the					
	above findings by t						
	No further informat	ion was provided prior to exit.					
	Reference:						
		p of disorders characterized					
		capacity and difficulty with					
		such as managing money,					
		ines, or social interactions.					
		v originates before the age of					

18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		<u></u>	OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G044	B, WING		07/28/2020
NAME OF P	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE	
CRI OAK	STREET ICF/MR			7811 OAK STREET MANASSAS, VA 20111	
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
W 252	Continued From page	e 20	W 25	2	
	causes, such as lack responsiveness. This from the website:	of stimulation and adult information was obtained inhactsheets/ViewFactShee			
	2. The facility staff failed to document the data collection Individual # 2's PCP {Person-Centered -Plan} outcome/goal for medication management in measurable terms. Individual # 2 was a 71 year-old male, who was admitted to [Name of Group Home] with				
	_	led but were not limited to: pility (1) and epilepsy (2).			
	through 11/30/2021 of Outcome: # 6 Medica 6: [Individual #2] des medication managem medication with a gla of 2 times offered a d Support Activities: 1) that it is time for him [Individual # 2] decide medication. 3) [Individual # 2] decide medication. 4) [Ir medication with a cus opens his mouth for s	nt PCP dated 02/01/2020 locumented, "Desired ation Management. Goal # tires to participate in his nent by swallowing all his ss of water 2 [two] times out lay at 100% until 01/31/2021. [Individual # 2] is reminded to take his medication. 2) les where he will take his idual # 2] is prompted to take hidividual #2] swallows the of water. 5) [Individual #2] staff to be sure he swallowed individual #2] is praised for ately.			
	Note" for Individual #	Group Home] "Progress 2 dated 06/01/2020 at "Time Time Out 11:00 pm [p.m.]			

documented, "6.1 Was the support activity

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	OF DEFICIENCIES CORRECTION			IPLE CONS	STRUCTION		(X3)	DATE SURVEY COMPLETED
		49G044	B. WING	3			07/28/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY	, STATE, ZIP CODE	883	0112012020
CRI OAK	CRI OAK STREET ICF/MR				AK STREET SSAS, VA 201	11		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH COR	ER'S PLAN OF CORRECTIVE ACTION SHOTE RENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 252	Continued From pag	e 21	W 2	252				
	10 No.	describe barriers and	V V Z	.42				
	participation level: Y							
	[medications] [sic] by helps him."							
	Note" for Individual # In: 10:00 pm. [p.m.].	Group Home] "Progress 2 dated 06/02/2020 at "Time Time Out 8:00 am [a.m.]						
	completed? Please	as the support activity describe barriers and es. Another staff assisted						
	him with his medicat							
	Note" for Individual #	Group Home] "Progress 2 dated 06/03/2020 at "Time						
	documented, "6.1 W completed? Please	Time Out 11:00 pm [p.m.] as the support activity describe barriers and						
		es. He was prompted to of his meds and how it helps						
	Note" for Individual #	Group Home] "Progress ! 2 dated 06/04/2020 at "Time						
	documented, "6.1 W	Time Out 8:00 am [a.m.] as the support activity describe barriers and						
		es. Another staff assisted						
	Note" for Individual # In: 7:00 am. [a.m.].	Group Home} "Progress to 2 dated 06/06/2020 at "Time Time Out 11:00 pm [p.m.] as the support activity						
	completed? Please	describe barriers and es. (Initials of Individual # 2)						

was notified by staff when it was time for

medication, he reviewed his medication with staff and staff gave him hand over hand support to

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DEPARTI	VILIAL OF HEVELLY VI	ID HOWAR SERVICES			FORM APPROVE
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO: 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G044	B. WING	· · · · ·	07/28/2020
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
CRI OAK	STREET ICF/MR		- 1	7811 OAK STREET MANASSAS, VA 20111	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
\\/\ 252	Continued From page	22	W 252		
VV 232			VV 25/		
	open his mouth for st	lage, staff prompted him to			
	•	nedication and he was			
	praised by staff for doing a tremendous job."				
	Review of Mame of (Group Home] "Progress			
	•	2 dated 06/09/2020 at "Time			
		Time Out 8:00 am [a.m.]			
		as the support activity			
	completed? Please of				
	•	es. [Initials of individual #2]			
	was physically suppo medication."	rted by staff with am [a.m.]			
	On 07/28/20 at 11:45	a.m., an interview was			
	conducted with ASM				
		m manager. After reviewing			
		ess notes described above,			
	ASM # 1 was asked i	f the data collection for			
		itten in measurable terms to			
		with a glass of water. ASM			
	# 1 stated no.	- 3			
	On 07/28/20 at appro	eximately 11:45 p.m., ASM #			
		was made aware of the			
	above findings by tele				
	No further information	n was provided prior to exit.			
	Reference:				
		of disorders characterized			
		apacity and difficulty with			
		uch as managing money,			
		es, or social interactions.			
	- meneculai disability i	commares before the abe of			

18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES					RM APPROVE IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ISTRUCTION	(X3) DATE COMP	
		49G044	B WING_			27/27/222	
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 0	7/28/2020
CRI OAK	STREET ICFIMR				DAK STREET ASSAS, VA 20111		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 252	Continued From pa	ge 23	W 2	<u></u>	*****		
	responsiveness. The from the website:	is information was obtained	VV 2.	J2			
	t.aspx?csid=100.						
	recurring seizures.	that causes people to have The seizures happen when					
	send out the wrong violent muscle spas	ells, or neurons, in the brain signals. They may have sms or lose consciousness.					
	https://medlineplus.	s obtained from the website: gov/epilepsy.html.					
	collection Individual						
	[Person-Centered-F communication in m	Plan] outcome/goal for neasurable terms.					
	admitted to [Name of	64 year-old female, who was of Group Home) with					
		ided but were not limited to: il disability (1) and epilepsy					
	through 07/31/2020	ent PCP dated 08/01/2020 documented, "Desired					
	[Individual #3] uses	nunication skills. Goal # 2: non-verbal cues to ants and needs. She will walk					
	indicate specific nee	n, purposefully vocalize to eds, holding staff's hands and					
24	or to eat, Monday to makes it 100% of th	reas/needs, etc e.g. go to bed Friday 5 (five) out of 5 which e time, until 7/31/2020.					
		Instructions: 1) (Individual #					

wants and needs. For instance; to go to bed or to eat, effectively to others from Mondays to Friday using nonverbal cues, PEC [Picture Exchange

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ISTRUCTION		TE SURVEY MPLETED
		49G044	B. WING			0	7/28/2020
NAME OF PROVIDER OR SUPPLIER CRI OAK STREET ICF/MR				STREE 7811 C	0774020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 252	Continued From page 24 Communication] chart. Frequency: Daily." Review of [Name of Group Home] "Progress Note" for Individual # 3 dated 06/08/2020 at "Time In: 3:00 pm. [p.m.]. Time Out 11:00 pm [p.m.] documented, "2.1 Was the support activity completed? Please describe barriers and participation level: Yes. [Initials of Individual # 3] was nonverbal and communicates with vocalizations and few gestures."		W 252				
	Note" for Individual # AM. [a.m.]. 9:04 AM support activity comp barriers and participa communicates non ve	Group Home] "Progress 3 dated 06/09/2020 at "8:49 documented, "2.1 Was the eleted? Please describe attion level: Yes. She erbally by giggling, smiling, es, facial expressions."					
	Note" for Individual # In: 3:00 pm. [p.m.]. T documented, "2.1 Wa completed? Please of participation level: Ye						
	Note" for Individual # AM. (a.m.). 8:21 AM support activity comp barriers and participa communicate her war	Group Home] "Progress 3 dated 06/12/2020 at "8:08 documented, "2.1 Was the leted? Please describe tion level: Yes to nts and needs by gesturing, alizations, gestures, facial					

On 07/28/20 at 11:45 a.m., an interview was

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		MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G044	B. WNG		07/28/2020	
NAME OF PROVIDER OR SUPPLIER CRI OAK STREET ICF/MR			12.	STREET ADDRESS, CITY, STATE, ZIP CODE	0172072020	
			7811 OAK STREET MANASSAS, VA 20111			
(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 SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
W 252	Continued From page	e 25	W 25		= 0	
	conducted with ASM [administrative staff		VV 25			
	member] # 1, program manager. After reviewing					
	Individual # 3's progress notes described above,					
	ASM # 1 was asked if the data collection for Individual # 3's outcome for communication was					
	written in measurable terms to identify Individual # 3's communication method and what their need					
	or want was identified					
	On 07/28/20 at approximately 11:45 p.m., ASM #					
	1, program manager	was made aware of the				
	above findings by tele	ephone.				
	No further information	n was provided prior to exit.				
	Reference:				4	
	(1) Refers to a group	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				
		lsy, or from nonphysical				
		of stimulation and adult				
		information was obtained				
	from the website:	nihfactsheets/ViewFactShee				
	t.aspx?csid=100.	minacisneets/ viewFactonee				
		nat causes people to have				
		ne seizures happen when				
		s, or neurons, in the brain ignals. They may have				
		is or lose consciousness.				
		obtained from the website				

https://medlineplus.gov/epilepsy.html.