PRINTED: 09/07/2020 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G011	B. WING		08/19/2020	
	ROVIDER OR SUPPLIER	.	5	STREET ADDRESS, CITY, STATE, ZIP CODE 1563 N 16TH STREET ARLINGTON, VA 22205		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 015	survey was conducted are required for completed for completed for completed for completed for persons. Subsistence Needs of CFR(s): 483.475(b) (c) [(b) Policies and procedured policies and procedured plan set forth in parasessment at parage and the communication this section. The policies and upon for LTC). At a minimal procedures must add (1) The provision of seand patients whether place, include, but are (i) Food, water, is supplies (ii) Alternate sout the following: (A) Temperation of the following: (B) Emergerand safety and for the following: (C) Fire detection and procedures for the following: (B) Emergerand safety and for the following: (C) Fire detection of the following are folicies and procedures for the following are folicies and procedures for the following are folicies and procedures for following are for following are for folicies and procedures for following are for following are for folicies for following are for folicies and procedures for folicies for following are for folicies for	cedures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of icies and procedures must lated every 2 years (annually lum, the policies and liress the following: subsistence needs for staff of they evacuate or shelter in e not limited to the following: medical and pharmaceutical rices of energy to maintain latures to protect patient health e safe and sanitary storage may lighting. lection, extinguishing, and and waste disposal. lect at §418.113(b)(6)(iii):]	E 015	to be used for emergency wasted disposal. In the unlikely occurred the public sewage system which gravity based to be off line. The emergency kit can with lid would be seen to be seen to be off line.	h lid ence of is ence	(X6) DATE
	erell Jones	Sull Cons		Clinical Director	9/14/2	

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.

Clinical Director

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		49G011	B. WING		0:	3/19/2020			
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E 015	The policies and profollowing: (iii) The provision hospice employees evacuate or shelter limited to the following (A) Food, where the preparedness pland (administration staff manager. Review of the proceed of the pr	patient care facilities only. cedures must address the on of subsistence needs for and patients, whether they in place, include, but are not ng: water, medical, and plies. te sources of energy to ng: mperatures to protect patient nd for the safe and sanitary s. nergency lighting. e detection, extinguishing, and e and waste disposal. s not met as evidenced by: rview and facility document nined that the facility staff nplete emergency The facility staff failed to tion that the emergency plan d procedures for waste and e: roximately 11:20 a.m. a review facility's emergency was conducted with ASM f member) # 2, program of the facility's emergency	E 015						

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
-		49G011	B. WING		08/19/2020
	ROVIDER OR SUPPLIER	= 1		STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 026	staff member) # 1, cliprogram manager, a QIDP [Qualified Intell Professional] # 1wer findings. No further information Roles Under a Waive CFR(s): 483.475(b)(8) [(b) Policies and procedure plan set forth in paragand the communication this section. The polibe reviewed and upd (annually for LTC).] A and procedures must (8) [(6), (6)(C)(iv), (7) [facility] under a waive in accordance with seprovision of care and care site identified by officials. *[For RNHCIs at §400 procedures. (8) The reviewed and alternative care management officials This STANDARD is repaired.	20 p.m. ASM (administrative nical director, ASM # 2, and OSM [other staff member ectual Disabilities is made aware of the in was provided prior to exit. In Declared by Secretary (a) of the emergency preparedness res, based on the emergency graph (a) of this section, and plan at paragraph (c) of cies and procedures must attend at least every 2 years at a minimum, the policies and dress the following:] (a) or (9)] The role of the er declared by the Secretary, ection 1135 of the Act, in the treatment at an alternate emergency management (3.748(b):] Policies and ole of the RNHCI under a se Secretary, in accordance act, in the provision of care site identified by emergency		While CRi does have an MOU with another agency to provide reciproservices at an alternative site, CR main source of alternative sites is within its own portfolio of ICF's a Group Homes. CRi has over 40 alternative sites in various areas Commonwealth of Virginia. This includes 12 other ICF facilities in different counties. The Emergency Response Team is contact and provides status reported the State Coordinator. This reported in the State Coordinator. This information will be inserted in the 16th Street Group Home specific Emergency and will be reviewed at the next steam meeting. The Program Marwill insure that the staff is trained this information. The Clinical Direction will review that this was accomplicating routine supervision and program visits. The CRi Risk Management Comma will review the Emergency Plan specific to N. 16th Street Group Honannual basis.	rocal distriction of the 6 s in rts to rting nation Plan house nager d on ector ished ittee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		49G011	B. WING _		0:	8/19/2020
	ROVIDER OR SUPPLIER TH STREET GRP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205	E	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 026	develop policies and emergency plan that	lete emergency The facility staff failed to procedures in the describe the facility's role in eatment at altered care sites	E 0	26		
	review of the facility's plan and interview wa (administration staff r manager. Review of preparedness plan fa policies and procedur that describe the faciliand treatment at alter	proximately 11:20 a.m. a emergency preparedness as conducted with ASM nember) # 2, program the facility's emergency iled failed to evidence res in the emergency plan lity's role in providing care red care sites under an 1135 ted, "We don't have it."				
W 000	staff member) # 1, cli program manager, a QIDP [Qualified Intell Professional] # 1wer findings.	e made aware of the	wo	000		
	Intermediate Care Fa Intellectual Disabilitie 08/19/20. The facility 42 CFR Part 483 Red	nual Medicaid survey for acilities for Persons with as (ICF/ID) was conducted on was not in compliance with quirements for Intermediate a Intellectually Disabled. The vey report will follow.				

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W 000	time of the survey. Tof three current Indivi#1, #2, and #3). QIDP CFR(s): 483.430(a) Each client's active trintegrated, coordinate qualified intellectual of This STANDARD is represented by the professional of the survey of the professional of the survey of the programs for community of the programs for c	to bed facility was six at the he survey sample consisted dual reviews, (Individuals dual professional). The professional dual dual dual dual dual dual dual du	W 06	staff on i active treativities spiritual/#2, and #2. The P staff on i treatment medication activities 4. The P staff on i document treatment for the P monthly individual document document for a quara udits and	Program Manager will retrain programs for communication in, medication management, and cultural activities for individual program Manager will retrain program Manager will retrain programs for communication on management, and spiritually for individual #3. Program Manager will retrain be implementation and the intation of all individuals' active troogram Manager will complete program audits to ensure all als' active treatment program itation is being implemented a steed accurately. Clinical Director will review/materly basis the monthly program of the individuals active treatment program itation is being implemented a steed accurately.	ng the nity d all #1, program ng active n, nd lal #2. program ng active n, cultural Program e	10/2/2020

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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W 159	Continued From pag diagnoses that includintellectual disability hypertrophy [2], and The PCP [Person Cedated 12/01/2019 the documented, "Desired Outcome: Chave the opportunity community activities Stores, Social Event week for 95% of the months by 11/30/20. Instructions: 1. [Indivito participate in his whis activities for the value of the service 10 am Sundaprovided with appropriate of the providing appropriate verbal supports) as in the service of the providing appropriate	e 5 ded but were not limited to: (1), benign prostatic vitamin D deficiency. enter Plan] for Individual # 1	W 159					
	before, during and a activity. 5. [Individual collected 1x [time] posheets. Frequency: "Desired Outcome: Oparticipate in poppin bubble pack every dime for 12 consecut Support Activities & 1. [Individual # 1] will take his medication. asked to pop the medication.	fter his community outing al # 1] will have his data er week on his data collection Weekly." Goal 2: [Individual # 1] will g his medicine from his ay for at least 90% of the tive months by 11/30/20.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	VA 355	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5563 N 16TH STREET ARLINGTON, VA 22205		0/10/2020
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 159	cup. 4. [Individual # and physical supports [Individual # 1] will be completing his medica will have his data coll pm. Frequency: Daily "Desired Outcome: Ghave the opportunity spiritual/cultural activia month for 100% of the months by 11/30/20. Instructions: 1. [Individual # 1] will flyers, pamphlets, brospiritual/cultural event 3. [Individual # 1] will chooses. 4. [Individual # 1] will chooses. 4. [Individual # 1] will be participates in his activate his data collecte Frequency: Monthly."	pp in to a large medicine will be given some verbal to pop his bubble pack. 5. given verbal praises for ation goal. 6. [Individual # 1] ected one time per day at 8 v." oal 10: [Individual # 1] will to participate and attend a ty of his choice at least once he time for 12 consecutive Support Activities & [and] dual # 1] will be asked if he a spiritual/cultural activity. be shown images (i.e. chures etc.) of different s that he can choose from. attend the activity that he al # 1] will be provided eeded during the activity. 5. given praises when he vity. 6. [Individual # 1] will d 1 [one] time per month. Illection Sheet" for Individual	W 1	59		
	# 1dated "February 20 Outcome: Goal 1: [Ind opportunity to participactivities (i.e Church, Events, Restaurants, of the time for 12 cons 11/30/20. Frequency: sheet revealed zeros of 02/20/20 through 02 the data sheet documents.	220" documented, "Desired ividual # 1] will have the ate in preferred community Shopping Stores, Social etc.) once a week for 95% ecutive months by Weekly." Review of data and blanks during the week 2/08/20. Further review of ented, "LEGEND: + = Chose not to participate.				

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	ROVIDER OR SUPPLIER	IE	55	REET ADDRESS, CITY, STATE, ZIP COD 63 N 16TH STREET RLINGTON, VA 22205	E		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 159	# 1dated "March 20 Outcome: Goal 1: [I opportunity to partic activities (i.e Church Events, Restaurants of the time for 12 cc 11/30/20. Frequenc sheet revealed zero of 03/08/20 through 03/21/20 and 03/22 review of the data s + = support provide	Collection Sheet" for Individual 20" documented, "Desired ndividual # 1] will have the sipate in preferred community n, Shopping Stores, Social s, etc.) once a week for 95% onsecutive months by cy: Weekly." Review of data so and blanks during the week 03/14/20, 03/15/20 through /20 through 03/28/20. Further theet documented, "LEGEND: d. C = Chose not to ividual not present.	W 159				
	# 1dated "May 2020 Outcome: Goal 2: [in popping his medievery day for at lea consecutive month: Daily." Review of co5/22/20, 05/23/20 of the data sheet do support provided. A = Individual not pother (not offered). The facility's "Data # 1dated "May 202 Outcome: Goal 10: opportunity to partispiritual/cultural action."	Collection Sheet" for Individual 0" documented, "Desired [Individual # 1] will have the					

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W 159	review of the data sh + = support provided participate. A = Indiv Incident. O = Other (Incident. O = Other (Incide	nrough 05/31/20. Further eet documented, "LEGEND: . C = Chose not to ridual not present. I = (not offered)." ollection Sheet" for Individual documented, "Desired dividual # 1] will participate ine from his bubble pack 190% of the time for 12 by 11/30/20. Frequency: ta sheet revealed zeros and 07/04/20, 07/05/20, 07/23/20 er review of the data sheet ND: + = support provided. C ipate. A = Individual not . O = Other (not offered)." ollection Sheet" for Individual 2020 through August 18, Desired Outcome: Goal 2: articipate in popping his bble pack every day for at 10 for 12 consecutive months noy: Daily." Review of data and blanks on 08/01/20, and 08/308/20. Further eet documented, "LEGEND: . C = Chose not to idual not present. I = (not offered)."	W 15	59				

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W 159	key [legend] because things to document of look at credible [com staff what they should I review the data collithem now monthly are problems. After review sheets for Individual community activities, and spiritual/cultural asked about the zero sheets. OSM # 1 states done." The [Name of Group QIDP" documented is responsible for training staff to ensure quality care." On 08/19/20 at 12:20 staff member) # 1, clip program manager are made aware of the fill No further information. References: [1] Refers to a group by a limited mental contact adaptive behaviors as schedules and routing Intellectual disability 18 and may result from autism or cerebral pacauses, such as lack	ment on what not to a reconsidering changing the a people are missing key in data sheet. I go back and puterized notes] and advise d have put on the data sheet. action quarterly, I am doing and filing them and addressing awing the data collection #1's active treatment for medication management activities, OSM # 1 was as and blanks on the data atted, "It looks like it's not Home's] document "Lead in part, "The lead QIDP is ang, mentoring, oversight of ay services and continuity of D. p.m. ASM (administrative inical director, ASM # 2, and OSM # 1, QIDP were	W 159			

ND PLAN OF CORRECTION IDENTIFICATION		900 10000000000000000000000000000000000			TE SURVEY MPLETED
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from the website: https://www.report.nih ctSheet.aspx?csid=10 [2] An enlarged prosts obtained from the we https://www.nlm.nih.g statebph.html. 2. The QIDP failed to programs for commun medication managem activities for Individual Individual # 2 was a 5 admitted to [Name of diagnoses that include moderate intellectual palsy [2], seizures [3]. The PCP [Person Cer dated 12/01/2019 thro documented, "Desired Outcome: Gr improve her communi vocalizations when pr 50% of the time for 12 11/30/20. Support Ac 1. [Individual # 2] will vocalizations that ava use. 2. [Individual # 2 to vocally respond wh questions. 3. [Individual prompted by staff sing and response structure	ate. This information was besite: ov/medlineplus/enlargedpro ensure the active treatment nication, recreation, ent and spiritual/cultural I # 2 were implemented. 9 year old female, who was Group Home] with ed but were not limited to: disability [1], mild cerebral and anxiety [4]. Inter Plan] for Individual # 2 ough 11/30/2020 Inter Plan] for Individual # 2 will cation with appropriate compted by staff at least the consecutive months by tivities & [and] Instructions: the prompted to use illable and comfortable to asked yes or no use # 2] will be verbally prompted en asked yes or no use # 2] will be verbally in singing when verbally ing the songs that have call es. 4. [Individual # 2] will	W 159			
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page from the website: https://www.report.nih.ctSheet.aspx?csid=10 [2] An enlarged prosta obtained from the web https://www.nlm.nih.g statebph.html. 2. The QIDP failed to programs for commur medication managem activities for Individual Individual # 2 was a 5 admitted to [Name of diagnoses that include moderate intellectual palsy [2], seizures [3], The PCP [Person Cerdated 12/01/2019 throdocumented, "Desired Outcome: Grimprove her communi vocalizations when promoted of the time for 12 11/30/20. Support Act 1. [Individual # 2] will vocalizations that avaiuse. 2. [Individual # 2] to vocally respond who questions. 3. [Individual prompted by staff sing and response structur receive verbal praise for the support of the structur receive verbal praise for the support of the	A9G011 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 [2] An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. 2. The QIDP failed to ensure the active treatment programs for communication, recreation, medication management and spiritual/cultural activities for Individual # 2 were implemented. Individual # 2 was a 59 year old female, who was admitted to [Name of Group Home] with diagnoses that included but were not limited to: moderate intellectual disability [1], mild cerebral palsy [2], seizures [3], and anxiety [4]. The PCP [Person Center Plan] for Individual # 2 dated 12/01/2019 through 11/30/2020	ROVIDER OR SUPPLIER STH STREET GRP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 [2] An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. 2. The QIDP failed to ensure the active treatment programs for communication, recreation, medication management and spiritual/cultural activities for Individual # 2 were implemented. Individual # 2 was a 59 year old female, who was admitted to [Name of Group Home] with diagnoses that included but were not limited to: moderate intellectual disability [1], mild cerebral palsy [2], seizures [3], and anxiety [4]. The PCP [Person Center Plan] for Individual # 2 dated 12/01/2019 through 11/30/2020 documented, "Desired Outcome: Goal 1: [Individual # 2] will improve her communication with appropriate vocalizations when prompted by staff at least 50% of the time for 12 consecutive months by 11/30/20. Support Activities & [and] Instructions: 1. [Individual # 2] will be prompted to use vocalizations that available and comfortable to use. 2. [Individual # 2] will be verbally prompted to respond in singing when verbally prompted to respond when sked yes or no questions. 3. [Individual # 2] will receive verbal praise for her participation when	ROVIDER OR SUPPLIER STH STREET GRP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 22 An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. 2. The QIDP failed to ensure the active treatment programs for communication, recreation, medication management and spiritual/cultural activities for Individual # 2 were implemented. Individual # 2 was a 59 year old female, who was admitted to [Name of Group Home] with diagnoses that included but were not limited to: moderate intellectual disability [1], mild cerebral palsy [2], seizures [3], and anxiety [4]. The PCP [Person Center Plan] for Individual # 2 dated 12/01/2019 through 11/30/2020 docoumented, "Desired Outcome: Goal 1: [Individual # 2] will improve her communication with appropriate vocalizations when prompted by staff at least 50% of the time for 12 consecutive months by 11/30/20. Support Activities & [and] Instructions: 1. [Individual # 2] will be verbally prompted to use vocalizations that available and comfortable to use vocalizations that available and comfortable to use vocalizations that available and comfortable to use vocalizations that proper in the verbally prompted by staff singing when verbally prompted to respond in singing when verbally prompted by staff singing when verbally prompted by staff singing when verbally prompted to respond is singing when verbally prompted to verball praise for her participation when	A BUILDING B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE STATESTREET GRP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 from the website: https://www.report.nih.gov/NIHfactsheets/ViewFa ctSheet.aspx/csid=100 [2] An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedpro statebph.html. Continued From page 10 from the website: https://www.nlm.nih.gov/medlineplus/enlargedpro statebph.html Individual # 2 was a 59 year old female, who was admitted to [Name of Group Home] with diagnoses that included but were not limited to: moderate intellectual disability [1], mild cerebral palsy [2], seizures [3], and anxiety [4]. The PCP [Person Center Plan] for Individual # 2 will improve her communication with appropriate vocalizations when prompted by staff at least 50% of the time for 12 consecutive months by 11/30/20. Support Activities & [and] instructions: 1. [Individual # 2] will be verbally prompted to vocally respond when asked yes or no questions. 3. [Individual # 2] will be verbally prompted by staff singing the songs that have call and response structures. 4. [Individual # 2] will receive verbal praise for her participation when

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
W 159	5. [Individual # 2] will [time] per day at 7 pm Daily." "Desired Outcome: If OUTCOME(s): MULT active engagement a stimulating her sense exhibit Disruptive Outdecrease signs/symp Cerebral Palsy, Inter mood disorder, Anxie quality and quantity integrity-to decrease therapy] services." So Instructions: Goal: [In multi-sensory activitiper week (8-15 times and/or community. If "Desired Outcome: Outling a straw after reasonable of the time for 11/30/20. Support A 1. When it is time for 11/30/20. Support A 1. When it is time for 11/30/20 in the medical water or juice bottle) water or juice bottle) verbally prompted to digest her medicatio given verbal praises medication intake ar	have his data collected 1x in [7:00 p.m.]. Frequency: RECREATION FI-SENSORY: to increase and effective learning through as; to decrease her need to a tours. GROSS MOTOR: to botoms/complications of Mild anittent Explosive Disorder, and to increase of sleep - to increase skin need for PT [physical Support Activities & [and] andividual # 2] participates in a serior 2-5 minutes, 2-3 times as per month in her home are requency: Twice a week." Goal 3: [Individual # 2] will neer and drink her liquids are eciving medications daily for 12 consecutive months by activities & [and] Instructions: ther medication [Individual # both and physically cation room. 2. [Individual # both hands (i.e. cup, and in both hands (i.e. cup, and in both hands (i.e. cup, and in a straw to be do drink all of liquids to help ans. 4. [Individual # 2] will be	W 15	59	
	[time] per day at 8 p	m [8:00 p.m.]. Frequency:			

Event ID: 549Z11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CALCULATION NUMBERS (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING _			08/19/2020	
	PROVIDER OR SUPPLIER 6TH STREET GRP HO	ME		STREET ADDRESS, CITY, STATE, ZIP 5563 N 16TH STREET ARLINGTON, VA 22205		00/13/2320	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACCORDER TO CROSS-REFERENCED TO DEFICIEN	OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
W 159	"Desired Outcome: have the opportunispiritual/cultural aconce a month for 1 consecutive month Activities & [and] In will be asked if she spiritual/cultural acishown images (i.e. etc.) of different spican choose from. It is the activity that she will be provided supduring the activity. praises when he paralled [Individual # 2] will time per month. From The facility's "Data # 2 dated "February Outcome: Goal 1: [communication with when prompted by for 12 consecutive Frequency: Daily." zeros and blanks of and 02/15/20. Furt documented, "LEG = Chose not to paralled present. I = Incident The facility's "Data # 2 dated "February Outcome: Goal 2: [supported by staff with the prompted by the promp	age 12 : Goal 10: [Individual # 2] will ity to participate and attend a stivity of her choice at least 100% of the time for 12 is by 11/30/20. Support instructions: 1. [Individual # 2] will be wants to participate in a stivity. 2. [Individual # 2] will be instructions: 1. [Individual # 2] will be instructions: 1. [Individual # 2] will be instructions: 1. [Individual # 2] will attend e chooses. 4. [Individual # 2] piports by staff as needed 5. [Individual # 2] will be given articipates in his activity. 6. have his data collected 1 [one] requency: Monthly." Collection Sheet" for Individual by 2020" documented, "Desired [Individual # 2] will improve her thappropriate vocalizations is staff at least 50% of the time months by 11/30/20. Review of data sheet revealed on 02/01/20, 02/06/20, 02/14/20 of the review of the data sheet send in the control of the interview of the data sheet send into 0 = Other (not offered)." Collection Sheet" for Individual py 2020" documented, "Desired [Individual # 2] will be with following her Recreational weekly for 25% of the time for inths. Frequency: Twice a data sheet revealed zeros and week of 02/16/20 through	W 1	59			

PRINTED: 09/07/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 49G011 B. WING 08/19/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5563 N 16TH STREET** NORTH 16TH STREET GRP HOME ARLINGTON, VA 22205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

W 159 Continued From page 13 W 159 02/22/20 and 02/23/20 through 02/29/20. Further review of the data sheet documented, "LEGEND: + = support provided. C = Chose not to participate. A = Individual not present. I = Incident. O = Other (not offered)." The facility's "Data Collection Sheet" for Individual # 2 dated "February 2020" documented, "Desired Outcome: Goal 3: [Individual # 2] will hold her drink container and drink her liquids using a straw after receiving medications daily for 100% of the time for 12 consecutive months by 11/30/20. Frequency: Daily." Review of data sheet revealed zeros and blanks on 02/06/20 and 02/09/20. Further review of the data sheet documented, "LEGEND: + = support provided. C = Chose not to participate. A = Individual not present. I = Incident. O = Other (not offered)." The facility's "Data Collection Sheet" for Individual # 1dated "February, May, June and July 2020" documented, "Desired Outcome: Goal 10: [Individual # 1] will have the opportunity to participate and attend a spiritual/cultural activity of his choice at least once a month for 100% of the time for 12 consecutive months by 11/30/20. Frequency: 1 Time Per Month." Review of data sheet revealed zeros and blanks on 02/01/20 through 02/29/20, 05/01/20 through 05/31/20, 06/01/20 through 06/30/20 and 07/01/20 through 07/31/20. Further review of the data sheet documented, "LEGEND: + = support provided. C = Chose not to participate. A = Individual not present. I = Incident. O = Other (not offered)." The facility's "Data Collection Sheet" for Individual

2 dated "March 2020" documented, "Desired Outcome: Goal 1: [Individual # 2] will improve her communication with appropriate vocalizations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		JULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING			08/19/2020	
	ROVIDER OR SUPPLIER 6TH STREET GRP HOME	Ē		STREET ADDRESS, CITY, STATE, ZIP C 5563 N 16TH STREET ARLINGTON, VA 22205	ODE		
(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 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 159	when prompted by st for 12 consecutive merequency: Daily." Rezeros and blanks on 03/09/20, 03/10/20, 03/16/20, 03/16/20, 03/17/20, 03/16/20, 03/17/20, 03/16/20, 03/17/20, 03/16/20, 03/17/20, 03/16/20, 03/17/20, 03/16/20, 03/17/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/16/20, 03/11/20, 03/18/2 data sheet document provided. C = Chose	taff at least 50% of the time fronths by 11/30/20. Review of data sheet revealed 03/01/20, 03/06/20, 03/12/20, 02/14/20, 03/15/20, 03/21/20 and 03/29/20. It data sheet documented, ort provided. C = Chose not adividual not present. I = (not offered)." Collection Sheet" for Individual 20" documented, "Desired adividual # 2] will be at following her Recreational eackly for 25% of the time for the sheet revealed zeros and the of 03/08/20 through 03/28/20. Further leet documented, "LEGEND: I. C = Chose not to vidual not present. I = (not offered)."	W 18	59			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G011 B. WIN			08/19/2020	
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CROSS		O BE COMPLETION			
W 159	# 2 dated "July 2020' Outcome: Goal 1: [Incommunication with a when prompted by st for 12 consecutive merequency: Daily." Regress and blanks on the data sheet docum support provided. Cea = Individual not preout the conducted with the Communication of the conducted with the Composition of the condu	ollection Sheet" for Individual documented, "Desired dividual # 2] will improve her appropriate vocalizations aff at least 50% of the time onths by 11/30/20. Review of data sheet revealed 07/24/20. Further review of mented, "LEGEND: + = = Chose not to participate. Sent. I = Incident. O = a.m., an interview was alDP [Qualified Intellectual mal]. When asked to ibility of the QIDP, OSM # 1 le for training and developing go over plans and data with ment on what not to be reconsidering changing the expeple are missing key in data sheet. I go back and puterized notes] and advise do have put on the data sheet. Rection quarterly, I am doing and filing them and addressing exwing the data collection #2's active treatment for reation, medication ritual/cultural activities, OSM the zeros and blanks on the 1 stated, "It looks like it's not p.m. ASM (administrative nical director, ASM # 2, d OSM # 1, QIDP were	W 159			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		49G011	B. WING			08/19/2020		
	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
W 159	References: [1] Refers to a group by a limited mental candaptive behaviors and routin Intellectual disability 18 and may result from the website: https://www.report.nilctSheet.aspx?csid=1 [2] A group of disorder ability to move and to posture. This informative website: https://www.nlm.nih.gy.html. [3] Symptoms of a brabecause of sudden, at the brain. This informative website: https://www.nlm.nih.gy.html. [4] Fear. This informative website: https://www.nlm.nih.gy.html. [5] Fear. This informative website: https://www.nlm.nih.gy.html.	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	W 159					
	programs for commun	ensure the active treatment nication, medication ritual/cultural activities for						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING		08/19/20	020	
	ROVIDER OR SUPPLIER	DME		STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OULD BE COM	(X5) MPLETION DATE	
W 159	admitted to [Nam diagnoses that in profound intellect [2] PICA [3], microgastroesophagea. The PCP [Person dated 12/01/2019 documented, "Desired Outcomneeds and wants Activities & [and] will use his commwhen prompted beday at least 100% months by 09/30/months by 09/30/m	e implemented. a 58 year old male, who was a of Group Home] with cluded but were not limited to: all disability [1], autistic disorder ocephaly (4), fear, and I reflux disease [5]. Center Plan] for Individual # 3 through 11/30/2020 e: I want to communicate my to others effectively. Support Instructions: 1. [Individual # 3] aunication program on his iPad y his staff daily for 15 minutes a of the time for 3 consecutive 2020. Frequency: Daily." e: I will pour my Benefiber of water and mix it every ning. Support Activities & [and] advidual # 3] will walk to the when notified by staff that it is norning or evening medications. Its Benefiber will be measured appropriate dose of Benefiber aff will provide 6-8oz [six to eight and then hand over the dividual # 3]. 3. [Individual # 3] uctions by staff on how to pour om the medication cup into aff will provide supervision and eded. 4. [Individual # 3] will use e powder into the water. Staff all directions and hand over hand	W 15				
	will provide verba	\$ • • · · · · · · · · · · · · · · · · ·					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.0	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G011	B. WING _			0	8/19/2020	
	PROVIDER OR SUPPLIER 6TH STREET GRP HOME	E	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205			0,10,20	
(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 CORRECTIC EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
W 159	medication (Benefiber stirs the medication. praised by staff if he [Individual # 3] progres Credible by staff. 8. independently obtain "Desired Outcome: [a religious activity. SInstructions: 1. [Indivireligious activity by grain a religious activity by grain a religious activity for the time for 12 consections of the time for 12 consection	er) into 6-8 oz of fluid and 6. [Individual # 3] will be participates in the goal. 7. ess will be documented in [Individual # 3] is able to in this goal. Frequency: Daily." [Individual # 3] will engage in [Support Activities & [and] [individual # 3] will engage in a going to church or engaging in in 30 minutes at least 75% of ecutive months by indual # 3] will be asked what inould like to explore. 2. The presented options that can be presented options that can control to spiritual care, nature g. 3. [Individual # 3] will be support to accomplish this is 3] will meet this goal when the severy five minutes to keep inctivity. 5. [Individual # 3] will the at the completion of Successful completion will redible. 7. This goal will be # 3] is able to independently	W 1	59				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G011 B. WING			08/19/	08/19/2020	
	ROVIDER OR SUPPLIER	/E	55	REET ADDRESS, CITY, STATE, ZIP CODE 63 N 16TH STREET RLINGTON, VA 22205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 159	through 05/31/20, 08/01/20 through 05/31/20, 08/01/20 through 05/31/20, 08/01/20 through 05/31/20, 08/01/20 through 05/31/20, 04/01/20	through 04/30/20, o5/01/20 16/01/20 through 06/30/20 and 18/18/20. Further review of the Inted, "LEGEND: + = support is enot to participate. A = Int. I = Incident. O = Other Collection Sheet" for Individual Inted, March, April, May, June and Inted, Support Activities & I. [Individual # 3] will engage in any going to church or engaging by for 30 minutes at least 75% consecutive months by ency: Weekly." Review of the zeros and blanks from 12/29/20, 03/01/20 through 16/01/20 through 06/30/20 and	W 159				
	# 3 dated "February documented, Supp Instructions: I will pa cup of water and evening. Frequency revealed zeros and 05/14/20, 05/18/20 through 07/04/20 at 08/08/20. On 08/19/20 at 11:: conducted with the Disabilities Profess describe the responstated, I'm response	Collection Sheet" for Individual y, May, July and August 2020" port Activities & [and] our my Benefiber powder into mix it every morning and y: Daily." Review of data sheet blanks on 02/17/20, 05/01/20, through 05/31/20, 07/03/20 and 08/01/02, 08/02/20 and 20 a.m., an interview was QIDP [Qualified Intellectual ional]. When asked to nsibility of the QIDP, OSM # 1 ible for training and developing off, go over plans and data with					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G011	B. WING			8/19/2020	
	ROVIDER OR SUPPLIER 6TH STREET GRP HOME	•		STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 159	key [legend] because things to document o look at credible [comp staff what they should I review the data colle them now monthly ar problems. After revies sheets for Individual a communication, medispiritual/cultural active about the zeros and the OSM # 1 stated, "It looks of the collection of the firm of the collection of the firm of the collection of	ment on what not to e reconsidering changing the e people are missing key n data sheet. I go back and puterized notes] and advise d have put on the data sheet. ection quarterly, I am doing d filing them and addressing ewing the data collection #3's active treatment for ication management and tities, OSM # 1 was asked blanks on the data sheets. locks like it's not done." p.m. ASM (administrative mical director, ASM # 2, d OSM # 1, QIDP were lidings. In was provided prior to exit. In was provided prior to exit. In of disorders characterized lipacity and difficulty with lich as managing money, les, or social interactions. In or social interactions. In or from nonphysical lof stimulation and adult of stimulation and adult information was obtained I developmental disorder	W 159				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING		08/19/2020	
	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 563 N 16TH STREET ARLINGTON, VA 22205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
W 159	throughout a person' acts and interacts with and learns.) This information the website: https://www.nlm.nih.grumdisorder.html. (3) A pattern of eating as dirt or paper. This from the website: https://medlineplus.gg. (4) A condition in whomuch smaller than the and sex. This information website: https://medlineplus.gg. (5) Stomach content the esophagus and in was obtained from the https://www.nlm.nih. PROGRAM IMPLEM CFR(s): 483.440(d)(). As soon as the interest formulated a client's each client must recurrent treatment program of interventions and seand frequency to supplicatives identified plan.	s life. It affects how a person th others, communicates, ormation was obtained from gov/medlineplus/autismspect g non-food materials, such s information was obtained ov/ency/article/001538.htm. sich a person's head size is nat of others of the same age nation was obtained from the gov/ency/article/003272.htm. s to leak back, or reflux, into rritate it. This information he website: gov/medlineplus/gerd.html. MENTATION 1) disciplinary team has individual program plan, eive a continuous active consisting of needed rvices in sufficient number opport the achievement of the in the individual program	W 159	 The Program Manager will retrain staff on implementing and documenting active treatment programs for communactivities, medication management, an spiritual/cultural activities for individu#2, and #3. The Program Manager will retrain staff on implementing and documenting treatment programs for communication recreation, medication management, a spiritual/cultural activities for individus. The Program Manager will retrain staff on implementing and documenting treatment programs for communication medication management, and spiritual activities for individual #3. The Program Manager will retrain staff on the implementation and documentation and individuals' active treatment proper their ISP. The Program Manager will complementally program audits to ensure all individuals' active treatment program done and the documentation is being implemented appropriately. The Clinical Director will review/ron a quarterly basis the monthly program docume implementation and program docume 	ng the nity d last #1, program ng active n, nd last #2. program ng active n, //cultural Program mentation ngrams ete are being monitor ram audits atment	
		not met as evidenced by: on, facility document review				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		49G011	49G011 B. WING			08/1	19/2020
	ROVIDER OR SUPPLIER TH STREET GRP HON	1E		STREET ADDRESS, CITY, STATE, ZIP CO 5563 N 16TH STREET ARLINGTON, VA 22205	DDE		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
W 249	facility staff failed to treatment program individuals in the sure 2, and # 3. 1. The facility staff Individual # 1's active community activities and spiritual/cultura. 2. The facility staff Individual # 2's active communication, recommunication, recommunication, mespiritual/cultural activities and spiritual/cultural activities and spiritual/cultural activities and spiritual/cultural Individual # 1's active community activities and spiritual/cultural Individual # 1 was a admitted to [Name of diagnoses that incluintellectual disability hypertrophy [2], and The PCP [Person Codated 12/01/2019 the documented, "Desired Outcome: 6	t was determined that the implement the active for three of three individuals rvey sample, Individuals # 1, failed to implement for retreatment program for set treatment program for reation, medication poiritual/cultural activities. failed to implement Individual interprogram for dication management and vities. failed to implement Individual interprogram for dication management and vities. failed to implement for retreatment program for dication management and vities. failed to implement for retreatment program for set medication management activities 75 year old male, who was of Group Home] with ded but were not limited to: (1), benign prostatic vitamin D deficiency.	W2	249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G011 B. WING			0	8/19/2020	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 249	Stores, Social Events week for 95% of the months by 11/30/20. Instructions: 1. [Indivito participate in his whis activities for the vill will be supported it activity on the white service 10 am Sunda provided with appropriate verbal supports) as rivill receive verbal probefore, during and at activity. 5. [Individual collected 1x [time] pesheets. Frequency: "Desired Outcome: Oparticipate in popping bubble pack every ditime for 12 consecut Support Activities & 1. [Individual # 1] will take his medication. asked to pop the meshed	(i.e Church, Shopping s, Restaurants, etc.) once a time for 12 consecutive Support Activities & [and] idual # 1] will be encouraged weekly house meeting to plan week ahead. 2. [Individual # n putting his preferred calendar board (i.e church ay). 3. [Individual # 1] will be wriate support by staff (i.e. uting of his choice, and ematerials/resources and needed. 4. [Individual # 1] aises and encouragement for his community outing all # 1] will have his data er week on his data collection Weekly." Goal 2: [Individual # 1] will g his medicine from his ay for at least 90% of the ive months by 11/30/20. [and] Instructions: I be reminded that it is time to 2. [Individual # 1] will be dicine from his bubble pack. I be shown exactly which toop in to a large medicine 1] will be given some verbal as to pop his bubble pack. 5. e given verbal praises for cation goal. 6. [Individual # 1] llected one time per day at 8	W 249				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		49G011	B. WING			08/19/2020	
	ROVIDER OR SUPPLIER 6TH STREET GRP HOMI			STREET ADDRESS, CITY, STATE, ZIP (5563 N 16TH STREET ARLINGTON, VA 22205	CODE	00/13/2020	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 249	spiritual/cultural actival a month for 100% of months by 11/30/20. Instructions: 1. [Individual stoparticipate in 2. [Individual # 1] will flyers, pamphlets, brospiritual/cultural even 3. [Individual # 1] will chooses. 4. [Individual # 1] will chooses. 4. [Individual supports by staff as in [Individual # 1] will be participates in his act have his data collecte Frequency: Monthly." The facility's "Data Collecte Frequency: Monthly."	to participate and attend a ity of his choice at least once the time for 12 consecutive Support Activities & [and] dual # 1] will be asked if he in a spiritual/cultural activity, be shown images (i.e. ochures etc.) of different its that he can choose from, attend the activity that he all # 1] will be provided eeded during the activity. 5. igiven praises when he ivity. 6. [Individual # 1] will ed 1 [one] time per month. Dilection Sheet" for Individual 200" documented, "Desired dividual # 1] will have the ate in preferred community Shopping Stores, Social etc.) once a week for 95% secutive months by weekly." Review of data and blanks during the week 2/08/20. Further review of ented, "LEGEND: + = Chose not to participate. Sent. I = Incident. O =	W 249				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI	(X3) DATE SURVEY COMPLETED		
		49G011	B. WING		08/19/2020	0
	ROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ARREST TO THE ADDROUGH AT		(5) LETION ATE
W 249	11/30/20. Frequentsheet revealed zerof 03/08/20 throug 03/21/20 and 03/2 review of the data + = support provided participate. A = In Incident. O = Oth The facility's "Data # 1dated "May 20 Outcome: Goal 2: in popping his me every day for at le consecutive mont Daily." Review of 05/22/20, 05/23/2 of the data sheet support provided. A = Individual not Other (not offered The facility's "Data # 1dated "May 20 Outcome: Goal 10 opportunity to par spiritual/cultural a a month for 100% months by 11/30/2 Month." Review of blanks on 05/01/2 review of the data + = support provided has no 05/01/2 review of the data + = s	ncy: Weekly." Review of data ros and blanks during the week th 03/14/20, 03/15/20 through 2/20 through 03/28/20. Further sheet documented, "LEGEND: led. C = Chose not to dividual not present. I = er (not offered)." a Collection Sheet" for Individual 20" documented, "Desired [Individual # 1] will participate dicine from his bubble pack ast 90% of the time for 12 hs by 11/30/20. Frequency: data sheet revealed zeros on 0 and 05/23/20. Further review documented, "LEGEND: + = C = Chose not to participate. present. I = Incident. O =)." a Collection Sheet" for Individual 20" documented, "Desired 0: [Individual # 1] will have the ticipate and attend a ctivity of his choice at least once of the time for 12 consecutive 20. Frequency: 1 Time Per of data sheet revealed zeros and 20 through 05/31/20. Further a sheet documented, "LEGEND: ded. C = Chose not to ndividual not present. I =	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TA VENEZATIVA PRESIDENT	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		49G011	B. WING _			08/19/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 249	every day for at least consecutive months is Daily." Review of data blanks on 07/03/20, Cand 07/31/20. Further documented, "LEGEN = Chose not to participresent. I = Incident. The facility's "Data Cottle # 1dated "August 01, 2020" documented, "I [Individual # 1] will participate from his bull least 90% of the time by 11/30/20. Frequer sheet revealed zeros 08/02/20, 08/07/20 ar review of the data she + = support provided. participate. A = Individent. O = Other (On 08/19/20 at 11:20 conducted with ASM member] # 2, program staff member] QIDP [Disabilities Profession data collection sheets treatment for communication of the data sheet s	ne from his bubble pack 90% of the time for 12 by 11/30/20. Frequency: as sheet revealed zeros and 17/04/20, 07/05/20, 07/23/20 be review of the data sheet ND: + = support provided. C 15 pate. A = Individual not O = Other (not offered)." 16 pollection Sheet" for Individual 17/04/20, 07/05/20, 07/23/20 18 pate. A = Individual not O = Other (not offered)." 18 pollection Sheet" for Individual 18 pollection Sheet" for Individual 19 pate. A = Individual not 19 pate. A = Individual not 19 pate. A = Individual not 19 pate. A = Individual 19 pate. A = Indivi	W 2	49		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		49G011	B. WING			08/	19/2020
	ROVIDER OR SUPPLIER			556	REET ADDRESS, CITY, STATE, ZIP CODE 63 N 16TH STREET LLINGTON, VA 22205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1098	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 249	ISP Implementation a Implementation of the its development. Co fully implemented, wi support, learning envengagement necession objectives/desired out ISPAll staff working fully engaged in active consumer." On 08/19/20 at 12:20 staff member) # 1, cl program manager armade aware of the fill No further information. References: [1] Refers to a group by a limited mental or adaptive behaviors a schedules and routing Intellectual disability 18 and may result from autism or cerebral parauses, such as lack responsiveness. The from the website: https://www.report.nictSheet.aspx?csid=1	Home's] policy "4.1 an (ISP)" documented, "G. and Consumer Engagement: e ISP begins at the time of imponents of the plan are the consumer receiving the rironment and active any to reach his or her intcomes as defined in the g with consumers must be re treatment with the In p.m. ASM (administrative inical director, ASM # 2, and OSM # 1, QIDP were andings. In was provided prior to exit. In disorders characterized apacity and difficulty with uch as managing money, es, or social interactions. In originates before the age of imphysical causes, such as alsy, or from nonphysical and of stimulation and adult as information was obtained In this information was In the consumers must be and	W	249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING			8/19/2020	
	ROVIDER OR SUPPLIER TH STREET GRP HOME			STREET ADDRESS, CITY, STATE, ZIP C 5563 N 16TH STREET ARLINGTON, VA 22205		0/13/2020	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 249	communication, recre	illed to implement for treatment program for eation, medication	W 249				
	Individual # 2 was a sadmitted to [Name of diagnoses that includ moderate intellectual palsy [2], seizures [3] The PCP [Person Cedated 12/01/2019 throdocumented, "Desired Outcome: Gimprove her communivocalizations when promoted to support Actional formula was a community of the time for 12 11/30/20. Support Actions 1. [Individual # 2] will vocalizations that availies was a community of the time for 12 11/30/20. Support Actional formula was a community of the time for 12 11/30/20. Support Actional for the time for 12 11/30/20. Support A	ed but were not limited to: disability [1], mild cerebral , and anxiety [4]. Inter Plan] for Individual # 2 bugh 11/30/2020 oal 1: [Individual # 2] will ication with appropriate compted by staff at least 2 consecutive months by tivities & [and] Instructions: be prompted to use ilable and comfortable to 2] will be verbally prompted en asked yes or no ual # 2] will be verbally in singing when verbally ging the songs that have call res. 4. [Individual # 2] will for her participation when a safe and healthy manner. have his data collected 1x [7:00 p.m.]. Frequency:					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG		COMPLETED	
		49G011	B. WING _		08	3/19/2020	
	ROVIDER OR SUPPLIER	E	STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205		DE		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
W 249	Cerebral Palsy, Inte mood disorder, Anxi quality and quantity integrity-to decrease therapy] services." Instructions: Goal: [I multi-sensory activit per week (8-15 time and/or community. "Desired Outcome: hold her drink conta using a straw after r 100% of the time for 11/30/20. Support A 1. When it is time for 2] will be verbally prassisted to the med 2] will be given her hold tightly [sic] grip water or juice bottle verbally prompted to digest her medicating given verbal praises medication intake a [Individual # 2] will be [time] per day at 8 p Daily." "Desired Outcome: have the opportunit spiritual/cultural activities."	ptoms/complications of Mild rmittent Explosive Disorder, ety disorder and to increase of sleep - to increase skin e need for PT [physical Support Activities & [and] ndividual # 2] participates in ites for 2-5 minutes, 2-3 times is per month in her home Frequency: Twice a week." Goal 3: [Individual # 2] will iner and drink her liquids eceiving medications daily for a 12 consecutive months by activities & [and] Instructions: In her medication [Individual # 2] will iner and physically iteration room. 2. [Individual # 2] will increase and physically iteration room. 2. [Individual # 2] will be a drink container with a straw to need in both hands (i.e. cup, and in both hands (i.e. cup, be of drink all of liquids to help ons. 4. [Individual # 2] will be a for completing her and holding her cup. 5. In ave his data collected 1x orm [8:00 p.m.]. Frequency: Goal 10: [Individual # 2] will y to participate and attend a ivity of her choice at least	W2	249			
	consecutive months Activities & [and] In will be asked if she spiritual/cultural act	20% of the time for 12 s by 11/30/20. Support structions: 1. [Individual # 2] wants to participate in a ivity. 2. [Individual # 2] will be flyers, pamphlets, brochures					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	49G011	B. WING				08/19/2020	
NAME OF PROVIDER OR SUPPLIER NORTH 16TH STREET GRP HOME		•	5563 N	T ADDRESS, CITY, STATE, ZIP CODE 16TH STREET IGTON, VA 22205			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
can choose from. 3. the activity that she convilled by provided supportion during the activity. 5. praises when he particularly a will have been month. From the facility's "Data Compart of the facility of t	ual/cultural events that he [Individual # 2] will attend hooses. 4. [Individual # 2] orts by staff as needed. [Individual # 2] will be given icipates in his activity. 6. ave his data collected 1 [one] quency: Monthly." collection Sheet" for Individual 2020" documented, "Desired dividual # 2] will improve her appropriate vocalizations aff at least 50% of the time onths by 11/30/20. eview of data sheet revealed 22/01/20, 02/06/20, 02/14/20 or review of the data sheet ND: + = support provided. Collection Sheet" for Individual 2020" documented, "Desired dividual # 2] will be the following her Recreational ekly for 25% of the time for as. Frequency: Twice a sta sheet revealed zeros and ek of 02/16/20 through 00 through 02/29/20. Further event documented, "LEGEND: C = Chose not to idual not present. I = not offered)."	W	249				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING		0	8/19/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 5563 N 16TH STREET ARLINGTON, VA 22205	Ε		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 249	using a straw after re 100% of the time for 11/30/20. Frequency sheet revealed zeros 02/09/20. Further redocumented, "LEGE! = Chose not to participate and attention of the facility's "Data C# 1dated "February, documented, "Desire [Individual # 1] will haparticipate and attentis choice at least or time for 12 consecutive frequency: 1 Time Psheet revealed zeros through 02/29/20, 05 06/01/20 through 06/07/31/20. Further redocumented, "LEGE = Chose not to participate and attention and to participate and attention and to participate and to participate and attention and to participat	ner and drink her liquids receiving medications daily for 12 consecutive months by 2 cally." Review of data and blanks on 02/06/20 and view of the data sheet ND: + = support provided. C ipate. A = Individual not and July 2020" and Outcome: Goal 10: ave the opportunity to a spiritual/cultural activity of a spiritual/cultural activity of a months by 11/30/20. Fer Month." Review of data and blanks on 02/01/20 through 05/31/20, 1/30/20 and 07/01/20 through 05/31/20, 1/30/20 and 07/01/20 through view of the data sheet ND: + = support provided. C sipate. A = Individual not and to 0 = Other (not offered)." Follection Sheet" for Individual 20" documented, "Desired addividual # 2] will improve her appropriate vocalizations taff at least 50% of the time nonths by 11/30/20. Review of data sheet revealed	W 2	49			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING			08/19/2020	
	ROVIDER OR SUPPLIER TH STREET GRP HOME			STREET ADDRESS, CITY, STATE, ZIP OF STATE, Z		3,10,2020	
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 249	# 2 dated "March 202 Outcome: Goal 2: [Insupported by staff with Therapy Activities we 12 consecutive month week." Review of da blanks during the we 03/14/20 and 03/22/2 review of the data shehe = support provided. participate. A = Indiv Incident. O = Other (The facility's "Data Comparticipate. A = Indiv Incident. O = Other (The facility's "Data Comparticipate. A = Indiv Incident. O = Other (The facility's "Data Comparticipate. A = Indiv Incident. O = Other (The facility's "Data Comparticipate. A = Indiv Incident. O = Other (The facility's "Data Compart Incident. O = Other (The facility and 03/18/2 data sheet document provided. C = Chose Individual not present (not offered)." The facility's "Data Comparticipate." The facility's "Data Comparticipate." Incommunication with a when prompted by stafor 12 consecutive modern prompted promp	collection Sheet" for Individual co" documented, "Desired dividual # 2] will be the following her Recreational ekly for 25% of the time forms. Frequency: Twice a ta sheet revealed zeros and ek of 03/08/20 through 0 through 03/28/20. Further eet documented, "LEGEND: C = Chose not to idual not present. I = not offered)." Collection Sheet" for Individual co" documented, and 3: [Individual # 2] will there and drink her liquids ceiving medications daily for 12 consecutive months by collections. Review of data and blanks on 03/01/20,	W 2	49			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49G011	B. WING			08/19/2020
	ROVIDER OR SUPPLIER TH STREET GRP HOME	:		STREET ADDRESS, CITY, STATE, ZIP CO 5563 N 16TH STREET ARLINGTON, VA 22205	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 249	A = Individual not pre Other (not offered)." On 08/19/20 at 11:20 conducted with ASM member] # 2, prograr staff member] QIDP Disabilities Professio data collection sheets treatment for commu medication managen activities, ASM # 2 at about the zeros and ASM # 2 stated that a program was not offel legend on the data castated, "It looks like in On 08/19/20 at 12:20 staff member) # 1, cl program manager ar made aware of the fil No further information References: [1] Refers to a group by a limited mental castated and routing Intellectual disability 18 and may result fro autism or cerebral par causes, such as lack responsiveness. The from the website:	a.m., an interview was [administrative staff m manager and OSM [other (Qualified Intellectual nal]. After reviewing the stor Individual #2's active nication, recreation, nent and spiritual/cultural nd OSM # 1 were asked blanks on the data sheets. The zeros indicated that the stred as documented on the oblection sheets. OSM # 1 the not done." In p.m. ASM (administrative inical director, ASM # 2, and OSM # 1, QIDP were notings. In was provided prior to exit. Of disorders characterized apacity and difficulty with such as managing money, sees, or social interactions. Originates before the age of the physical causes, such as also, or from nonphysical to find the province of the stimulation and adult is information was obtained the gov/NIHfactsheets/ViewFa	W 24	19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION	_ (X:	(X3) DATE SURVEY COMPLETED		
		49G011	B. WING _			08/19/2020	
	ROVIDER OR SUPPLIER	Е		STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205		17	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	pag		W 2	49			
	ability to move and to posture. This informative website:	ers that affect a person's o maintain balance and nation was obtained from the gov/medlineplus/cerebralpals					
	https://www.nlm.nih.gov/medlineplus/cerebralpals y.html. [3] Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.						
	website:	nation was obtained from the gov/medlineplus/anxiety.html					
	# 3's active treatmen	lication management and					
	Individual # 3 was a 58 year old male, who was admitted to [Name of Group Home] with diagnoses that included but were not limited to: profound intellectual disability [1], autistic disorder [2] PICA [3], microcephaly (4), fear, and gastroesophageal reflux disease [5].						
	dated 12/01/2019 thre documented, "Desired Outcome: I needs and wants to d Activities & [and] Inst	enter Plan] for Individual # 3 rough 11/30/2020 want to communicate my others effectively. Support tructions: 1. [Individual # 3] fication program on his iPad					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		49G011	B. WING _				08/19/2020
	ROVIDER OR SUPPLIER		,	5563 N	FADDRESS, CITY, STATE, ZIP CO 16TH STREET GTON, VA 22205	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W 249	day at least 100% of months by 09/30/202 "Desired Outcome: I powder into a cup of morning and evening Instructions: 1. [Individual # 3's] E by staff so that the awill be given. Staff wounces] of fluid and medication to [Individual # 3's] ounces] of fluid and medication to [Individual be given instructions the medication from 6-80z of fluid. Staff wassistance as needed a spoon to mix the pwill provide verbal diassistance as needed goal will be met if [Inmedication (Benefibe stirs the medication. praised by staff if he [Individual # 3] progredible by staff. 8. independently obtain "Desired Outcome: a religious activity. Instructions: 1. [Individual # 3] progredible staff. 8. independently obtain "Desired Outcome: a religious activity by gareligious activity he was only 30/2020. 1. [Individual activity he was only 30/2020. 1. [Indivision in the control of the time for 12 consequences.]	the time for 3 consecutive to. Frequency: Daily." will pour my Benefiber water and mix it every years Support Activities & [and] idual # 3] will walk to the en notified by staff that it is ing or evening medications. Benefiber will be measured opropriate dose of Benefiber will provide 6-8oz [six to eight then hand over the dual # 3]. 3. [Individual # 3] ons by staff on how to pour the medication cup into will provide supervision and d. 4. [Individual # 3] will use owder into the water. Staff rections and hand over hand d. 5. [Individual # 3] This dividual # 3] pours his er) into 6-8 oz of fluid and 6. [Individual # 3] will be participates in the goal. 7. ess will be documented in [Individual # 3] is able to in this goal. Frequency: Daily." [Individual # 3] will engage in Support Activities & [and] individual # 3] will engage in a going to church or engaging in in 30 minutes at least 75% of	. W2	249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING _			08/19/2020	
	ROVIDER OR SUPPLIER TH STREET GRP HOME			STREET ADDRESS, CITY, STATE, ZIP 5563 N 16TH STREET ARLINGTON, VA 22205		50/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 249	walking or star gazing given the necessary's goal. 4. [Individual # staff uses 2-3 prompth him engaged in the a be given verbal praise positive outcome. 6. be documented in Cremet when [Individual [sic] met the goal. From the facility's "Data Commet when [Individual [sic] met the goal. From the facility's "Data Commet when prompted by his day at least 100% of months by 09/30/2020 Review of data sheet on 02/01/20 through 05/31/20, 06/08/01/20 through 05	to spiritual care, nature g. 3. [Individual # 3] will be support to accomplish this 3] will meet this goal when s every five minutes to keep ctivity. 5. [Individual # 3] will e at the completion of Successful completion will edible. 7. This goal will be # 3] is able to independently equency: Weekly." Dilection Sheet" for Individual March, April May July 2020" brough August 18, 2020 d Outcome: [Individual # 3] cation program on his iPad s staff daily for 15 minutes a the time for 3 consecutive 0. Frequency: Daily." revealed zeros and blanks 02/29/20, 03/01/20 through rough 04/30/20, o5/01/20 01/20 through 06/30/20 and 18/20. Further review of the ed, "LEGEND: + = support not to participate. A = . I = Incident. O = Other Dilection Sheet" for Individual March, April, May, June and ed, Support Activities & Individual # 3] will engage in going to church or engaging or 30 minutes at least 75%	W 2-	49			

PRINTED: 09/07/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 49G011 B. WING 08/19/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5563 N 16TH STREET** NORTH 16TH STREET GRP HOME ARLINGTON, VA 22205 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 249 W 249 Continued From page 37 data sheet revealed zeros and blanks from 02/23/20 through 02/29/20, 03/01/20 through 03/31/20, 04/01/20 through 04/30/20, o5/01/20 through 05/31/20, 06/01/20 through 06/30/20 and 07/01/20 through 07/31/20. The facility's "Data Collection Sheet" for Individual #3 dated "February, May, July and August 2020" documented, Support Activities & [and] Instructions: I will pour my Benefiber powder into a cup of water and mix it every morning and evening, Frequency: Daily," Review of data sheet revealed zeros and blanks on 02/17/20, 05/01/20, 05/14/20, 05/18/20 through 05/31/20, 07/03/20 through 07/04/20 and 08/01/02, 08/02/20 and 08/08/20. On 08/19/20 at 11:20 a.m., an interview was conducted with ASM [administrative staff member] # 2, program manager and OSM [other staff member] QIDP [Qualified Intellectual Disabilities Professional]. After reviewing the data collection sheets for Individual #3's active treatment for communication, medication management and spiritual/cultural activities, ASM # 2 and OSM # 1 were asked about the zeros and blanks on the data sheets. ASM # 2 stated that the zeros indicated that the program was not offered as documented on the legend on the data collection sheets. OSM # 1 stated, "It looks like it's not done."

Facility ID: VAICFMR16

made aware of the findings.

On 08/19/20 at 12:20 p.m. ASM (administrative staff member) # 1, clinical director, ASM # 2, program manager and OSM # 1, QIDP were

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 10	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G011	B. WING_			08/19/2020	
NAME OF PROVIDER OR SUPPLIER NORTH 16TH STREET GRP HOME				STREET ADDRESS, CITY, STATE, ZIP COD 5563 N 16TH STREET ARLINGTON, VA 22205	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 249	by a limited mental adaptive behaviors schedules and routi Intellectual disability 18 and may result f autism or cerebral pcauses, such as lac responsiveness. The from the website: https://report.nih.go t.aspx?csid=100. (2) A neurological at that begins early in throughout a person acts and interacts wand learns.) This in the website: https://www.nlm.nih rumdisorder.html. (3) A pattern of eatin as dirt or paper. The from the website: https://medlineplus. (4) A condition in who much smaller than the and sex. This information website: https://medlineplus. (5) Stomach content the esophagus and was obtained from the sex obtained f	p of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. It originates before the age of rom physical causes, such as palsy, or from nonphysical sk of stimulation and adult is information was obtained v/nihfactsheets/ViewFactShee and developmental disorder childhood and lasts a life. It affects how a person with others, communicates, formation was obtained from agov/medlineplus/autismspect and non-food materials, such is information was obtained gov/ency/article/001538.htm. Thich a person's head size is that of others of the same age mation was obtained from the gov/ency/article/003272.htm. This to leak back, or reflux, into irritate it. This information	W2	249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		49G011	B. WING		08/19/2020	
NAME OF PROVIDER OR SUPPLIER NORTH 16TH STREET GRP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 5563 N 16TH STREET ARLINGTON, VA 22205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		