STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G070	A. BUILDING _____ B. WING _____	01/08/2020

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BURKE ICF ID	9332 BURKE ROAD BURKE, VA 22015

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/7/20 through 1/8/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		2/17/20
W 000	INITIAL COMMENTS An unannounced annual Fundamental survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted 1/7/20 through 1/8/20. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Mentally Retarded. The Life Safety Code survey report will follow. The census in this six bed facility was six at the time of the survey. The survey sample consisted of three current individual reviews (Individuals #1, #2 and #3).	W 000	1. The Program Nurse will review the Medication Administration Policy with program staff with a focus on the procedures of two staff reviewing all new doctor's orders and ensuring they are accurately documented and implemented for individual #2. 2. The Nursing Coordinator will work in collaboration with the Program Nurse to review all individual's physician's orders to ensure they are accurately documented and implemented. 3. The Nurse, QIDP, and Program Manager will meet on a weekly basis during operation meetings to communicate regarding all new orders received during the week. 4. The Nursing Coordinator and/or Clinical Director will complete random quarterly record reviews to ensure the doctor's orders are accurately documented and implemented for all individuals.
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for one of three individuals in the survey sample, Individual #2. The facility staff failed to document instructions for one on one staffing supervision at all times, per a physician's order dated 6/28/19,	W 111		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Terell Jones — Clinical Director — 1/21/20

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

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W 111	Continued From page 1 on Individual #2's June 2019 and July 2019 supervision, data collection forms. The findings include: Individual #2 was admitted to the group home on 12/11/14. Individual #2's diagnoses included but were not limited to profound intellectual disabilities and constipation. Individual #2's behavior support plan dated 10/1/18 through 9/30/19 documented the individual presented with hand mouthing behaviors. Review of Individual #2's clinical record revealed a physician's order dated 6/28/19 that documented, "(Individual #2) needs one on one staffing at all times to prevent her injuring herself." The order was changed on 7/19/19. A note signed by LPN (licensed practical nurse) on 6/28/19 documented, "(Individual #2) consulted with (name of physician) at (name of wound healing center) to follow up for wound care to her right and left palms. The Dr. (doctor) indicated that her wounds are better and she does not need to come to the facility again unless there is any concerns. He indicated that (Individual #2) is to have one on one supervision to prevent reoccurring and continue to wear hand gloves to prevent hand mouthing..." Individual #2's June 2019 and July 2019 supervision data collection forms documented, "Directions: Specialized Supervision: Provide (Individual #2) with specialized supervision in the form of 1:1 (one on one) supervision. When (Individual #2) is awake staff will provide 1:1. When (Individual #2) is in bed Staff will continue	W 111		

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W 111	Continued From page 2 to provide close supervision." The instructions failed to document one on one staffing at all times, per the 6/28/19 physician's order. On 1/8/20 at 3:25 p.m., an interview was conducted with DSP (direct support staff) #2 (who worked the night shift). DSP #2 stated the direct support staff are made aware of physician orders regarding supervision via verbal communication provided by the program manager or nurse and via the supervision, data collection forms. DSP #2 was asked what type of supervision was provided to Individual #2 during the night shift from 6/28/19 through 7/19/19. DSP #2 stated 30-minute checks were provided. When asked if he was aware Individual #2 was supposed to be provided one on one supervision during that time period, DSP #2 stated Individual #2 was only supposed to be provided one on one supervision when she was awake and 30 minute checks while asleep during that time period. On 1/8/20 at 4:44 p.m., an interview was conducted with ASM (administrative staff member) #1 (the program manager), ASM #2 (the qualified intellectual disabilities professional) and LPN (licensed practical nurse) #1. ASM #1 was asked who was responsible for ensuring the supervision, data -collection forms accurately reflected the physician's orders. ASM #1 stated the nurse was responsible. ASM #1, ASM #2 and LPN #1 were made aware of the above concern. The group home policy titled, "Written Record Management" failed to document specific information regarding the accuracy of supervision, data collection forms. No further information was presented prior to exit.	W 111		

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W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the QIDP (qualified intellectual disabilities professional) failed to ensure implementation of an individual's PCP (person centered plan) for one of three individuals in the survey sample, Individual #1. The QIDP failed to ensure implementation of Individual #1's choking/aspiration protocol for drinking techniques. On 1/7/20 and 1/8/20, staff was observed providing beverages to Individual #1 directly from a cup although the protocol documented to use a spoon. The findings include: Individual #1 was admitted to the group home on 6/17/19. Individual #1's diagnoses included but were not limited to moderate mental retardation and cerebral palsy. Individual #1's choking/aspiration protocol included in the PCP and was signed by LPN (licensed practical nurse) #1 on 10/22/19, which documented, "TECHNIQUES FOR DRINKING: Offer liquids periodically throughout the meal. Give all liquids via 1/2 teaspoon amounts. Only spoon for liquids- No cups or straws. Wait for swallow." On 1/7/20 at approximately 3:00 p.m., ASM (administrative staff member) #2 (the qualified	W 159	2/17/20 1. The Program Nurse will provide training to program staff on Individual #1"s Aspiration Protocol and individual #1's Mealtime Adaptive Equipment orders during the next staff meeting. 2. The Program Nurse will provide training to program staff on all other individual's aspiration protocols and Mealtime Adaptive Equipment during the staff meeting. 3. The Program Manager, Program Nurse, and Nutritionist will complete random mealtime observations on a quarterly basis to ensure program staff are following individual #1 and all other individual's aspiration protocols during meals and using the appropriate Mealtime adaptive equipment per the doctor's orders. 4. The Clinical Director and/or Mission Effectiveness will complete random Quarterly audits to monitor the process and ensure staff are following the aspiration protocols and using the mealtime adaptive equipment in accordance with the doctor's orders.	

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W 159	Continued From page 4 intellectual disabilities professional) was observed assisting Individual #1 with a thickened beverage. ASM #2 was observed placing the cup to Individual #1's mouth and Individual #1 was observed sipping the beverage from the rim of the cup. Later during the observation, ASM #2 was observed providing the beverage to Individual #1 with a spoon. On 1/8/20 at approximately 7:40 a.m., DSP (direct support staff) #1 was observed assisting Individual #1 with drinking a thickened beverage. DSP #1 was observed placing the cup to Individual #1's mouth and Individual #1 was observed sipping the beverage from the rim of the cup. Later during the observation, LPN (licensed practical nurse) #1 was observed handing DSP #1 a spoon and DSP #1 was observed providing the beverage to Individual #1 with the spoon. On 1/8/20 at 3:29 p.m., an interview was conducted with DSP #1. DSP #1 was asked if she was familiar with Individual #1's choking/aspiration protocol. DSP #1 stated she was familiar to an extent. DSP #1 was asked if anything special should be done regarding beverages. DSP #1 stated she thought she knew why this surveyor was asking this question. DSP #1 stated during this morning she had used a cup, but she corrected herself. DSP #1 stated she was supposed to use a spoon so she did not give Individual #1, too much liquid at once. DSP #1 confirmed she was supposed to use a spoon at all times. On 1/8/20 at 3:36 p.m., an interview was conducted with LPN #1. LPN #1 was asked why staff is supposed to provide Individual #1	W 159		

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W 159	Continued From page 5 beverages via a spoon. LPN #1 stated Individual #1 is at a high risk for aspiration and providing beverages via a spoon is safer because the individual does not receive a high amount of liquid. On 1/8/20 at 4:24 p.m., an interview was conducted with ASM #2. ASM #2 confirmed the choking/aspiration protocol was part of Individual #1's PCP. ASM #2 was asked to describe Individual #1's aspiration protocol related to beverages. ASM #2 stated she would like to obtain the protocol. ASM #2 obtained the protocol and stated Individual #1 should be provided beverages in 1/2 teaspoon amounts on a spoon. ASM #2 was informed of this surveyor's observation as documented above. ASM #2 stated this observation was conducted the first day the surveyor was in the home and there was a "balance of different things." ASM #2 stated she did begin using a spoon during the observation. ASM #2 was asked if the QIDP was responsible for ensuring an individual's choking/aspiration protocol is implemented. ASM #2 stated this is a shared responsibility but she does play a role in the responsibility. On 1/8/20 at 4:44 p.m., an interview was conducted with ASM #1 (the program manager), ASM #2 and LPN #1. ASM #1, ASM #2 and LPN #1 were made aware of the above concern. ASM #1 stated that Individual #1 was a newer individual to the home, so the staff was still trying to remember the individual's protocols and that the nurse "kicks in" and corrects/supports staff when needed. The facility policy titled, "Qualified Mental Retardation Professional (QMRP)" (also known	W 159		

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W 159	Continued From page 6 as QIDP) documented, "The QMRP is responsible for the integration, coordination, monitoring and development of the Individual Service Plan (also known as PCP), and to ensure quality active treatment in the program..." No further information was presented prior to exit.	W 159	1. The Program Nurse will provide training to program staff on Individual #1"s Aspiration Protocol and individual #1's Mealtime Adaptive Equipment orders during the next staff meeting.	2/17/20
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure the implementation of a PCP (person centered plan) for one of three individuals in the survey sample, Individual #1. The facility staff failed to implement Individual #1's choking/aspiration protocol for drinking techniques. On 1/7/20 and 1/8/20, staff was observed providing beverages to Individual #1 directly from a cup although the protocol documented to use a spoon. The findings include: Individual #1 was admitted to the group home on 6/17/19. Individual #1's diagnoses included but	W 249	2. The Program Nurse will provide training to program staff on all other individual's aspiration protocols and Mealtime Adaptive Equipment during the staff meeting. 3. The Program Manager, Program Nurse, and Nutritionist will complete random mealtime observations on a quarterly basis to ensure program staff are following individual #1 and all other individual's aspiration protocols during meals and using the appropriate Mealtime adaptive equipment per the doctor's orders. 4. The Clinical Director and/or Mission Effectiveness will complete random Quarterly audits to monitor the process and ensure staff are following the aspiration protocols and using the mealtime adaptive equipment in accordance with the doctor's orders.	

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W 249	Continued From page 7 were not limited to moderate mental retardation and cerebral palsy. Individual #1's choking/aspiration protocol included in the PCP and was signed by LPN (licensed practical nurse) #1 on 10/22/19, which documented, "TECHNIQUES FOR DRINKING: Offer liquids periodically throughout the meal. Give all liquids via 1/2 teaspoon amounts. Only spoon for liquids- No cups or straws. Wait for swallow." On 1/7/20 at approximately 3:00 p.m., ASM (administrative staff member) #2 (the qualified intellectual disabilities professional) was observed assisting Individual #1 with a thickened beverage. ASM #2 was observed placing the cup to Individual #1's mouth and Individual #1 was observed sipping the beverage from the rim of the cup. Later during the observation, ASM #2 was observed providing the beverage to Individual #1 with a spoon. On 1/8/20 at approximately 7:40 a.m., DSP (direct support staff) #1 was observed assisting Individual #1 with drinking a thickened beverage. DSP #1 was observed placing the cup to Individual #1's mouth and Individual #1 was observed sipping the beverage from the rim of the cup. Later during the observation, LPN (licensed practical nurse) #1 was observed handing DSP #1 a spoon and DSP #1 was observed providing the beverage to Individual #1 with the spoon. On 1/8/20 at 3:29 p.m., an interview was conducted with DSP #1. DSP #1 was asked if she was familiar with Individual #1's	W 249		

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W 249	Continued From page 8 choking/aspiration protocol. DSP #1 stated she was familiar to an extent. DSP #1 was asked if anything special should be done regarding beverages. DSP #1 stated she thought she knew why this surveyor was asking this question. DSP #1 stated during this morning she had used a cup, but she corrected herself. DSP #1 stated she was supposed to use a spoon so she did not give Individual #1, too much liquid at once. DSP #1 confirmed she was supposed to use a spoon at all times. On 1/8/20 at 3:36 p.m., an interview was conducted with LPN #1. LPN #1 was asked why staff is supposed to provide Individual #1 beverages via a spoon. LPN #1 stated Individual #1 is at a high risk for aspiration and providing beverages via a spoon is safer because the individual does not receive a high amount of liquid. On 1/8/20 at 4:24 p.m., an interview was conducted with ASM #2. ASM #2 confirmed the choking/aspiration protocol was part of Individual #1's PCP. ASM #2 was asked to describe Individual #1's aspiration protocol related to beverages. ASM #2 stated she would like to obtain the protocol. ASM #2 obtained the protocol and stated Individual #1 should be provided beverages in 1/2 teaspoon amounts on a spoon. ASM #2 was informed of this surveyor's observation as documented above. ASM #2 stated this observation was conducted the first day the surveyor was in the home and there was a "balance of different things." ASM #2 stated she did begin using a spoon during the observation. On 1/8/20 at 4:44 p.m., an interview was	W 249		

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W 249	Continued From page 9 conducted with ASM #1 (the program manager), ASM #2 and LPN #1. ASM #1, ASM #2 and LPN #1 were made aware of the above concern. ASM #1 stated Individual #1 was a newer individual to the home so staff was still trying to remember the individual's protocols and that the nurse "kicks in" and corrects/supports staff when needed. The facility policy titled, "Individual Service Plan (ISP)" (also known as PCP) documented, "G. ISP Implementation and Individual Engagement: Implementation of the ISP begins at the time of its development. Components of the plan are fully implemented, with the individual receiving the support, learning environment and active engagement necessary to reach his or her objectives/desired outcomes as defined in the ISP." No further information was presented prior to exit.	W 249		