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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G014	A. BUILDING ______ B. WING ______	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINERVA FISHER HALL GROUP HOME	8207 WOLFTRAP RD VIENNA, VA 22180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/12/19 through 11/14/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	1. The day support staff will be retrained by the day support manager on ensuring and promoting the rights of individual #1, and individual #3 during meal time to include ensuring the clothing protectors are used appropriately by staff, ensuring staff are sitting with the individuals during meals instead of standing over the individuals, and ensuring staff are using the appropriate adaptive equipment per the doctor's orders during meals.	12/23/19
W 000	INITIAL COMMENTS An unannounced annual Medicaid ICF/ID Health Care Certification survey was conducted 11/12/19 through 11/14/19. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Mentally Retarded. The Life Safety Code survey report will follow. The census in this nine bed facility was seven at the time of the survey. The survey sample consisted of four current Individual reviews (Individuals #1, #2, # 3 and # 4).	W 000	2. The day support Manager will retrain day support staff on ensuring and promoting the rights of all individuals during meal time to include ensuring the clothing protectors are used appropriately by staff, ensuring staff are sitting with the individuals during meals instead of standing over the individuals, and ensuring staff are using the appropriate adaptive equipment per the doctor's orders during meals.	
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to allow individuals to exercise their rights for dignity during a meal for two of four individuals in the survey sample, Individuals # 1 and # 3. The findings include:	W 125	3. The day support Manager will conduct monthly mealtime observations as needed and model appropriate behaviors to ensure day support staff are promoting the rights of all individuals during mealtime. 4. The residential QIDP will complete unannounced day support observations to ensure day support staff are promoting the rights of the individuals during mealtime. 5. The residential Program Manager will monitor/review the completion of the day support observations on a monthly basis. 6. CRi Mission Effectiveness will also conduct periodic record reviews/ staff observations to prevent deficiencies.	RECEIVED DEC 09 2019 VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Terell Jones [signature] | TITLE: Clinical Director | (X6) DATE: 12/3/19

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

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1a. The facility staff failed to ensure Individual # 1's clothing protector was used properly during lunch. OSM (other staff member) # 5 CIS [community integrated specialist] placed Individual # 1's clothing protector on and then placed the remaining length of the clothing protector on top of the table and placed Individuals #1's plate of food, and drink on top of the clothing protector that was on the table.

Individual # 1 was admitted to [Name of Group Home] on 05/27/03, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], impulse disorder [2], mild cerebral palsy [3] and self-injurious behavior [4].

On 11/13/19 at approximately 11:00 a.m., an observation was conducted of Individual # 1 in the dining area at [Name of Day Program]. Individual # 1 was seated in a regular straight back chair at a table. OSM [other staff member] # 5, CIS [community integrated specialist] of [Name of Day Program], provided and placed a plastic clothing protector on Individual # 1. After attaching the clothing protector around Individual # 1's neck OSM # 5 placed the remaining length of the clothing protector on top of the table in front of Individual # 1. OSM # 5 then placed Individual # 1's plate of food, and drink on top of the clothing protector that was placed on the table. Individual # 1 was then verbally cued to eat and Individual # 1 was observed to eat her meal independently while the plate was on the clothing protector.

On 11/13/19 at approximately 12:38 p.m., an interview was conducted with OSM # 5. When asked why Individual # 1's clothing protector was placed on the table then the lunch plate placed on

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top of the clothing protector OSM # 5 stated, "To keep food from spilling on the floor, keep her shoes clean and to prevent her from falling."

On 11/13/19 at approximately 12:38 p.m., an interview was conducted with OSM # 4, QIM [quality improvement manager] for [Name of Day Program]. When informed of the observation stated above regarding the use of the clothing protector, OSM # 4 stated, "It's not dignified and the apron [clothing protector] should be used appropriately."

On 11/13/19 at approximately 4:10 p.m., an interview was conducted with OSM # 1, QIDP [Qualified Intellectual Disabilities Professional] and ASM (administrative staff member) # 2, program director of [Name of Group Home]. After being informed of the observation stated above regarding the use of Individual # 1's clothing protector at [Name of Day Program], ASM # 2 stated, "It's not dignified. We have to go adn talk with them, we don't do it here [Name of Group Home]."

The facility's policy "2.1 Human Rights Plan" documented in part, "2.1.4 Dignity. Individuals shall be treated with dignity as a human being and free from abuse."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

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References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) Impulse control disorders are characterized by an inability to resist the impulse to perform an action that is harmful to one's self or others. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/Impulse+Control+Disorders.

(3) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

(4) Self-harm refers to a person's harming their own body on purpose. This information was obtained from the website: https://medlineplus.gov/selfharm.html.

1b. The facility staff failed stood over Individual # 1 during the entire time she ate her lunch.

On 11/13/19 at approximately 11:00 a.m., an observation was conducted of Individual # 1 in the dining area at [Name of Day Program]. Individual # 1 was seated in a regular straight back chair at a table. OSM [other staff member] # 5 provided assistance to Individual # 1 by placing a designated portion of Individual # 1's food [lunch] from a container sent from [Name of Group

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Home] onto Individual # 1's plate. Further observation revealed OSM # 5 stood at Individual# 1's side during the entire time Individual # 1 was eating her lunch.

On 11/13/19 at approximately 12:38 p.m., an interview was conducted with OSM # 5. When asked if it was dignified to stand over Individual # 1 while she ate her lunch, OSM # 5 stated, "I think so."

On 11/13/19 at approximately 1:20 p.m., an interview was conducted with OSM # 4, QIM [quality improvement manager] for [Name of Day Program]. When informed of the observation documented above, OSM # 4 stated, "It's not dignified. Unless there is a reason to stand and assist someone during a meal, they should be seated next to them. [Name of Individual # 1] does not need someone to stand and assist her; they should have been seated next to her."

On 11/13/19 at approximately 4:10 p.m., an interview was conducted with OSM # 1, QIDP [Qualified Intellectual Disabilities Professional] and ASM (administrative staff member) # 2, program director of [Name of Group Home]. After being informed of the observation stated above, OSM # 1 stated, "It's not dignified. They should have been seated by her side."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

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2. The facility staff failed to ensure Individual # 3's clothing protector was used properly during lunch. OSM [other staff member] # 3, APM [assistant program manager] of [Name of Day Program] placed a plastic clothing protector on Individual # 1. After attaching the clothing protector around Individual # 1's neck OSM # 3 placed the remaining length of the clothing protector over the top of the lap tray in front of Individual # 3 and then placed Individual # 3's plate of food, and drink on top of the clothing protector that was placed over the lap tray.

Individual # 3 was admitted to (Name of Group Home) on 06/13/1999, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], cerebral palsy [2], and seizure disorder [3].

On 11/13/19 at approximately 12:05 p.m., an observation was conducted of Individual # 3 in the dining area at [Name of Day Program]. Individual # 3 was seated in her wheelchair with the lap tray attached. OSM [other staff member] # 3, APM [assistant program manager] of [Name of Day Program] provided and placed a plastic clothing protector on Individual # 1. After attaching the clothing protector around Individual # 1's neck OSM # 3 placed the remaining length of the clothing protector over the top of the lap tray in front of Individual # 3. OSM # 3 then placed Individual # 3's plate of food, and drink on top of the clothing protector that was placed over the lap tray. Individual # 3 was then verbally cued to eat and Individual # 3 was observed to eat her meal independently while the plate was on the clothing protector.

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On 11/13/19 at approximately 1:10 p.m., an interview was conducted with OSM # 3. When asked why Individual # 3's clothing protector was placed on top of her lap tray then the lunch plate placed on top of the clothing protector, OSM # 3 stated, "To catch the food and keep her [Individual # 3] clean."

On 11/13/19 at approximately 1:20 p.m., an interview was conducted with OSM # 4, QIM for [Name of Day Program]. When informed of the observation stated above regarding the use of the clothing protector, OSM # 4 stated, "It helps protect the wheelchair and the seat."

On 11/13/19 at approximately 4:10 p.m., an interview was conducted with OSM # 1, QIDP [Qualified Intellectual Disabilities Professional] and ASM (administrative staff member) # 2, program director of [Name of Group Home]. After being informed of the observation documented above regarding the use of Individual # 3's clothing protector at [Name of Day Program], ASM # 2 stated, "It's not dignified. We have to go and talk with them, we don't do it here [Name of Group Home]."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized

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W 125	Continued From page 7 by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.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.	W 125	1. The Program Manager will review individuals #1, #2, #3, and #4's active treatment programs to ensure they accurately reflect the needs of individuals #1, #2, #3, and #4 and update if needed. 2. The Program Manager will review all individuals' active treatment programs to ensure they accurately reflect the needs of the individuals and update if needed. 3. The Program Manager will provide training to the QIDP and other direct support staff to ensure staff understands how to implement the goals/objections and understand how to accurately document the individuals' progress on the data collection forms.	12/23/19
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 record reviews, and staff interview, it was determined that the QIDP [Qualified Intellectual Disabilities Professional] failed to coordinate and monitor the individuals' active treatment programs for four of four individuals in the survey sample, Individuals # 1, # 2, # 3 and # 4. The findings include: 1a. The QIDP (Qualified Intellectual Disabilities	W 159	4. The QIDP will complete monthly assessments and will ensure that all services and needs are met and are accurately reflected on the Monthly QIDP note. The Program Manager will review/monitor this process to ensure compliance and prevent future deficiencies. 5. Mission Effectiveness and/or the Clinical Director will also conduct quarterly record reviews to prevent deficiencies.	

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Professional) failed to implement Individual # 1's meal prep, clothing choice and bed making program.

Individual # 1 was admitted to [Name of Group Home] on 05/27/03, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], impulse disorder [2], mild cerebral palsy [3] and self-injurious behavior [4].

The PCP [Person Centered Plan] for Individual # 1 with a start date of 04/01/2019 documented, "Desired Outcome: # 2. At the appropriate time [Individual # 1] will assist with meal prep for 5 [five] minutes with 100% accuracy for 12 consecutive months. Start Date: 03/31/2019. End Date 04/01/2020."

"Desired Outcome: # 3. At the appropriate time [Individual # 1] will choose her outfit from two weather appropriate options during the weekday mornings with no more than three gestural prompts with 80% accuracy for 12 consecutive months. Start Date: 03/31/2019. End Date 04/01/2020."

"Desired Outcome: # 5. At the appropriate time [Individual # 1] will make her own bed daily every morning with no more than three prompts with staff support at 80% accuracy for 12 consecutive months by 3/31/20. Start Date: 03/31/2019. End Date 04/01/2020."

The data collection sheet dated "October 2019 documented, "Support Activity # 2: At the appropriate time [Individual # 1] will follow a 4 [four] step task of making her meal each day for 5 [five] minutes with 100% accuracy for 12 consecutive months by 3/31/20." Under "Key" it

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documented, " '+' = participated, '-' = chose not to participate, 'C' = cancelled (write reason), 'A' = Absent, '0 [zero]' - not offered." Further review of the data sheet revealed "0s" documented every day on 10/11/19 through 10/31/19 indicating the program was not implemented 21 of 31 days.

"Support Activity # 3:" documented same as "Desired Outcome: # 3" as documented above. Further review of the data sheet revealed zeros documented on 10/11/19, 10/14/19, 10/15/19 and 10/31/19 indicating the program was not implemented four of 31 days.

"Support Activity # 5:" documented same as "Desired Outcome: # 5" as documented above. Further review of the data sheet revealed zeros documented on 10/08/19, 10/12/19, 10/13/19 and 10/31/19 indicating the program was not implemented four of 31 days.

On 11/13/19 at 3:03 p.m., an interview was conducted with OSM [other staff member] # 1, the QIDP [Qualified Intellectual Disabilities Professional]. When asked to describe her responsibilities as the QIDP, OSM # 1 stated, "I review outcomes on a monthly and quarterly basis. If the individual shows improvement, I modify or revise the outcome to challenge the individual." When asked about data collection, OSM # 1 stated, "Ensure the data is being collected correctly and how to collect the data." OSM # 1 further stated, "Training staff during monthly staff meetings, coordinate the PCP/ISP [Person Centered Plan] / [Individual Service Plan]. After reviewing, the PCP and data collection sheets dated October 2019, OSM # 1 stated, "If it is coded as a zero that means it was not implemented." OSM # 1 stated that

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outcomes # 2, # 3 and # 5 were not implemented according to the PCP.

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) Impulse control disorders are characterized by an inability to resist the impulse to perform an action that is harmful to one's self or others. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/Impulse+Control+Disorders.

(3) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

(4) Self-harm refers to a person's harming their own body on purpose. This information was obtained from the website: https://medlineplus.gov/selfharm.html.

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1b. The QIDP failed to specify the frequency of the data collection for Individual # 1's medication management outcome.

The PCP [Person Centered Plan] for Individual # 1 with a start date of 04/01/2019 documented, "Outcome # 1. At the appropriate time, [Individual # 1] will come to the medication area sit in the chair until her medications are ready at 100% accuracy for 12 consecutive months.

The data collection sheet dated "October 2019 documented "Support Activity # 1" the same as "Outcome # 1." Review of the data collection sheet revealed data was collected one time per day. Further review of the data collect failed to evidence weather data was collected in the a.m. or p.m.

On 11/13/19 at 3:03 p.m., an interview was conducted with OSM [other staff member)] # 1, the QIDP regarding the frequency of the data collection of Individual # 1's medication management outcome. After reviewing the PCP and data collection sheets dated October 2019, OSM # 1 was asked to explain the statement "At the appropriate time" about outcome # 1. OSM # 1 stated, "Every time she gets her medications." When asked how often that was, OSM # 1 stated, "In the morning, when she gets home from day program and at night." OSM # 1 confirmed it was three times a day. When asked if the data collection specifies the data should be taken or measured if Individual # 1 is receiving medication three times a day OSM # 1 stated, "We should have specified a.m., p.m. or both."

On 11/13/19 at approximately 5:07 p.m., ASM

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MINERVA FISHER HALL GROUP HOME	8207 WOLFTRAP RD VIENNA, VA 22180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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[administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] were made aware of the findings.

No further information was provided prior to exit.

2a. The QIDP (Qualified Intellectual Disabilities Professional) failed to implement Individual # 2's activity participation program.

Individual # 2 was admitted to [Name of Group Home] on 02/16/2005, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], epilepsy [2] and cerebral palsy [3].

The PCP for Individual # 2 with a start date of 03/01/2019 documented, "Desired Outcome: # 7. [Individual # 2] will participate in the activities of her choice in the community one time per month at 100% accuracy for 12 consecutive months by 2/28/20.

The data collection sheet dated "October 2019 documented the same as "Desired Outcome: # 7" as documented above. Further review of the data sheet revealed zeros were documented on every day from 10/01/19 through 10/31/19 indicating the program was not implemented 31 of 31 days.

On 11/13/19 at 3:35 p.m., an interview was conducted with OSM # 1, the QIDP regarding the implementation of Individual # 2's PCP outcome. After reviewing, the PCP and data collection sheets dated October 2019. OSM # 1 stated that outcome # 7 was not implemented according to the PCP.

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On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100.

[2] A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

[3] A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

2b. The QIDP failed to specify the frequency of the data collection for Individual # 2's tooth

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brushing outcome.

The PCP for Individual # 2 with a start date of 03/01/2019 documented, "Desired Outcome: # 1. At the appropriate time, [Individual # 2] will brush her teeth with hand over hand assistance from staff for 2 minutes each day at 100% accuracy for 12 consecutive months by 2/28/20.

The data collection sheet dated "October 2019 documented the same as "Desired Outcome: # 7" as documented above. Review of the data collection sheet revealed data was collected one time per day. Further review of the data collect failed to evidence weather data was collected in the a.m. or p.m.

On 11/13/19 at 3:35 p.m., an interview was conducted with OSM # 1, the QIDP regarding the frequency of the data collection of Individual # 2's tooth brushing outcome. After reviewing the PCP and data collection sheets dated October 2019, OSM # 1 was asked to explain the statement "At the appropriate time" in regard to outcome # 1, OSM # 1 stated, "Every time she brushes her teeth" OSM # 1 confirmed it was two times a day. When asked if the data collection specifies the data should be taken or measured if Individual # 2 is brushing her teeth two times a day OSM # 1 stated, "We should have specified morning or night or both."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] were made aware of the findings.

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No further information was provided prior to exit.

3. The QIDP (Qualified Intellectual Disabilities Professional) failed to implement Individual # 2's activity participation program.

Individual # 3 was admitted to (Name of Group Home) on 06/13/1999, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], cerebral palsy [2], and seizure disorder [3].

The PCP for Individual # 3 with a start date of 07/01/2019 documented, "Desired Outcome: # 2. [Individual # 3] will sign bathroom when she needs to be assisted with toileting each day at 100% accuracy for 12 consecutive months by 6/30/20."

"Desired Outcome: # 7. [Individual # 3] will purchase the item of her choice within budget once per month at 100% accuracy for 12 consecutive months by 6/30/20."

The data collection sheet dated "October 2019 documented the same as "Desired Outcome: # 2" as documented above. Further review of the data sheet revealed zeros documented on 10/01/19 and 10/03/19 indicating the program was not implemented two of 30 days. "Support Activity # 7:" documented the same as "Desired Outcome: # 7" as documented above. Further review of the data sheet revealed zeros were documented on every day from 10/01/19 through 10/31/19 indicating the program was not implemented in 30 of 30 days.

On 11/13/19 at 3:55 p.m., an interview was conducted with OSM # 1, the QIDP regarding the

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implementation of Individual # 3's PCP outcomes. After reviewing the PCP and data collection sheets dated October 2019, OSM # 1 stated that outcomes # 2 and # 7 were not implemented according to the PCP.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.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.

4. The QIDP (Qualified Intellectual Disabilities Professional) failed to implement Individual # 2's activity participation program.

Individual # 4 was admitted to (Name of Group Home) on 05/19/2016, diagnoses in the clinical record included but were not limited to: profound intellectual disability [2], Lennox Gastaut syndrome [3] and swallowing difficulties.

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The PCP for Individual # 4 with a start date of 07/01/2019 documented, "Desired Outcome: # 5. [Individual # 4] will make 1 [one] purchase every month in the community with 100% accuracy for 12 consecutive months by 6/30/20."

The data collection sheet dated "October 2019 documented the same as "Desired Outcome: # 5" as documented above. Further review of the data sheet revealed zeros documented from 10/01/19 through 10/31/19 indicating the program was not implemented 31 of 31 days.

On 11/13/19 at 4:40 p.m., an interview was conducted with OSM # 1, the QIDP regarding the implementation of Individual # 4's PCP outcome. After reviewing the PCP and data collection sheets dated October 2019, OSM # 1 stated that outcome # 5was not implemented according to the PCP.

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

References:

[1] Dycem® is a non-slip, rubber-like plastic material used to stabilize surfaces. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.html.
[2] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money,

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W 159	Continued From page 18 schedules and routines, or social interactions. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100 [3] This syndrome usually begins between the ages of 3 and 5, but can start as late as adolescence. Children may have several different types of seizure with this syndrome. These include tonic (where the muscles suddenly become stiff), atonic (where the muscles suddenly relax), myoclonic, tonic clonic and atypical absences. Atypical absences often last longer than normal absences and are different as a child may be responsive and aware of their surroundings.	W 159	1. The Program Manager will review individual's #1 and #2"s ISP and data collection records. The Program Manger will update individuals #1 and #2 ISP and data collection records to include the frequency of the data collection. 2. The Program Manager will review all individuals ISP and data collection records to ensure the frequency of the data is specified. The Program Manager will update the ISP and data collection records if needed. 3. The Program Manager will provide training to the QIDP on Writing Measurable goals with a focus on ensuring the frequency of data is specified. The Program Manager will review/ monitor this process on a monthly basis to ensure compliance and prevent deficiencies. 4. Mission Effectiveness and/or the Clinical Director will also conduct quarterly record reviews to prevent deficiencies.	12/23/19
W 237	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(iv) Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the residential staff failed to specify the frequency of the data collection for two of four individuals in the survey sample, Individuals # 1 and # 2. The findings include: 1. The facility staff failed to specify the frequency of the data collection for Individual # 1's outcomes of medication management.	W 237		

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Individual # 1 was admitted to [Name of Group Home] on 05/27/03, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], impulse disorder [2], mild cerebral palsy [3] and self-injurious behavior [4].

The PCP [Person Centered Plan] for Individual # 1 with a start date of 04/01/2019 documented, "Outcome # 1. At the appropriate time, [Individual # 1] will come to the medication area sit in the chair until her medications are ready at 100% accuracy for 12 consecutive months.

The data collection sheet dated "October 2019 documented "Support Activity # 1" the same as "Outcome # 1." Review of the data collection sheet revealed data was collected one time per day. Further review of the data collect failed to evidence weather data was collected in the a.m. or p.m.

On 11/13/19 at 3:03 p.m., an interview was conducted with ASM administrative staff member] # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] regarding the frequency of the data collection of Individual # 1's medication management outcome. After reviewing the PCP and data collection sheets dated October 2019, ASM # 2 and OSM # 1 were asked to explain the statement "At the appropriate time" in regard to outcome # 1. OSM # 1 stated, "Every time she gets her medications." When asked how often that was ASM # 2 stated, "In the morning, when she gets home from day program and at night." ASM # 2 and OSM # 1 confirmed it was three times a day. When asked if the data collection specifies the data should be

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taken or measured if Individual # 1 is receiving medication three times a day, ASM # 2 and OSM # 1 could not provide an answer. OSM # 1 stated, "We should have specified a.m., p.m. or both."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) Impulse control disorders are characterized by an inability to resist the impulse to perform an action that is harmful to one's self or others. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/Impulse+Control+Disorders.

(3) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

(4) Self-harm refers to a person's harming their

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own body on purpose. This information was obtained from the website: https://medlineplus.gov/selfharm.html.

2. The facility staff failed to specify the frequency of the data collection for Individual # 2's outcomes for tooth brushing.

Individual # 2 was admitted to [Name of Group Home] on 02/16/2005, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], epilepsy [2] and cerebral palsy [3].

The PCP for Individual # 2 with a start date of 03/01/2019 documented, "Desired Outcome: # 1. At the appropriate time, [Individual # 2] will brush her teeth with hand over hand assistance from staff for 2 minutes each day at 100% accuracy for 12 consecutive months by 2/28/20.

The data collection sheet dated "October 2019 documented the same as "Desired Outcome: # 7" as stated above. Review of the data collection sheet revealed data was collected one time per day. Further review of the data collect failed to evidence weather data was collected in the a.m. or p.m.

On 11/13/19 at 3:35 p.m., an interview was conducted with ASM # 2, program manager, and OSM # 1, the QIDP regarding the frequency of the data collection of Individual # 2's tooth brushing outcome. After reviewing the PCP and data collection sheets dated October 2019, ASM # 2 and OSM # 1 were asked to explain the statement "At the appropriate time" in regard to outcome # 1. OSM # 1 stated, "Every time she brushes her teeth" When asked how often that

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was ASM # 2 stated, "In the morning and at night." ASM # 2 and OSM # 1 confirmed it was two times a day. When asked if the data collection specifies the data should be taken or measured if Individual # 2 is brushing her teeth two times a day, ASM # 2 and OSM # 1 could not provide an answer. OSM # 1 stated, "We should have specified morning or night or both."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100.

[2] A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

[3] A group of disorders that affect a person's ability to move and to maintain balance and

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W 237	Continued From page 23 posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.	W 237	1. The Program Manager will review individuals #1, #2, #3, and #4's active treatment programs to ensure they accurately reflect the needs of individuals #1, #2, #3, and #4 and update if needed.	12/23/19
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the residential staff failed to ensure an Individual was receiving services consistent with the PCP [Person Centered Plan] for four of four individuals in the survey sample, Individuals # 1, # 2, # 3 and # 4. The findings include: 1. The facility staff failed to implement Individual # 1's outcome for meal preparation, choosing clothing and making her bed. Individual # 1 was admitted to [Name of Group Home] on 05/27/03, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], impulse disorder [2], mild cerebral palsy [3] and self-injurious behavior [4].	W 249	2. The Program Manager will review all individuals active treatment programs to ensure they accurately reflect the needs of the individuals and update if needed. 3. The Program Manager will provide training to the QIDP and other direct support staff to ensure staff understands how to implement the goals/objections and understand how to accurately document the individuals' progress on the data collection forms. 4. The QIDP will complete monthly assessments and will ensure that all services and needs are met and are accurately reflected on the Monthly QIDP note. The Program Manager will review/monitor this process to ensure compliance and prevent future deficiencies. 5. Mission Effectiveness and/or the Clinical Director will also conduct quarterly record reviews to prevent deficiencies.	

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MINERVA FISHER HALL GROUP HOME	8207 WOLFTRAP RD VIENNA, VA 22180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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The PCP [Person Centered Plan] for Individual # 1 with a start date of 04/01/2019 documented, "Desired Outcome: # 2. At the appropriate time [Individual # 1] will assist with meal prep for 5 [five] minutes with 100% accuracy for 12 consecutive months. Start Date: 03/31/2019. End Date 04/01/2020."

"Desired Outcome: # 3. At the appropriate time [Individual # 1] will choose her outfit from two weather appropriate options during the weekday mornings with no more than three gestural prompts with 80% accuracy for 12 consecutive months. Start Date: 03/31/2019. End Date 04/01/2020."

"Desired Outcome: # 5. At the appropriate time [Individual # 1] will make her own bed daily every morning with no more than three prompts with staff support at 80% accuracy for 12 consecutive months by 3/31/20. Start Date: 03/31/2019. End Date 04/01/2020."

The data collection sheet dated "October 2019 documented, "Support Activity # 2: At the appropriate time [Individual # 1] will follow a 4 [four] step task of making her meal each day for 5 [five] minutes with 100% accuracy for 12 consecutive months by 3/31/20." Under "Key" it documented, " '+' = participated, '-' = chose not to participate, 'C' = cancelled (write reason), 'A' = Absent, '0 [zero]' - not offered." Further review of the data sheet revealed "0s" documented every day on 10/11/19 through 10/31/19 indicating the program was not implemented 21 of 31 days.

"Support Activity # 3:" documented same as "Desired Outcome: # 3" as documented above. Further review of the data sheet revealed zeros

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documented on 10/11/19, 10/14/19, 10/15/19 and 10/31/19 indicating the program was not implemented four of 31 days.

"Support Activity # 5:" documented same as "Desired Outcome: # 5" as documented above. Further review of the data sheet revealed zeros documented on 10/08/19, 10/12/19, 10/13/19 and 10/31/19 indicating the program was not implemented four of 31 days.

On 11/13/19 at 3:03 p.m., an interview was conducted with ASM [administrative staff member] # 2, program manager, and OSM [other staff member] # 1, the QIDP [Qualified Intellectual Disabilities Professional] regarding the implementation of Individual # 1's PCP outcomes. After reviewing, the PCP and data collection sheets dated October 2019, OSM # 1 stated, "If it is coded as a zero that means it was not implemented." ASM # 2 and OSM # 1 stated that outcomes # 2, # 3 and # 5 were not implemented according to the PCP.

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website:

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https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) Impulse control disorders are characterized by an inability to resist the impulse to perform an action that is harmful to one's self or others. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/Impulse+Control+Disorders.

(3) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

(4) Self-harm refers to a person's harming their own body on purpose. This information was obtained from the website: https://medlineplus.gov/selfharm.html.

2. The facility staff failed to implement Individual # 2's outcome for activity participation.

Individual # 2 was admitted to [Name of Group Home] on 02/16/2005, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], epilepsy [2] and cerebral palsy [3].

The PCP for Individual # 2 with a start date of 03/01/2019 documented, "Desired Outcome: # 7. [Individual # 2] will participate in the activities of her choice in the community one time per month at 100% accuracy for 12 consecutive months by 2/28/20.

The data collection sheet dated "October 2019

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documented the same as "Desired Outcome: # 7" as documented above. Further review of the data sheet revealed zeros were documented on every day from 10/01/19 through 10/31/19 indicating the program was not implemented 31 of 31 days.

On 11/13/19 at 3:35 p.m., an interview was conducted with ASM # 2, program manager, and OSM # 1, the QIDP regarding the implementation of Individual # 2's PCP outcome. After reviewing the PCP and data collection sheets dated October 2019, ASM # 2 and OSM # 1 stated that outcome # 7 was not implemented according to the PCP.

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100.

[2] A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms

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or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

[3] A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpals y.html.

3. The facility staff failed to implement Individual # 3's outcome for toileting and purchasing.

Individual # 3 was admitted to (Name of Group Home) on 06/13/1999, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], cerebral palsy [2], and seizure disorder [3].

The PCP for Individual # 3 with a start date of 07/01/2019 documented, "Desired Outcome: # 2. [Individual # 3] will sign bathroom when she needs to be assisted with toileting each day at 100% accuracy for 12 consecutive months by 6/30/20."

"Desired Outcome: # 7. [Individual # 3] will purchase the item of her choice within budget once per month at 100% accuracy for 12 consecutive months by 6/30/20."

The data collection sheet dated "October 2019 documented the same as "Desired Outcome: # 2" as documented above. Further review of the data sheet revealed zeros documented on 10/01/19 and 10/03/19 indicating the program was not implemented two of 30 days. "Support Activity # 7:" documented the same as "Desired Outcome:

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7" as documented above. Further review of the data sheet revealed zeros were documented on every day from 10/01/19 through 10/31/19 indicating the program was not implemented in 30 of 30 days.

On 11/13/19 at 3:55 p.m., an interview was conducted with ASM # 2, program manager, and OSM # 1, the QIDP regarding the implementation of Individual # 3's PCP outcomes. After reviewing the PCP and data collection sheets dated October 2019, ASM # 2 and OSM # 1 stated that outcomes # 2 and # 7 were not implemented according to the PCP.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.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.

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4 The facility staff failed to implement Individual # 4's outcome for purchasing.

Individual # 4 was admitted to (Name of Group Home) on 05/19/2016, diagnoses in the clinical record included but were not limited to: profound intellectual disability [2], Lennox Gastaut syndrome [3] and swallowing difficulties.

The PCP for Individual # 4 with a start date of 07/01/2019 documented, "Desired Outcome: # 5. [Individual # 4] will make 1 [0ne] purchase every month in the community with 100% accuracy for 12 consecutive months by 6/30/20."

The data collection sheet dated "October 2019 documented the same as "Desired Outcome: # 5" as documented above. Further review of the data sheet revealed zeros documented from 10/01/19 through 10/31/19 indicating the program was not implemented 31 of 31 days.

On 11/13/19 at 4:40 p.m., an interview was conducted with ASM # 2, program manager, and OSM # 1, the QIDP regarding the implementation of Individual # 4's PCP outcome. After reviewing the PCP and data collection sheets dated October 2019, ASM # 2 and OSM # 1 stated that outcome # 5was not implemented according to the PCP
.

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

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W 249	Continued From page 31 References: [1] Dycem® is a non-slip, rubber-like plastic material used to stabilize surfaces. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.html. [2] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100 [3] This syndrome usually begins between the ages of 3 and 5, but can start as late as adolescence. Children may have several different types of seizure with this syndrome. These include tonic (where the muscles suddenly become stiff), atonic (where the muscles suddenly relax), myoclonic, tonic clonic and atypical absences. Atypical absences often last longer than normal absences and are different as a child may be responsive and aware of their surroundings.	W 249	1. The Nursing Coordinator will retrain the LPN involved in the deficient practice on the medication administration policy with an emphasis on ensuring all drugs and biologicals are kept locked except when being prepared for administration for individual #3 and all other individuals in the home. 2. The Program Manager will retrain program staff on the Medication Administration Policy with an emphasis on ensuring all drugs and biologicals are kept locked except when being prepared for administration for all individuals. 3. The Program Manager and Program Nurse will monitor the process by conducting random medication administration observations to ensure program staff are ensuring all drugs and biologicals are kept locked except when being prepared for administration. 4. Annual Recertification Medication training is required by all staff. The Clinical Director will review that all staff members complete the training in a timely manner.	12/23/19
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to secure medications during	W 382		

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the medication administration observation for Individual # 3 by leaving her medications on top of the medication cart and failing to lock the medication cart after leaving the medication room unattended while Individual # 3 was left in the room alone.

The findings include:

Individual # 3 admitted to (Name of Group Home) on 06/13/1999, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], cerebral palsy [2], and seizure disorder [3].

On 11/13/19 at approximately 7:10 a.m., the medication administration observation was conducted with LPN [licensed practical nurse] # 2 in the group home's medication room. Individual # 3 was observed to bringing herself to the medication room, by independently operating her motorized wheelchair. LPN # 2 closed the door after Individual # 3 entered the room. LPN # 2 opened the medication cart, removed ten bubble packs/cards containing ten different medications and placed then on top of the medication cart. As LPN # 2 was dispensing the medications from the bubble card into the medication cup the medication room door opened and another Individual, who resided in the home was attempting to enter the room. Another staff member from the home was trying to redirect the Individual. The Individual dropped to the floor just inside the room and the staff member was trying to assist the Individual up to their feet to be redirected. LPN # 2 walked away from the medication cart, to the door of the room and assisted the other staff member in getting the Individual to their feet who was then redirected by

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the staff member to another part of the home. LPN # 2 stated, "I need to wash my hands", left the medication room and walked into a bathroom next to the medication room. Further observations revealed that when LPN # 2 left the medication room, the door closed and Individual # 3's medications were left on top of the medication cart. The medication cart was unlocked and Individual # 3 was in the room without supervision. An observation of the medications on top of the medication cart revealed the following: Amitiza [for intestinal disorders], Baclofen [for muscle spasms], Cranberry tablet [for prevention of urinary tract infection], B-complex [nutritional supplement], Phyntoin [for seizures], Risaquad [probiotic], Vitamin C [treat and prevent scurvy], Vitamin D3 [for osteoporosis] and a Multivitamin [for vitamin deficiency].

On 11/13/19 at approximately 8:30 a.m., an interview was conducted with LPN # 2. When asked to describe the process for securing medications when medications are not being prepared, LPN # 2 stated, "Put the medications away, lock the medication cart, and take the key for the medications with me." When asked why it was important to secure medications, LPN # 2 stated, "You cannot leave the medications unattended because someone could grab them." When informed of the above observation, LPN # 2 stated, "I was overwhelmed. I should have stayed there [in the room] and used the hand sanitizer." LPN # 2 further stated that Individual # 3 could not have reached the top of the medication cart or opened the drawers but that someone else could have come into the room while he was in the bathroom.

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The facility's policy "3.4 Medication Management" documented in part, "Medication Administration Procedures: I. Do not leave medications unattended at any time. All poured medications must remain [sic] with eyesight."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.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.

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W 436 — CFR(s): 483.470(g)(2)

The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by:
Based on observations, staff interview and clinical record review, it was determined that the residential staff failed to provide a specialized place mat during dinner for one of four Individuals in the survey sample, Individual # 2. Facility staff failed to provide Individual # 4 with a Dycem place mat [1] during dinner.

The findings include:

Individual # 4 admitted to (Name of Group Home) on 05/19/2016, diagnoses in the clinical record included but were not limited to: profound intellectual disability [2], Lennox Gastaut syndrome [3] and swallowing difficulties.

On 11/12/19 at approximately 5:55 p.m., an observation was conducted of Individual # 4 eating dinner. Individual # 4 was in a chair, at a table in the dining room with another staff member next to him. Observation of the place setting revealed Individual # 4's drink was provided along with a flat plastic spoon and a scoop dish with a plate guard. Further observation of the meal failed to evidence the use of a Dycem mat for the plate to set on.

Provider's Plan of Correction (W 436) — Completion date: 12/23/19

1. The Program Manager will review individual #4's mealtime adaptive equipment for accuracy as well as all other individuals' adaptive equipment.

2. The Program Manager will retrain program staff on the correct mealtime adaptive equipment to be used for individual #4.

3. The Program Manager will retrain program staff on the correct mealtime adaptive equipment to be used for all individuals in the home.

4. The Program Manager and/or Program Nurse will conduct monthly mealtime observations to ensure staff are using the correct adaptive equipment. The Program Manager and/or Program Nurse will model the appropriate behaviors for staff to follow during mealtime.

5. Mission Effectiveness and/or the Clinical Director will also conduct quarterly observations and record reviews to prevent deficiencies.

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The POS [physician's order sheet] dated 11/01/19 through 11/30/19 and signed by the physician on 11/06/19 documented, "Adaptive Equipment. Flat plastic maroon spoon, Scoop dish with plate guard, Dycem mat."

The "Nutritional Assessment' dated 04/12/2019 documented, "Adaptive Equipment: Per 02/2018 POS - Flat plastic maroon spoon, Scoop dish with plate guard, dycem mat."

On 11/13/19 at approximately 9:30 a.m., an interview was conducted with ASM [administrative staff member] # 2, program manager. When asked what a Dycem mat is used for, ASM # 2 stated, "To keep the plater from sliding on the table." When asked how staff know what adaptive equipment should be used for Individual # 4's meals, ASM # 4 stated, "The adaptive equipment is posted in the kitchen." ASM # 4 went into the kitchen with this surveyor and opened up a kitchen cabinet. Observation of the inside of the cabinet door revealed a paper with the initials of Individual # 4 on the top of the page. Further observation of the sheet of paper documented, "Adaptive Equipment: Flat Plastic Large Spoon, Scoop Dish, Plateguard and Dycem Mat." Above the name of each piece of adaptive equipment was a photograph of the piece of adaptive equipment. When informed of the above observation, ASM # 2 stated that the Dycem mat should have been used during Individual # 4's meal.

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified

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	49G014	A. BUILDING ___ B. WING ___	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINERVA FISHER HALL GROUP HOME	8207 WOLFTRAP RD VIENNA, VA 22180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 37 Intellectual Disabilities Professional) were made aware of the findings. No further information was provided prior to exit. References: [1] Dycem® is a non-slip, rubber-like plastic material used to stabilize surfaces. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.html. [2] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=100 [3] This syndrome usually begins between the ages of 3 and 5, but can start as late as adolescence. Children may have several different types of seizure with this syndrome. These include tonic (where the muscles suddenly become stiff), atonic (where the muscles suddenly relax), myoclonic, tonic clonic and atypical absences. Atypical absences often last longer than normal absences and are different as a child may be responsive and aware of their surroundings.	W 436		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455		

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W 455	Continued From page 38 This STANDARD is not met as evidenced by: Based on observations and staff interviews it was determined that the facility staff failed to follow infection control practices during the medication administration observation, during the preparation of a meal and following the incontinence care of one of four individuals in the survey sample, Individual # 3. The findings include: 1a. The facility staff failed DSP [direct support professional] # 4 was observed with his fingers on the inside of the medication cup when preparing and administering medications. On 11/12/19 at approximately 4:22 p.m., an observation was conducted of DSP [direct support professional] # 4 preparing medications for administration. After entering [Name of Group Home's] the medication room, DSP # 4 picked up a set of keys from the top of the medication cart, opened the drawer to the medication cart, and removed three bubble pack cards. DSP #4 closed the drawer and removed two small plastic medication cups from a stack of cups on top of the medication cart. As DSP # 4 removed the cups from the stack, he was observed placing his fingers inside each cup as he turned the cups right side up. DSP # 4 then dispensed medications into each of the two cups, transferred the tablets to a small plastic bag, and crushed them. DSP #4 then poured the crushed tablets back into each of the cups, mixed the crushed medications with applesauce in each of the cups and administered the medications to an individual who resided at the home.	W 455	1. The Program Manager will review the medication administration and infection control policies with the staff involved in supervision with an emphasis on ensuring staff does not place their fingers inside of the medication cup while administering medications to individual #3 as well as all individuals in the home. 2. The Program Nurse will train all program staff on the medication administration policy as well as the infection control policy with an emphasis on what constitutes contamination of the medications. 3. The Program Manager and/or Program Nurse will conduct random unannounced medication administration observations to ensure infection control practices are being rendered appropriately for individual #3 and all other individuals during medication administration. The Clinical Director will monitor the process. 4. Annual Recertification Medication Administration Training is required by all staff. The Clinical Director will review that all staff members complete the training in a timely manner.	12/23/19

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On 11/13/19 at approximately 4:30 p.m., an interview was conducted with DSP # 4. When informed him of the above observation DSP # 4 stated, "I knew I had put my fingers inside the cups, I should have held them by the bottom and kept my fingers on the outside of the cups."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] were made aware of the findings.

No further information was provided prior to exit.

1b. The facility staff failed to protect Individual's food from contamination by holding cooked turkey burgers with their fingers while cutting them.

On 11/12/19 at approximately 5:50 p.m., an observation of OSM [other staff member] # 1, QIDP [Qualified Intellectual Disabilities Professional] preparing meals in the kitchen of [Name of Group Home]. OSM # 1 was observed cutting up a turkey burger on an Individual's plate. While using a pair of kitchen shears, OSM # 1 cup up the burger and held it in place on the plate using her bare fingers. After cutting up the burger, OSM # 1 picked up another burger with her bare fingers and using the kitchen shears, cut it in half and placed it on the Individual's plate. After preparing the Individual's plates with the dinner items, including the chopped up turkey burgers, the Individuals were given their plates and ate their dinners.

On 11/13/19 at approximately 5:00 p.m., an

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interview was conducted with OSM #1 regarding the preparation of the turkey burgers. OSM # 1 stated, "We have a policy that no gloves are to be used in the kitchen when preparing an individual's food." When asked if it was appropriate to touch an Individual's food with bare hands, OSM # 1 stated, "I don't think so."

On 11/13/19 at approximately 5:05 p.m., an interview was conducted with ASM [administrative staff member] # 1, clinical director. When informed of the observation above, ASM # 1 stated, "She should have used a utensil to hold the burgers while cutting them." When asked about the policy of not using gloves when preparing an Individual's food, ASM # 1 stated, "She [OSM # 1] misunderstood. We have a practice of not using gloves to cook food; she shouldn't have touched the food with her bare hands."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

1c. The facility staff failed to remove gloves and wash hands after providing incontinence care to Individual # 3.

Individual # 3 diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], cerebral palsy [2], and seizure disorder [3].

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On 11/12/19 at 4:10 p.m., DSP [direct support professional] # 1 was observed coming out an Individual # 3's bedroom wearing blue plastic disposable gloves on each hand and carrying a plastic bag with some items inside. DSP # 1 was observed walking through the home to the front door while still wearing the gloves. He then pushed on the exit bar of the front door, opened the door, walked outside to the dumpster, threw the bag into the dumpster, removed the blue plastic gloves, threw them into the dumpster. DSP #1 then re-entered the home through the front door, went to a supply closet, removed an eight-ounce carton of a liquid supplement, took it to the kitchen, placed it on the counter and proceeded to the living room to join the other staff and Individuals. DSP # 1 was not observed washing his hands at any time during the observation.

At approximately 4:25 p.m., another staff member was observed retrieving the liquid supplement and giving it to an individual and she began to drink it.

On 11/12/19 at 4:40 p.m., an interview was conducted with DSP # 1. When asked why he was wearing blue plastic disposable gloves when he came out of an individual's bedroom earlier, DSP # 1 stated, "I was changing [Name of Individual # 3]." When asked what was in the bag he took out side, DSP # 1 stated, "It was the soiled diaper and wipes." After being informed of the above observation, DSP # 1 stated, "I should have taken the gloves off before coming out of the room." When asked why that was important, DSP # 1 stated, "To prevent the spread of germs." When asked to describe the process that is followed after removing disposable gloves,

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DSP # 1 stated, "Wash your hands." DSP # 1 further stated, "I should have washed my hands after taking off the gloves and before I got the protein drink for [Name of Individual]."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP [Qualified Intellectual Disabilities Professional] were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.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.

W 475 MEAL SERVICES W 475
CFR(s): 483.480(b)(2)(iv)

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W 475	Continued From page 43 Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations and staff interviews and clinical record review, it was determined that the facility staff failed to provide the proper size spoon for eating while eating dinner for one of four individuals in the survey sample, Individual # 2. The facility staff failed to provide Individual # 2 with a regular size spoon to eat her dinner. The findings include: Individual # 2 admitted to [Name of Group Home] on 02/16/2005, diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], epilepsy [2] and cerebral palsy [3]. On 11/12/19 at approximately 5:55 p.m., an observation was conducted of Individual # 2 during the dinner. Individual # 2 was seated at the dining room table, with other individuals who resided at [Name of group Home]. Individual # 2 was provide with a regular cup, a dinner plate with plate guard and a table spoon as her utensil to eat her meal with. Further observations during the meal revealed Individual # eating her entire meal using the tablespoon. The "Nutritional Assessment" for Individual # 2 dated 04/04/2019 documented in part, "Adaptive Equipment: per 03/219 POS [physician's order sheet]: Plate guard if attempting to feed herself." Further review of the "Nutritional Assessment" failed to evidence the use of a tablespoon for eating meals.	W 475	1. The Program Manager will review individual #2's mealtime adaptive equipment documentation for accuracy as well as all other individuals adaptive equipment documentation. 2. The Program Manager will retrain program staff on the correct mealtime adaptive equipment to be used for individual #2. 3. The Program Manager will retrain program staff on the correct mealtime adaptive equipment to be used for all individuals in the home. 4. The Program Manager and/or Program Nurse will conduct monthly mealtime observations to ensure staff are using the correct adaptive equipment. The Program Manager and/or Program Nurse will model the appropriate behaviors for staff to follow during mealtime. 5. Mission Effectiveness and/or the Clinical Director will also conduct quarterly observation and record reviews to prevent deficiencies.	12/23/19

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The POS for Individual # 2 dated 11/01/2019 to 11/30/2019 documented in part, "Treatment Orders: plate with guard if feeding self." Further review of the POS failed to evidence the use of a tablespoon to eat meals.

On 11/13/19 at 9:30 a.m., an interview was conducted with ASM [administrative staff member] # 2, program manager. After informed of the above observation ASM # 2 stated, she [Individual # 2] should have been provided with a regular teaspoon and not a table spoon."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100.

[2] A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was

W 475 (Plan of Correction) — 12/23/19

1. The day support staff will be retrained by the day support manager on ensuring table service is provided for individual #3 and all other individuals supported who can and will eat at a table including individuals in wheelchairs.
2. The day support Manager will conduct monthly mealtime observations as needed and model appropriate behaviors to ensure day support staff are ensuring all individuals are sitting at the table during meals.
3. The residential QIDP will complete unannounced day support observations to ensure day support staff are promoting the rights of the individuals during mealtime and all individuals including individual #3 are sitting at the table during meal times at day support. In the event any individual(s) prefers not to sit at the table, their preference(s) will be honored for them to sit where they wish and the individual(s) ISP will include the individual(s) preference.
5. The residential Program Manager will monitor/review the completion of the day support observations on a monthly basis.
6. CRi Mission Effectiveness and/or the Clinical Director will also conduct periodic day support record reviews/ staff observations to prevent deficiencies.

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obtained from the website:
https://medlineplus.gov/epilepsy.html.

[3] A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

W 483 | DINING AREAS AND SERVICE | W 483

CFR(s): 483.480(d)(2)

The facility must provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and clinical record review it was determined that the facility staff failed to provide an opportunity for an individual to eat at a table for one of four individuals in the survey sample, Individual # 3. The facility staff failed to provide an opportunity for Individual # 3 to eat lunch at a table in the dining area at (Name of Day Program).

The findings include:

Individual # 3's diagnoses in the clinical record included but were not limited to: profound intellectual disability [1], cerebral palsy [2], and seizure disorder [3].

On 11/13/19 at approximately 12:05 p.m., an observation was conducted of Individual # 3 in the dining area at [Name of Day Program]. Individual

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3 was seated in her wheelchair with the lap tray attached. OSM [other staff member] # 3, APM [assistant program manager] of [Name of Day Program] provided and placed a plastic clothing protector on Individual # 1. Observation of Individual # 3's wheelchair revealed it was back from the table and behind other individuals who were seated at the table. Further observation of the position of Individual # 3's wheelchair revealed it was next to the support pillar of the room. Observations during the meal revealed staff were able to walk between Individual # 2's wheelchair and the table to get around the table to assist those individuals seated at the table. Observations of the table revealed three empty seats.

On 11/13/19 at approximately 1:10 p.m., an interview was conducted with OSM # 3. When informed of the above observation of Individual # 3 not being at the table to eat with the other individuals, OSM # 3 stated, "She should have been brought up to the table."

On 11/13/19 at approximately 1:20 p.m., an interview was conducted with OSM # 4, QIM for [Name of Day Program]. When informed of the above observation of Individual # 3 not being at the table to eat with the other individuals, OSM # 4 stated, "Staff should be more observant of her proximity to others for socialization."

On 11/13/19 at approximately 4:10 p.m., an interview was conducted with OSM # 1, QIDP [Qualified Intellectual Disabilities Professional] and ASM (administrative staff member) # 2, program director of [Name of Group Home]. After being informed of the observation of Individual # 3 not being at the table to eat with the

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other individuals at [Name of Day Program], ASM # 2 stated, "She should have been brought up to the table it also promotes her socialization."

On 11/13/19 at approximately 5:07 p.m., ASM [administrative staff member] # 1, clinical director, ASM # 2, program manager, and OSM [other staff member)] # 1, the QIDP (Qualified Intellectual Disabilities Professional) were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.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.