CENTER	MENT OF HEALTH AN S FOR MEDICARE & OF DEFICIENCIES	ID HUMAN VICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIP	LE CONSTRUCTION	FOR OMB N	D: 09/07/2020 M APPROVED O. 0938-0391 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1	S		PLETED
		49G014	B. WING		80	3/27/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	IOME		8207 WOLFTRAP RD VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
€ 000	survey was conducte facility was in substar	nergency Preparedness d on 08/27/2020. The ntial compliance with 42 CFR ment for Long-Term Care	E 00	1. The Program Manager will train prostaff during the staff meeting on the individual's rights as it pertains to dinion an emphasis on ensuring staff are sitting assisting the individuals with meals are fraining from standing over individual during all mealtimes.	ng with ng down id	10/2/2020
W 125	An unannounced and Care Certification sur 08/27/2020. The facility 42 CFR Part 483 Intermediate Care Far Retarded. The Life Stollow. The census in this ning the time of the survey consisted of four curr (Individuals #1, #2, #PROTECTION OF CCFR(s): 483.420(a)(3) The facility must ensurable facility individual clients to e of the facility, and as including the right to to due process.	nual Medicaid ICF/ID Health vey was conducted on lity was not in compliance B Requirements for cilities for the Mentally safety Code survey report will ne bed facility was seven at 7. The survey sample ent Individual reviews 3 and # 4). LIENTS RIGHTS	W 00	2. The Program Manager will train prostaff during the staff meeting on the individuals' rights as it pertains to dinion an emphasis on ensuring staff are sitting assisting the individuals with meals are refraining from standing over all individuring mealtimes. 3. The Program Manager, QIDP, and Program Nurse will complete monthly observations during mealtime to ensurare following the appropriate mealtime guidelines and ensuring the rights of a individuals during mealtimes. 4. The Clinical Director will monitor completion of the monthly mealtime observations on a quarterly basis.	ng with ng down id riduals or re staff e	
	Based on observation document review, it was facility staff failed to a their rights for dignity	on, staff interview and facility was determined that the allow individuals to exercise during a meal for one of survey sample, Individual #				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Terell Jones

The findings include:

Clinical Director

9/15/2020

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

DEPARTMENT OF HEALTH AND HUMAN SYICES CENTERS FOR MEDICARE & MEDICAID SERVICES				\bigcirc		D: 09/07/2020 MAPPROVED	
CENTER	S FOR MEDICARE & I					OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY PLETED
		49G014	B. WING			08.	/27/2020
NAME OF PE	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	OME			3207 WOLFTRAP RD VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
W 125	Continued From page	1	w	125			
	While Individual # 1 w DSP [direct support p to Individual # 1 while physical cues.	ras eating their breakfast, rofessional] #2, stood next providing verbal and					
	admitted to [Name of	ed but were not limited to: lisability [1], impulse bral palsy [3] and					
	observation was condining area at [Name # 1 was seated in a rethe dining room table. professional] # 2, provprotector on Individual Individual # 1 with thei disposable bowl and professional individual # 1 standing next to	vided and placed a clothing I # 1, then provided r breakfast in a paper provided a white plastic at with. Observations meal revealed DSP # 2 dual # 1 while they ate erbal and physical cues to					
		ed with DSP # 2. When d to be standing next to ey were eating their					
	interview was conduct staff member] # 1, pro informed of the above	timately 12:10 p.m., an ed with ASM [administrative gram manager. When observation ASM # 1 e sitting next to the resident		i			

		D HUMAN VICES			\bigcirc	FORM	APPROVED
	• •	MEDICAID SERVICES	1). 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49G014	B. WING			08/	27/2020
NAME OF PR	ROVIDER OR SUPPLIER			- ;	STREET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	OME			8207 WOLFTRAP RD		
			<u> </u>	'	VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
W 125	Continued From page	2	w	125	5		
	or across from them in	n order to assist." When					
	-	appropriate to stand next to					
	an individual while the	ey were eating, ASM # 1					
		.1 Human Rights Plan" 2.1.4 Dignity. Individuals					
		ignity as a human being					
	and free from abuse."	· ·					
	[administrative staff manager, and ASM #	proximately 12:30 p.m., ASM nember] # 1, program 2, the QIDP [Qualified s Professional] were made					
	aware of the findings.	-					
	No further information	n was provided prior to exit.					
	by a limited mental ca adaptive behaviors su schedules and routine This information was	of disorders characterized apacity and difficulty with uch as managing money, es, or social interactions. obtained from the website: n.gov/NIHfactsheets/ViewFa					
	an inability to resist the action that is harmful information was obtain	sorders are characterized by the impulse to perform an to one's self or others. This ned from the website: ary.thefreedictionary.com/lm ders.					
	ability to move and to	ers that affect a person's maintain balance and ation was obtained from the					

https://www.nlm.nih.gov/medlineplus/cerebralpals

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SVICES MEDICAID SERVICES		0	FORM): 09/07/2020 1 APPROVED): 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G014	B. WING	08/	27/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·		
MINERVA	FISHER HALL GROUP H	OME		207 WOLFTRAP RD /IENNA, VA 22180			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 125	Continued From page y.html.	3	W 125	The Program Manager will retrain staff on the implementation of individ- active treatment program for meal program.	lual #1's	10/2/2020	
W 159			W 159	program per the ISP. 2. The Program Manager will retrain staff on the implementation of Individuative treatment range of motion exerthe ISP. 4. The Program Manager will retrain	lual #2's cises per		
	integrated, coordinate qualified intellectual d This STANDARD is n Based on record reviewas determined that t Intellectual Disabilities coordinate and monito treatment programs for the survey sample, Inc. 4.	isability professional. ot met as evidenced by: ews, and staff interview, it he QIDP [Qualified e Professional] failed to or the individuals' active or four of four individuals in dividuals # 1, # 2, # 3 and #		staff on the implementation of individual active treatment program for the remodishes per the ISP. 5. The Program Manager will retrain staff on the implementation of all indiactive treatment programs per their IS6. The Program Manager will retrain on writing individual #4's medication administration goal in measurable terms.	lual #3's oval of program oviduals' Ps. the QIDP ms. The		
	professional] failed to active treatment for m implemented according centered plan]. 2. The QIDP [qualified professional] failed to active treatment for rawas implemented according centered plan]. 3. The QIDP (qualified professional) failed to active treatment for the active treatment for the professional) failed to active treatment for the implementation of the active treatment for the active treatment	g to the PCP [person intellectual disabilities ensure Individual #2's nge of motion exercises ording to the PCP [person intellectual disabilities		ISP will be updated and amended and measurable terms. 6. The Program Manager will review individuals' goals with the QIDP and they are all written in measurable term update and amend if necessary. 7. The Program Manager will monitorshift weekly as they implement the in ISP goals to ensure they are implement goals per the ISP. 8. The Clinical Director will audit the Quarterly to ensure all goals are written measurable terms and staff are implement goals per the ISP.	all ensure as and r staff on dividual's ating the e program en in		

DEPARTMENT OF HEALTH AND HUMAN VICES CENTERS FOR MEDICARE & MEDICAID SERVICES				()	FORM	1 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	49G014	B. WING			08/2	27/2020
NAME OF PROVIDER OR SUPPLIER	- 	-1		STREET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA FISHER HALL GROUP	HOME			8207 WOLFTRAP RD VIENNA, VA 22180		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
professional) failed management outcome (person centered plana professional) failed management outcome (person centered plana professional) for line diagnoses that inclus profound intellectual disorder [2], mild cesself-injurious behave Individual #1's PCP 03/31/2021 docume [Individual #1] will a [preparation] for 5 [in accuracy for 12 contact Activities & Instructing staff that she would [Individual #1] will will will will will will will wil	ded intellectual disabilities to define the medication me of Individual #4's PCP an) in measurable terms. a 46 year old female, who me of Group Home] with ded but were not limited to: I disability [1], impulse rebral palsy [3] and for [4]. dated 04/01/2020 through med, "Desired Outcome: ssist with meal preprive] minutes with 100% secutive months. Support fons: 1. [Individual #1] signs to like to have food. 2. Walk with staff to the kitchen. Fer hand assist [Individual #1] edients. 4. [Individual #1] edients. 4. [Individual #1] edients. 4. [Individual #1] edients. 5. Ves praise from staff for her less will document in her less and the level of [Credible. 7. Progress will be by the QIDP [qualified less professional]. 8. When followed a 4 [four] step task of lich day for 5 minutes with 12 consecutive months. Type: luency: Weekly."	W	159			

		\ /			\bigcirc			MAPPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ONSTRUCTION		(X3) DATE	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 159 Continued From page 5 documented the letter "C". Further review of the data collection sheets documented "Key C-cancelled."		B. WING_				08/	/27/2020	
AND PLAN OF CORRECTION 49G014 NAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 159 Continued From page 5 documented the letter "C". Further review of the data collection sheets documented "Key C-		}	STF	REET ADDRESS, CITY, STATE, ZIP COD	Ę			
MINERVA	FISHER HALL GROUP H	IOME			7 WOLFTRAP RD NNA, VA 22180			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	,	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
	documented the letter data collection sheets cancelled." Review of Individual # for August 1, 2020 the documented a minus the data collection she chose not to participal On 8/27/20 at approximaterview was conducted a minus the data collection she chose not to participal On 8/27/20 at approximaterview was conducted staff member] #2, QIL Disabilities Profession of the PCP. ASM #2 document for staff to sterms of what they callo abilities, and to give in independent life as point the Individual's PCF stated some goals/ou due to restrictions so cancelled. ASM #2 stated some goals/ou due to restrictions so cancelled. ASM #2 stated the home had Individual # 1's outcome was reviewed stated the home had Individual # 1's outcome was the kitchen due to On 8/27/20 at 11:42 a conducted with DSP [#1 and ASM # 2. DSF Individual # 1 to assist Individual # 1 to Individual # Individual # Individual # Individual # Individual # Individual # Ind	r "C". Further review of the adocumented "Key C- #1's data collection sheets rough August 26, 2020 sign "-". Further review of eets documented "Key [-] = te." imately 10:52 a.m., an ted with ASM [administrative DP [Qualified Intellectual hal], regarding the purpose stated that the PCP was a see individuals' progress in a chieve, their limitations, adviduals as much of an assible. ASM #2 was asked as were reviewed. ASM #2 tcomes could not be done the programs were tated staff was instructed by arters to keep individuals in all #1's meal preparation d with ASM #2. ASM #2 peen taking the meals to the the since March 2020, so the could not be a Individual #1 stated she offered the with meal preparation in test and second because the	W	159				
		20 through July 31, 2020						İ

DEPARTMENT OF HEALTH AND HUMAN

		D HUMAN VICES			\bigcirc		APPROVED	
		MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		49G014	B. WING			08/	27/2020	
NAME OF P	ROVIDER OR SUPPLIER		•	s	TREET ADDRESS, CITY, STATE, ZIP CODE			
MINERVA	FISHER HALL GROUP H	OME			i207 WOLFTRAP RD /IENNA, VA 22180			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 159	menus consisted of cand sandwiches. Of 2020 through July 31 that consisted of wars stated Individual # 1 opreparation of these room. When asked if preparation outcome implemented in their of the Individual # 1 opreparation outcome implemented in their of the Individual # 1 opreparation outcome implemented in their of the Individual # 1 opreparation outcome implemented in their of Individual # 1 opreparation outcome implemented in their of Individual # 1 opreparation outcome implemented in their of Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcome implemented in their outcome Individual # 1 opreparation outcom	SP #1 and ASM #2. The old foods such as wraps the 61 days between June1, 2020, there were 43 meals as and sandwiches. ASM #2 could have assisted with meals in Individual # 1's findividual # 1's meal could have been room, ASM #2 stated yes. Home's] document "Lead a part, "The lead QIDP is 19, mentoring, oversight of 2 services and continuity of 2 services and continuity of 2 services and continuity of 3 services and difficulty with 10 services and difficulty with 11 services, or social interactions. Sobtained from the website: 11 n.gov/NIHfactsheets/ViewFa 100 sorders are characterized by 19 services and continuity of 19 services. This 19 services are characterized by 19 services are	W	159				

DEPART	MENT OF HEALTH AN	ID HUMAN (VICES			\bigcirc		ED: 09/07/2020 RM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	OMB NO					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		TE SURVEY MPLETED	
		49G014	B. WING			0	8/27/2020	
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u>		
	FIGUED HALL COOUD II	IOME		820	07 WOLFTRAP RD			
WIINERVA	FISHER HALL GROUP H	IOME		VII	ENNA, VA 22180			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 159	Continued From page ability to move and to posture. This informat website: https://www.nlm.nih.gry.html. (4) Self-harm refers to own body on purpose obtained from the well https://medlineplus.gd 2. The facility staff fail #2's PCP for range of lindividual #2 was a 4 admitted to [Name of diagnoses that include profound intellectual of [2] and seizure disord lindividual #2's PCP d 06/30/2021 document [Individual #2] will act range of motion exercises.	maintain balance and ation was obtained from the ov/medlineplus/cerebralpals a person's harming their and the information was bosite: ov/selfharm.html. Ided to implement Individual motion exercises. Tyear old female, who was Group Home] with ed but were not limited to: disability [1], cerebral palsy		1159				
	months by 06/30/21. Instructions: 1. Notify to begin her range of	uracy for 12 consecutive Support Activities & [Individual #2] that it is time motion exercises. 2. Assist nat. 3. Demonstrate each						
	only move to the poin the movement. 4. Giv [Individual #2] to performers. 5. Praise [performs the exercise	orm demonstrated Individual #2] when she . 6. If [Individual # 2] is nan 3 prompts to perform						

[Individual # 2] had difficulty with and report goal

	MENT OF HEALTH AN	D HUMAN VICES MEDICAID SERVICES			\bigcirc	FC	ORM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		49G014	B. WING				08/27/2020
NAME OF PR	ROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				820	7 WOLFTRAP RD		
MINERVA	FISHER HALL GROUP H	OME		VIE	NNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 159	to be successful complete document which rang performed successful her responses to support of the QIDP. 10. [Individual is outcome when shin 3 [three] range of move with no more the duration of 10 minute consecutive months. Frequency: Daily." The data collection ship through July 31, 2020 documented the letter documented in part, review of the data colfollowing documentat coronavirus pandemic remain cancelled as a consecutive was conducted in the property of the PCP. ASM #2 document for staff to terms of what they can be abilities, and to give independent life as prif the Individual's PCF stated some goals/out due to restrictions so cancelled. ASM #2 sthe company headquestimes and to support of the company headquest independent life as prif the Individual's PCF stated some goals/out due to restrictions so cancelled. ASM #2 sthe company headquest.	c. If [Individual # 2] is found cleting a given exercise(s) e of motion exercises she ly. 8. Staff will document corts and services in will be reviewed monthly by dual #2] will have achieved the has actively participated notion exercises 3 times a an 3 verbal prompts for a stat 100% accuracy for 12. Type: Skill Building. Type: Skill Building. Type: Skill Building. Type: Skill Building. Type: Junder "Key" it C-cancelled." Further lection sheet revealed the ion, "Due to ongoing c, all in home activities a safety precaution." Imately 10:52 a.m., an atted with ASM [administrative DP [Qualified Intellectual hal], regarding the purpose stated that the PCP was a see individuals as much of an obsible. ASM #2 was asked Ps were reviewed. ASM #2 atcomes could not be done	W	159			

exercise outcome was reviewed with ASM #2.

PRINTED: 09/07/2020

F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	SIDLE CONSTRUCTION		<u>J. 0938-0391</u>	
			(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	49G014	B. WING	-	08.	/27/2020	
OVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODI			
FISHER HALL GROUP H	OME		8207 WOLFTRAP RD VIENNA, VA 22180			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
After reviewing Individual #3's PCP data and collection sheet, the p When asked if Individual and could have been imple # 2 stated yes. On 8/27/20 at 12:10 p aware of the above con the short of the s	dual # 2's data collection through July 31, 2020, coording to the data program was cancelled. ual # 2's exercise outcome emented in their room, ASM a.m., ASM #1 was made concern. was presented prior to exit. If intellectual disabilities ensure Individual #3's e removal of dishes was PCP (person centered plan). mitted to (name of group vidual #3's diagnoses limited to profound mental sorder and seasonal	W	159			
place his dishes in the minutes and with no m at 100% accuracy for 9/30/20. Start Date: 1	sink after eating within 5 nore than 3 verbal prompts 12 consecutive months by 0/01/2019. End Date:					
when: when i am ab the sink with no promp Instructions: 1. After e verbally prompt (Indivi to the sink. 2. (Individ- in the sink with no mor from staff. 3. Staff will	le to take my own dishes to oting. Support Activities & ating meals, staff will dual #3) to take his dishes ual #3) will place his dishes re than 3 verbal prompts praise (Individual #3) for					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page After reviewing Individes sheets for July1, 2020 ASM #2 stated that accollection sheet, the page when asked if Individes could have been impleated by the stated yes. On 8/27/20 at 12:10 paware of the above consumers of the above consumers of the short of the stated yes. On 8/27/20 at 12:10 paware of the above consumers of the short of the stated yes. No further information 3. The QIDP (qualified professional) failed to active treatment for the implemented per the functional #3 was adminimated but were not retardation, seizure disallergies. Individual #3's PCP da "Desired Outcome: (National With no mat 100% accuracy for 9/30/20. Start Date: 109/30/2020. I no long when: when i am about the sink with no promples in the sink with no promples in the sink with no moniform staff. 3. Staff will his participation. 4. Professional programmers in the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no moniform staff. 3. Staff will his participation. 4. Professional page with the sink with no	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 After reviewing Individual # 2's data collection sheets for July1, 2020 through July 31, 2020, ASM #2 stated that according to the data collection sheet, the program was cancelled. When asked if Individual # 2's exercise outcome could have been implemented in their room, ASM # 2 stated yes. On 8/27/20 at 12:10 p.m., ASM #1 was made aware of the above concern. No further information was presented prior to exit. 3. The QIDP (qualified intellectual disabilities professional) failed to ensure Individual #3's active treatment for the removal of dishes was implemented per the PCP (person centered plan). Individual #3 was admitted to (name of group home) on 8/3/09. Individual #3's diagnoses included but were not limited to profound mental retardation, seizure disorder and seasonal	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 After reviewing Individual # 2's data collection sheets for July1, 2020 through July 31, 2020, ASM #2 stated that according to the data collection sheet, the program was cancelled. When asked if Individual # 2's exercise outcome could have been implemented in their room, ASM # 2 stated yes. On 8/27/20 at 12:10 p.m., ASM #1 was made aware of the above concern. No further information was presented prior to exit. 3. The QIDP (qualified intellectual disabilities professional) failed to ensure Individual #3's active treatment for the removal of dishes was implemented per the PCP (person centered plan). Individual #3 was admitted to (name of group home) on 8/3/09. Individual #3's diagnoses included but were not limited to profound mental retardation, seizure disorder and seasonal allergies. Individual #3's PCP dated 9/20/19 documented, "Desired Outcome: (Name of Individual #3) will place his dishes in the sink after eating within 5 minutes and with no more than 3 verbal prompts at 100% accuracy for 12 consecutive months by 9/30/20. Start Date: 10/01/2019. End Date: 09/30/20.20. I no longer need this outcome when: when i am able to take my own dishes to the sink with no prompting. Support Activities & Instructions: 1. After eating meals, staff will verbally prompt (Individual #3) to take his dishes to the sink. 2. (Individual #3) to take his dishes to the sink with no more than 3 verbal prompts from staff. 3. Staff will praise (Individual #3) for his participation. 4. Progress will be documented	ISHER HALL GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 After reviewing Individual # 2's data collection sheets for July 1, 2020 through July 31, 2020, ASM #2 stated that according to the data collection sheet, the program was cancelled. When asked if Individual # 2's exercise outcome could have been implemented in their room, ASM #2 stated yes. On 8/27/20 at 12:10 p.m., ASM #1 was made aware of the above concern. No further information was presented prior to exit. 3. The OIDP (qualified intellectual disabilities professional) failed to ensure Individual #3's active treatment for the removal of dishes was implemented per the PCP (person centered plan). Individual #3 was admitted to (name of group home) on 8/3/09. Individual #3's diagnoses included but were not limited to profound mental retardation, seizure disorder and seasonal allergies. Individual #3's PCP dated 9/20/19 documented, "Desired Outcome: (Name of Individual #3) will place his dishes in the sink after eating within 5 minutes and with no more than 3 verbal prompts at 100% accuracy for 12 consecutive months by 9/30/20. Start Date: 10/01/2019. End Date: 09/30/2020. I no longer need this outcome when: when I am able to take my own dishes to the sink. 2. (Individual #3) will peace his dishes to the sink vill no prompting. Support Activities & Instructions: 1. After eating meals, staff will verbally prompt (Individual #3) to take his dishes to the sink vill no prompting. Support Activities & Instructions: 1. After eating meals, staff will verbally prompt (Individual #3) to take his dishes to the sink vill no prompting comments of the sink will no more than 3 verbal prompts from staff. 3. Staff will presses will be documented	SUMMAY STATEMENT OF DETICIENCIES (SACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 After reviewing Individual # 2's data collection sheets for July 1, 2020 through July 31, 2020, ASM #2 stated that according to the data collection sheets for July 1, 2020 through July 31, 2020, ASM #2 stated that according to the data collection sheet, the program was cancelled. When asked if Individual # 2's exercise outcome could have been implemented in their room, ASM #2 stated yes. On 8/27/20 at 12:10 p.m., ASM #1 was made aware of the above concern. No further information was presented prior to exit. 3. The QIDP (qualified intellectual disabilities professional) failed to ensure Individual #3's active treatment for the removal of dishes was implemented per the PCP (person centered plan). Individual #3 was admitted to (name of group home) on 8/30/9. Individual #3's diagnoses included but were not limited to profound mental retardation, seizure disorder and seasonal allergies. Individual #3's PCP dated 9/20/19 documented, "Desired Outcome: (Name of Individual #3) will place his dishes in the sink after eating within 5 mitutes and with no more than 3 verbal prompts at 100% accuracy for 12 consecutive months by 9/30/20. Start Date: 10/01/20/19. End Date: 09/30/20/20. I no longer need this outcome whem when I am able to take my own dishes to the sink with no prompting. Support Activities & Instructions: 1. After eating meals, staff will verbally prompt (Individual #3) to take his dishes in the sink with no more than 3 verbal prompts from staff. 3. Staff will praise (Individual #3) for his participation. 4. Progress will be documented	

	DEPARTMENT OF HEALTH AND HUMAN VICES CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G014 IAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 159 Continued From page 10 be monitored monthly by the QIDP. 6. (Individual #3) will have achieved this outcome when he has placed his dishes in the sink after eating within 5 minutes and with no more than 3 verbal prompts at 100% accuracy for 12 consecutive months. Type: Skill Building." Review of Individual #3's data collection sheets for June 2020 through August 2020 revealed documentation that the above outcome was cancelled because all in home activities were cancelled as a safety precaution due to COVID-19. On 8/27/20 at 10:52 a.m., an interview was conducted with ASM (administrative staff member) #2 (the QIDP [qualified intellectual disabilities professional]), regarding the purpose of the PCP (person centered plan). ASM #2			\bigcirc	FOR	ED: 09/07/2020 MAPPROVED O. 0938-0391	
			(X2) MUL A. BUILD		DISTRUCTION		E SURVEY PLETED
		49G014	B. WING			30	3/27/2020
NAME OF P	ROVIDER OR SUPPLIER	·		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	IOME			WOLFTRAP RD NNA, VA 22180		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 159	be monitored monthly #3) will have achieved placed his dishes in the minutes and with not at 100% accuracy for Type: Skill Building." Review of Individual if for June 2020 throug documentation that the cancelled because at cancelled as a safety COVID-19. On 8/27/20 at 10:52 acconducted with ASM member) #2 (the QID disabilities profession of the PCP (person of the PCP (person of the PCP) their limitation individuals as much a possible. ASM #2 steensuring active treatrimplemented and she collection at the end	y by the QIDP. 6. (Individual d this outcome when he has he sink after eating within 5 more than 3 verbal prompts 12 consecutive months. #3's data collection sheets h August 2020 revealed he above outcome was I in home activities were precaution due to a.m., an interview was (administrative staff OP [qualified intellectual hal]), regarding the purpose	W	159			

to ensure documentation is done and programs are done according to PCPs. ASM #2 was asked if individuals' PCPs were reviewed due to COVID-19 restrictions. ASM #2 stated some goals (outcomes) could not be done due to restrictions so the programs were cancelled. ASM #2 stated staff was instructed by the company headquarters to keep individuals in their rooms. Individual #3's dishes outcome was reviewed with ASM #2. ASM #2 stated the home had been using disposable kitchenware (plates,

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				OWR M	<u>0. 0938-0391</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
· <u> </u>		49G014	B. WING			08	/27/2020	
NAME OF P	ROVIDER OR SUPPLIER			รา	TREET ADDRESS, CITY, STATE, ZIP CODE		·	
MINIEDVA	FIGURE HALL CROUD H	OME		82	07 WOLFTRAP RD			
MIMERAN	FISHER HALL GROUP H	IOME		V	ENNA, VA 22180			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ΒE	(X5) COMPLETION DATE	
W 159	Continued From page	e 11 March 2020. At this time,	w	159				
	ASM #1 (the program	manager) joined the						
	interview. ASM #1 st	ated the purpose of outcome was to teach the	-					
		ers and to not leave dishes						
		stated that according to the	ŀ					
	data collection sheets							
	•	he program could have						
	disposable kitchenwa	ividual #3 to throw the						
	disposable kitchenwa	ie in the hash.						
	On 8/27/20 at 12:10 p	o.m., ASM #1 was made						
	aware of the above co	oncern.						
	No further information	was presented prior to exit.						
į	professional) failed to management outcome	d intellectual disabilities define the medication e of Individual #4's PCP a) in measurable terms.						
		nitted to (name of group dividual #4's diagnoses						
	included but were not	limited to profound						
	intellectual disability, s							
		al #4's PCP dated 6/13/20 i Outcome: #6 Medication						
	•	vidual #4) will participate in						
		ement each day at 100%		1			1	
		cutive months by 6/30/20. I						
	no longer need this or	itcome when: I am able to						
		tions on my own. Support						
	Activities & Instruction							
	(Individual #4's) favori	te pudding flavor dication. 2. Staff will inform]	
	(Individual #4) about h							
i	-	perate and participate in his						
ļ		tion, 4. Staff will praise		-				

DEPARTMENT OF HEALTH AND HUMAN (

PRINTED: 09/07/2020

		ID HUMAN VICES MEDICAID SERVICES			\bigcirc	FOR	:D: 09/07/2020 RM APPROVED O. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		ONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		49G014	B. WING			08	3/27/2020
	ROVIDER OR SUPPLIER FISHER HALL GROUP H	OME		820	REET ADDRESS, CITY, STATE, ZIP CODE 17 WOLFTRAP RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 159	(Individual #4) for his noted via (name of conotes. 6. Progress with QIDP (qualified in professional). 7. (Indiachieved this outcome fully in his medication 100% accuracy for 12 Skill Building." On 8/27/20 at 10:52 conducted with ASM member) #2 (the QID the PCP. ASM #2 standoument for staff to terms of what they care abilities, and to give independent life as pindividuals' PCPs shoutcomes, ASM #2 smedication managem with ASM #2 and ASI Individual #4 participate was documented in ristated the individual participate by being thow Individual #4 will #2 stated he will dem be accepting of medication measured in mea	efforts. 5. Progress will be imputer system) progress ill be monitored monthly by tellectual disabilities ividual #4) will have e when he has participated management each day at 2 consecutive months. Type: a.m., an interview was (administrative staff iP), regarding the purpose of ated the PCP was a see individuals' progress in an achieve, their limitations, individuals as much of an ossible. When asked if build contain measurable tated, "Yes." Individual #4's ment outcome was reviewed if will was asked how ated and how the outcome measurable terms. ASM #2 resists medications so he will cooperative. When asked I evidence cooperation, ASM in the PCP. ASM #2 stated als (outcomes) for individuals' tonsible for ensuring they are	W	159			

DEPART	MENT OF HEALTH AN	ID HUMAN (VICES			\bigcap		D: 09/07/2020 MAPPROVED
		MEDICAID SERVICES			<i>Q</i>). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE	
		49G014	B. WING			08/	27/2020
NAME OF P	ROVIDER OR SUPPLIER		_1. ,	8	STREET ADDRESS, CITY, STATE, ZIP CODE	1 50.	2.72020
				8	3207 WOLFTRAP RD		
MINERVA	FISHER HALL GROUP H	OME		١	/IENNA, VA 22180		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	lD ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	COMPLETION DATE
					1. The Program Manager will retrain th	e QIDP	10/2/2020
W 231	Continued From page	: 13			on writing individual #4's medication		1
W 231	INDIVIDUAL PROGR	AM PLAN	w:		administration goal in measurable terms		
	CFR(s): 483.440(c)(4))(iii)			ISP will be updated and amended and w	ritten in	
					measurable terms.		
	The objectives of the	individual program plan	ŀ	i			
		behavioral terms that			2. The Program Manager will review al		
	provide measurable	ndices of performance.			individuals' goals with the QIDP and en		
					they are all written in measurable terms		
	This STANDARD is n	ot met as evidenced by:			update and amend the plan if necessary.		
		ew, facility document review			0 00 0		
	and residential record	review, it was determined			3. The Program Manager will review ar		
		iled to ensure outcomes on			monitor all new goals written by the QII		
		al service plan/ person			ensure they are all written in measurable	terms.	
	centered plan) were d	eveloped in measurable			A The Clinical Division 111 1241		į
	terms for one of four i	ndividuals in the survey	İ		4. The Clinical Director will audit the p	rogram	
		The facility staff failed to			Quarterly to ensure all goals are written measurable terms.	ın [
	define the medication measurable terms for	management outcome in Individual #4.			measurable terms.	i	
	The findings include:						
	lndividual #4 was adm	nitted to (name of group					
		dividual #4's diagnoses		ł		ļ	
	included but were not						
	intellectual disability, s						
	constipation. Individua						ļ
	centered plan) dated 6			ļ		ļ	ļ
		Medication Management.				ľ	
		articipate in his medication				1	
		y at 100% accuracy for 12		ļ			
		y 6/30/20. I no longer need		Ì		ŀ	
		l am able to administer my					
		n. Support Activities & ill select (Individual #4's)					
	favorite pudding flavor		1				ł
	medication 2 Staff or	ill inform (Individual #4)		ĺ			
	about his medication.		1			ľ	
ĺ	cooperate and particip					i	
		ff will praise (Individual #4)	1	ļ			ĺ

DEPARTMENT OF HEALTH AND HUMAN (VICES
CENTERS FOR MEDICARE & MEDICAID S	<u>ĭĽŔVICES</u>



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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				SURVEY LETED
		49G014	B. WING			08/2	27/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MINEDVA	FISHER HALL GROUP H	IOME		8	8207 WOLFTRAP RD		
MANGERAN	I IOHEN HAEL GROUP N	- Carlo		١	VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 231	Continued From page	e 14	w:	231	1		
	for his efforts. 5. Prog	gress will be noted via	İ				
		/stem) progress notes. 6.					
	Progress will be moni	tored monthly by the QIDP					
		disabilities professional). 7.					
		ve achieved this outcome					
		ated fully in his medication					
		ay at 100% accuracy for 12					
	consecutive months.	Type: Skill Building."					
	On 8/27/20 at 10:52	a.m., an interview was					
	conducted with ASM						
		P), regarding the purpose of					
	the PCP. ASM #2 sta	ated the PCP was a					
	document for staff to	see individuals' progress in					
		n achieve, their limitations,					,
		ndividuals as much of an					
		ossible. When asked if					
		ould contain measurable					
		tated, "Yes." Individual #4's					
		nent outcome was reviewed					
	with ASM #2 and ASI						
		ated and how the outcome					
		neasurable terms. ASM #2 resists medications so he will					
		cooperative. When asked					
		l evidence cooperation, ASM					
		nonstrate calmness and will					
		cations. ASM #2 stated this					
	was not documented						
	On 8/27/20 at 12:10	p.m., ASM #1 (the program					
		aware of the above concern.					
		d, "4.1 Individual Service					
		cumented, "C. (Name of					
		nat an ISP will contain at a					
		outcomes and measurable					
	objectives/desired ou identified need."	utcomes for addressing each					

DEPART	MENT OF HEALTH AN	ID HUMAN ()ICES					D: 09/07/2020 MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>		D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		49G014	B. WING			08,	/27/2020
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MINICOVA	FISHER HALL GROUP H	OME		8	207 WOLFTRAP RD		
MINTIVAN		OME		ν	/IENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 231	Continued From page	15	w:	231	1. The Program Manager will retrain p staff during the staff meeting on the implementation of individual #1's pcp f	•	10/2/2020
W 249	No further information PROGRAM IMPLEME CFR(s): 483.440(d)(1		w:	249	preparation, individual #2's pcp for rang	ge of	
	each client must receit treatment program co interventions and servand frequency to supp	ndividual program plan, ve a continuous active			 The Program Manger will retrain prostaff on the implementation of all indiviSP goals. The Program Manager will work with QIDP and modify individual #3's PCP fremoval of dishes goal. The ISP will be updated with the modification. 	iduals' th the for the	
	Based on staff intervinerview, it was determined to ensure an Inconservices consistent with Centered Plan of Indiviners and Indiviners and Indivine Indiviners Indivi	ned that the residential staff lividual was receiving th the PCP [Person ee of four individuals in the duals # 1, # 2 and # 3. ed to implement Individual			 The Program Manager will train the ownen goals should be modified per the The Program Manager will review all individual's ISP data to determine if the need to be modified per the data and wi amend the ISP, update, and modify the necessary. The Program Manager will review the implementing all of the individuals goal weekly basis to ensure the goals are being implemented per the ISP. 	data. goals II goals if estaff s on a	
i	#2's PCP for range of3. The facility staff faile	ed to modify and implement			6. The Program Manager will review the data on a monthly basis and work with to QIDP to modify the goals if necessary.		
:	The findings include:	r the removal of dishes. 46 year old female, who			7. The Clinical Director will audit the p on a Quarterly basis to ensure the goals implemented correctly by staff and ensu goals are modified if necessary per the collection.	are re	
,		To Jour old territate, with	1			11	1

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN VICES MEDICAID SERVICES			\bigcirc	FORM	0: 09/07/2020 MAPPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49G014	B. WING			08/	27/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	OME		}	207 WOLFTRAP RD IIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
W 249	diagnoses that includ profound intellectual of disorder [2], mild cere self-injurious behavious lindividual #1's PCP di 03/31/2021 documen [Individual #1] will ass [preparation] for 5 [fiviaccuracy for 12 conse Activities & Instruction staff that she would lill [Individual #1] will wa 3. Staff will hand over to mix the food ingred the pot with staff assi grounding her food to [Individual #1] receive attempts. 6. Progress responses to services participating via [by] of monitored monthly by intellectual disabilities [Individual #1] has fol making her meal each	the of Group Home] with the ed but were not limited to: disability [1], impulse abral palsy [3] and ar [4]. ated 04/01/2020 through the disability meal prepulse is with meal prepulse minutes with 100% are utive months. Support and the staff to the kitchen. The hand assist [Individual #1] stires at and assist [Individual #1] dients. 4. [Individual #1] stires at and a staff for her are significant with the right texture. 5. The ses praise from staff for her are will document in her and the level of credible. 7. Progress will be a the QIDP [qualified as professional]. 8. When allowed a 4 [four] step task of the day for 5 minutes with 2 consecutive months. Type:	W	249			

cancelled."

Review of Individual #1's data collection sheets

documented the letter "C". Further review of the data collection sheets documented "Key C-

Review of Individual #1's data collection sheets for August 1, 2020 through August 26, 2020 documented a minus sign [-]. Further review of the data collection sheets documented "Key [-] =

for June1, 2020 through July 31, 2020

	MENT OF HEALTH AN	ID HUMAN VICES MEDICAID SERVICES			FOR	:D: 09/07/2020 :M APPROVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	O. 0938-0391 E SURVEY PLETED
		49G014	B. WING		80	3/27/2020
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP C	ODE	
MINERVA	FISHER HALL GROUP H	OME		07 WOLFTRAP RD ENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 249	chose not to participal on 8/27/20 at approximaterview was conducted staff member] #2, QIL Disabilities Profession of the PCP. ASM #2 document for staff to sterms of what they call abilities, and to give in independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life as positive independent life individual # 1 outcome because Individual # 1 outcome beca	imately 10:52 a.m., an ted with ASM [administrative DP [Qualified Intellectual hal], regarding the purpose stated that the PCP was a see individuals' progress in a achieve, their limitations, adviduals as much of an absible. ASM #2 was asked as were reviewed. ASM #2 toomes could not be done the programs were tated staff was instructed by arters to keep individuals in all #1's meal preparation d with ASM #2. ASM #2 toomes could not be implemented the since March 2020, so the could not use the kitchen this time, ASM #1, program anterview. After reviewing ta collection sheets for July 31, 2020, ASM #1	W 249			
	COVID-19. When ask Home] was cleared fro ASM # 1 stated, "On A reviewing Individual # for August 1, 2020 thr # 1 was asked about to on August 1, 2020 and	ted when [Name of Group om active COVID-19 cases,				

Individual # 1 chose not to participate. When asked if the outcome for Individual # 1's meal

	MENT OF HEALTH AN S FOR MEDICARE & 1	ID HUMAN (VICES MEDICAID SERVICES			FOR	D: 09/07/2020 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		SURVEY
		49G014	B. WING _		08	/27/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	OME		8207 WOLFTRAP RD VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	preparation was then as choosing not to pa that he would talk to the documented the data. On 8/27/20 at 11:42 a conducted with DSP #1. DSP #1 stated shassist with meal preparation of cold food June1, 2020 through reviewed with DSP # consisted of cold food sandwiches. Of the 6 2020 through July 31 that consisted of wrap and ASM #1 stated in assisted with prepara Individual # 1's room. The [Name of Group Individual Service Plates Implementation of the its development. Confully implemented, wisupport, learning envengagement necessarian in the its development.	offered if staff had coded it articipate, ASM # 1 stated he staff member who on the above dates. a.m., an interview was [direct support professional] he offered Individual # 1 to aration in the room on and because the meals ds. At this time, menus for July 31, 2020, were 1 and ASM #1. The menus ds such as wraps and 61 days between June1, 2020, there were 43 meals as and sandwiches. DSP #1 advidual # 1 could have attion of these meals in Home's] policy "4.1 and (ISP)" documented, "G. and Consumer Engagement: as ISP begins at the time of mponents of the plan are the consumer receiving the	W 2	249		

consumer."

ISP ...All staff working with consumers must be fully engaged in active treatment with the

On 8/27/20 at 12:10 p.m., ASM #1 was made

No further information was presented prior to exit.

aware of the above concern.

	MENT OF HEALTH AN S FOR MEDICARE &	ID HUMAN VICES MEDICAID SERVICES			\bigcirc		PRINTED: 09/07/2020 FORM APPROVED MB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		X3) DATE SURVEY COMPLETED
		49G014	B. WING		···		08/27/2020
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STR	EET ADDRESS, CITY, STATE, ZIP CO	ODE	
MINERVA	FISHER HALL GROUP H	IOME		,	7 WOLFTRAP RD NNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIAT	(XS) COMPLETION E DATE
W 249	by a limited mental candaptive behaviors standardive behaviors sta	of disorders characterized apacity and difficulty with uch as managing money, es, or social interactions. obtained from the website: n.gov/NIHfactsheets/ViewFa 00 sorders are characterized by the impulse to perform an to one's self or others. This ned from the website: ary.thefreedictionary.com/Implers. That affect a person's maintain balance and ation was obtained from the ov/medlineplus/cerebralpals of a person's harming their this information was obtained from the ov/selfharm.html. The ded to implement Individual motion exercises. Tyear old female, who was Group Home] with ed but were not limited to: disability [1], cerebral palsy	W	249			

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN VICES MEDICAID SERVICES			\bigcirc	FORM	D: 09/07/2020 MAPPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49G014	B. WING			08/	27/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	IOME			07 WOLFTRAP RD ENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	range of motion exerce more than 3 verbal properties at 100% accomments by 06/30/21. Instructions: 1. Notify to begin her range of [Individual #2] to the range of motion exerce only move to the point the movement. 4. Given the mo	cively participate in 3 [three] cises 3 times a week with no compts for a duration of 10 curacy for 12 consecutive Support Activities & [Individual #2] that it is time motion exercises. 2. Assist mat. 3. Demonstrate each cise on [Individual # 2] and at of resistance. Do not force eve verbal prompts to corm demonstrated [Individual #2] when she e. 6. If [Individual #2] is han 3 prompts to perform ment which exercises ifficulty with and report goal 7. If [Individual # 2] is found pleting a given exercise(s) the of motion exercises she lly. 8. Staff will document	W	249			
	this outcome when sh in 3 [three] range of n week with no more th	ne has actively participated notion exercises 3 times a nan 3 verbal prompts for a s at 100% accuracy for 12					

Frequency: Daily."

The data collection sheet dated July1, 2020 through July 31, 2020 for Individual #1 documented the letter "C". Under "Key" it documented in part, "C- cancelled." Further review of the data collection sheet revealed the following documentation, "Due to ongoing coronavirus pandemic, all in home activities remain cancelled as a safety precaution."

	MENT OF HEALTH AN	ID HUMAN VICES MEDICAID SERVICES			\bigcirc	F	TED: 09/07/2020 ORM APPROVED
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) I	NO. 0938-0391 DATE SURVEY COMPLETED
		49G014	B. WING				08/27/2020
NAME OF PE	ROVIDER OR SUPPLIER	•	•	STF	EET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	IOME			7 WOLFTRAP RD NNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	Continued From page	2 21	w	249			
	interview was conduct staff member] #2, QIE Disabilities Profession of the PCP. ASM #2 document for staff to sterms of what they cat abilities, and to give in independent life as point the Individual's PCF stated some goals/out due to restrictions so cancelled. ASM #2 stated company headquatheir rooms. Individual exercise outcome was At this time, ASM #1, the interview. After redata collection sheets July 31, 2020, ASM # the data collection sheets July 31, 2	tated staff was instructed by arters to keep individuals in al #2's range of motion s reviewed with ASM #2. program manager, joined eviewing the Individual # 2's for July1, 2020 through 11 stated that according to eet, the program was ed if Individual # 2's ald have been implemented 11 stated yes. D.m., ASM #1 was made oncern. It was presented prior to exit. The program was eat of the program was eat oncern. The program was eat of the program was eat oncern. The program was eat of the program was eat oncern. The program was eat of the program was eat oncern. The program was eat of the program was eat oncern. The program was eat of the program was eat oncern. The program was eat of the program was eat oncern. The program was eat of the program was eat once e					
	social interactions. The	his information was obtained					

https://www.report.nih.gov/NIHfactsheets/ViewFa

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN VICES MEDICAID SERVICES			\bigcirc	FORM	D: 09/07/2020 MAPPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		49G014	B. WING			08/	27/2020
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	OME		_	3207 WOLFTRAP RD VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
W 249	ability to move and to posture. This informate website: https://www.nlm.nih.gy.html. [3] Symptoms of a brabecause of sudden, at the brain. This informate website: https://www.nlm.nih.gml. 3. The facility staff fail Individual #3's PCP (premoval of dishes. Individual #3 was adrahome) on 8/3/09. Individual #3 was adrahome) on 8/3/09. Individual #3's PCP (premoval of dishes. Individual #3's PCP displace his dishes in the minutes and with no reat 100% accuracy for		W	249			

09/30/2020. I no longer need this outcome when...: when i am able to take my own dishes to the sink with no prompting. Support Activities & Instructions: 1. After eating meals, staff will verbally prompt (Individual #3) to take his dishes to the sink. 2. (Individual #3) will place his dishes in the sink with no more than 3 verbal prompts from staff. 3. Staff will praise (Individual #3) for

	MENT OF HEALTH AN	D HUMAN VICES MEDICAID SERVICES			Q	FOF	ED: 09/07/2020 RM APPROVED IO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		49G014	B. WING			08	3/27/2020
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>·</u>	
				1	8207 WOLFTRAP RD		
MINERVA	FISHER HALL GROUP H	OME		١,	VIENNA, VA 22180		
0(4) 10	CUMMADV CT	ATEMENT OF DEFICIENCIES	1 15		PROVIDER'S PLAN OF CORRECTI	ON .	1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 249	in (name of computer be monitored monthly intellectual disabilities #3) will have achieved placed his dishes in the minutes and with no reat 100% accuracy for Type: Skill Building." Review of Individual # for June 2020 through documentation that the cancelled because all cancelled as a safety COVID-19. On 8/27/20 at 10:52 a conducted with ASM (member) #2 (the QIDI the PCP. ASM #2 stated document for staff to sterms of what they call abilities, and to give in independent life as poif individuals' PCPs we COVID-19 restrictions goals (outcomes) coul restrictions so the program 4SM #2 stated staff we company headquarter rooms. Individual #3's reviewed with ASM #2 had been using dispose cups, utensils) since MASM #1 (the program	rogress will be documented system). 5. Progress will by the QIDP (qualified professional). 6. (Individual distribution that are sink after eating within 5 more than 3 verbal prompts 12 consecutive months. By data collection sheets a August 2020 revealed e above outcome was in-home activities were precaution due to Common that it is a sink after eating within 5 more than 3 verbal prompts 12 consecutive months. By data collection sheets a August 2020 revealed e above outcome was in-home activities were precaution due to Common an interview was a see individuals' progress in a chieve, their limitations, adviduals as much of an achieve, their limitations, adviduals as much of an assible. ASM #2 was asked ere reviewed due to a ASM #2 stated some and not be done due to grams were cancelled. The as instructed by the stokeep individuals in their as dishes outcome was asked extended to the consequence of the consequence of the common was asked the home as able kitchenware (plates, March 2020. At this time, manager) joined the	W	249			
ĺ		ated the purpose of outcome was to teach the ers and to not leave dishes					

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



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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G014	B. WING		08/27/2020	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINERVA FISHER HALL GROUP HOME		8	207 WOLFTRAP RD			
MINERVA	FISHER HALL GROUP H	OME	\	/IENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE	
			1	1. The Program Nurse will contact t	he 10/2/2020	
W 249	Continued From page	2 4	W 249	pharmacy to receive a list of do not	crush	
	on the table. ASM #1	stated that according to the		medications.	Ì	
	data collection sheets	s, the program was		2. The Program Nurse will contact t	he	
		he program could have		physician to change the form of the		
		ividual #3 to throw the		medication so that individual #1 car	1	
	disposable kitchenwa	re in the trash.		swallow it.		
	O= 9/97/90 =£ 49:40 =	m ASM #1 was made	ļ	3. The Program Nurse will audit and	1	
ļ	aware of the above of	o.m., ASM #1 was made		review all individuals' medications a	li .	
	aware or the above of	blicem.		compare it to the list of do not crus		
	No further information	n was presented prior to exit.		medications received from the phar		
W 369			W 369	to ensure no other individual in the		
	CFR(s): 483.460(k)(2			is on a medication that can not be	notifie	
	,,			crushed.		
		administration must assure			iou tha	
	that all drugs, includir		1	4. The Nursing Coordinator will rev		
	self-administered, are	e administered without error.		medication administration policy w		
			1	staff who made the medication erro		
	This STANDARD is	not met as evidenced by:		will provide training on administerio	ng	
		n, clinical record review and		individual #1's nasal spray.	,	
		determined that the facility		5. The Program Manager will review	•	
		ter medication according to		discuss the medication error with p	rogram	
		one of two individuals during		staff during the staff meeting.		
		nistration observation,		6. The Nursing Coordinator will rev		
		cility staff crushed the		medications on a quarterly basis to		
		ex ER [extended release] [5]		there are no medications being crus	shed	
		it to Individual # 1 and failed	1	and administered when the pill sho	uld not	
	nostril Individual # 1.	ses of nasal spray into each		be crushed.	İ	
	HOSKII IIIUIVIUUAI # 1.			7. The Program Nurse and Program	1	
	The findings include:		ĺ	Manager will conduct random quar	terly	
			1	medication administration observa	- I	
	1a. The facility staff of	crushed the medication,		ensure the medications are being p	j.	
	Divalproex ER [exter	nded release] [5] prior to		per policy.		
}	administering it to Inc	dividual # 1.		8. The Clinical Director will overses	and	
				monitor the quarterly medication		
		46 year old female, who was	1	observations.		
	admitted to [Name of	r Group Homel with		ODSELVACIONS.		

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN VICES MEDICAID SERVICES			\bigcirc	FOR	ED: 09/07/2020 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED	
		49G014	B. WING			08	3/27/2020
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	٦.	STREET ADDRESS, CITY, STATE, ZIP CODE		
	FIGURE IIII GEGUE II				8207 WOLFTRAP RD		
MINERVA	FISHER HALL GROUP H	OME		,	VIENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETION DATE
	profound intellectual of disorder [2], mild cere self-injurious behavior. On 08/27/2020 at app medication administrate conducted with LPN (1). At 7:25 a.m. Individe the medication room of Home]. Individual #1 positioned upright. LFD Divalproex from a bube a small medication out tablets and pills for Interpoured the medication into a small plastic porthe "pill crusher", crus poured the crushed mof applesauce and mix administered the applemedications to Individe Further observation reconsumed all of the momentum of the POS [physician on 08/01/20 To 08/31/20" documented in part, "It 250MG [milligram] ER [substitute] For; Deparamental programmental in part on the transfer of the positive Mood Dysre (1/2017)." The facility's drug book Nursing Drug Guide." 1217. Depakote/valpr Warning: Give drug with the self-transfer of the graph of the positive drug with the programmental of the positive Mood Dysre (1/2017)."	ed but were not limited to: disability [1], impulse bral palsy [3] and - [4]. roximately 7:20 a.m. the discensed practical nurse) # dual # 1 was brought into of the [Name of Group was sitting in a chair PN # 1 dispensed dible pack of medication into p along with three other dividual # 1. LPN # 1 then as including the Divalproex uch, inserted the pouch into hed all the medications, edications into a small cup ked them together. LPN # 1 esauce mixed with ual # 1 by use of a spoon. evealed that Individual # 1 edications and applesauce. rder sheet] dated "From for Individual # 1 Divalproex TAB [tablet] [extended release] Sub kote ER 250MG Tab. Take vice daily. DX [diagnosis] egulation Disorder. Date k entitled "Lippincott Documented in part, "Page oic acid. [Divalproex]	W	369			

	<u></u>
DEPARTMENT OF HEALTH AND HUMAN ()VICES
CENTERS FOR MEDICARE & MEDICAID S	ERVICES



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

AND BLAN OF CORRECTION IN IMPER-		A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		49G014	B. WING			08	/27/2020	
NAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CO 8207 WOLFTRAP RD VIENNA, VA 22180				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 369	cut, crushed or chever On 08/27/19 at apprinterview was condupractical nurse] # 1. Individual# 1's medication, LPN # 1 takes a longer periorover time." When a medication can be a After reviewing the f Divalproex [Depakorstatement that the morushed or chewed, Divalproex for Indivibeen crushed. The facility's policy documented in part, Administration: F. N for administration: F. N for administrative staff manager, and ASM Intellectual Disabilities aware of the finding No further information. References: (1) Depakote ER is for the treatment of episodes associated without psychotic fereigned.	hole, ER tablets must not be ved." oximately 9:27 a.m., an cted with LPN [licensed When asked if they crushed cation of Divalproex ER, LPN on asked what the letters 'ER' to meant in terms of the stated, "Extended release. It did to dissolve so it dissolves sked if an extended release rushed LPN # 1 stated no. acility's drug book for te/valproic acid] and the nedication should not be cut, LPN # 1 stated the dual # 1 should not have 13.4 Medication Management" "Preparations for Medication ote any special instructions oproximately 12:30 p.m., ASM member] # 1, program # 2, the QIDP [Qualified es Professional] were made	W	369				

	MENT OF HEALTH AN	ID HUMAN VICES MEDICAID SERVICES			\bigcirc		FOR	D: 09/07/2020 M APPROVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		(X3) DATE	O. 0938-0391 E SURVEY PLETED
		49G014	B. WING			_	08	/27/2020
NAME OF P	ROVIDER OR SUPPLIER	·	<u> </u>		STREET ADDRESS, CITY, ST.	ATE, ZIP CODE		
MINERVA	FISHER HALL GROUP H	IOME		Į.	8207 WOLFTRAP RD			
					VIENNA, VA 22180			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	patients down to the a complex partial seizur isolation or in associal seizures. Depakote E product intended for administration. Depaks wallowed whole and chewed. This informat website: https://dailymed.nlm.rm?setid=0dc024ce-eicc (2) Refers to a group by a limited mental calcadative behaviors suschedules and routine. This information was https://www.report.nih.ctSheet.aspx?csid=10 (3) Impulse control disan inability to resist the action that is harmful information was obtain http://medical-dictionalpulse+Control+Disord (4) A group of disorder ability to move and to posture. This informal website:	age of 10 years with res that occur either in ation with other types of R is an extended-release once-a-day oral kote ER tablets should be should not be crushed or ation was obtained from the anih.gov/dailymed/druglnfo.cf fc8-4690-7cb5-639c728fcca of disorders characterized apacity and difficulty with ach as managing money, as, or social interactions. Obtained from the website: a.gov/NIHfactsheets/ViewFa oo one's self or others. This ned from the website: ary.thefreedictionary.com/Im ers.	W	369				
		a person's harming their . This information was osite:						

\ /			FOR	M APPROVED
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		(X3) DAT	E SURVEY
49G014	B. WING		08	3/27/2020
PHOME		STREET ADDRESS, CITY, STATE, ZIP CO 8207 WOLFTRAP RD VIENNA, VA 22180	DDE	
NCY MUST BE PRECEDED BY FULL	ID PREFI TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
gov/selfharm.html. If failed to administer two doses ticasone, into each nostril for approximately 7:20 a.m., the stration observation was N (licensed practical nurse) # lividual # 1 was brought into m of the [Name of Group # 1 was sitting in a chair LPN # 1 removed a bottle of s box, put on a pair of latex stered one spray into the right adividual # 1 then placed the not the box. In order sheet] dated "From 1/20" for Individual # 1 try. "Fluticasone SPR [spray] 50 Use 2 [two] sprays in each or chronic sinusitis. Date proximately 9:27 a.m., and ducted with LPN [licensed 1. When asked how many istered into each of Individual # 1 stated, "I only gave one ed what the physician's order e nasal spray, LPN # 1 stated uld have received two sprays in 1/2.4 Medication Management"	W	369		
	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G014 PHOME STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) age 28 5.gov/selfharm.html. If failed to administer two doses ticasone, into each nostril for approximately 7:20 a.m., the stration observation was N (licensed practical nurse) # dividual # 1 was brought into am of the [Name of Group # 1 was sitting in a chair LPN # 1 removed a bottle of its box, put on a pair of latex stered one spray into the right andividual # 1 then placed the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 and the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 and the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 and the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 and the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 and the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 and the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 and the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 and the into th	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G014 B. WING P HOME STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) Age 28 S.gov/selfharm.html. If failed to administer two doses ticasone, into each nostril for approximately 7:20 a.m., the stration observation was N (licensed practical nurse) # dividual # 1 was brought into run of the [Name of Group # 1 was sitting in a chair LPN # 1 removed a bottle of is box, put on a pair of latex stered one spray into the right notividual # 1 then placed the into the box. An order sheet] dated "From //20" for Individual # 1 rt, "Fluticasone SPR [spray] 50 Use 2 [two] sprays in each for chronic sinusitis. Date proximately 9:27 a.m., an ducted with LPN [licensed 1. When asked how many instered into each of Individual # 1 stated, "I only gave one ed what the physician's order lee nasal spray, LPN # 1 stated and have received two sprays in y "3.4 Medication Management"	### MEDICAID SERVICES (x1) PROVIDER/SUPPLIER/CLIA (x2) MULTIPLE CONSTRUCTION A. BUILDING	AND HUMAN (VICES MEDICAL SERVICES OMB N (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MORE (X2) MULTIPLE CONSTRUCTION (X3) MORE (X2) MULTIPLE CONSTRUCTION (X3) MORE (X3) MULTIPLE CONSTRUCTION (X3) MORE (X4) MULTIPLE CONSTRUCTION (X3) MORE (X5) MUNING (X6) MUNING (X6) MUNING (X7) MUNING (X7) MUNING (X7) MUNING (X8)

for administration."

PRINTED: 09/07/2020

	MENT OF HEALTH AN	ID HUMAN VICES MEDICAID SERVICES			\bigcirc	FOR	D: 09/07/2020 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G014	B. WING			08,	/27/2020	
MINERVA	ROVIDER OR SUPPLIER FISHER HALL GROUP H	- 4		8	STREET ADDRESS, CITY, STATE, ZIP CODE 8207 WOLFTRAP RD VIENNA, VA 22180			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE IATE	(X5) COMPLETION DATE	
W 475	[administrative staff mmanager, and ASM #Intellectual Disabilities aware of the findings. No further information References: [1] Used to relieve synsneezing and a runny itchy, watery eyes cau allergies (caused by adust, or pets). Prescriused to relieve symptosuch as sneezing and are not caused by alle obtained from the weth https://medlineplus.gotml. MEAL SERVICES CFR(s): 483.480(b)(2) Food must be served This STANDARD is massed on observation staff interview, it was estaff failed to provide the during a meal for one survey sample, Individing appropriate adaptive estaff alled to provide Individing propriate adaptive estaff and served.	proximately 12:30 p.m., ASM member] # 1, program 2, the QIDP [Qualified is Professional] were made a was provided prior to exit. Imptoms of rhinitis such as a stuffy, or itchy nose and used by hay fever or other in allergy to pollen, mold, ption fluticasone is also come of nonallergic rhinitis arunny or stuffy nose which ergies. This information was insite: Invidruginfo/meds/a695002.h In clinical record review and determined that the facility the appropriate utensil of four individuals in the lival # 1. The facility staff dual # 1. The facility staff dual # 1 with the		369	1. The Program Manager will retrain staff during the staff meeting on the appropriate eating utensils that should by individual #1 during mealtime per the doctor's order. 2. The Program Manager will retrain staff during the staff meeting on all of individuals' adaptive equipment that shused during mealtime per the doctors' and the program Manager, Program No QIDP will conduct random weekly me observations to ensure staff are using the appropriate eating utensils for all individuals. The Clinical Director will conduct Quarterly mealtime observations to enstaff are utilizing the appropriate adapted equipment.	be used he program the would be proders. when altime he iduals.	10/2/2020	

	MENT OF HEALTH AN	ID HUMAN VICES MEDICAID SERVICES			\bigcirc	FORM	1 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	
		49G014	B, WING			08/	27/2020
	ROVIDER OR SUPPLIER FISHER HALL GROUP H	HOME	,	82	REET ADDRESS, CITY, STATE, ZIP CODE 207 WOLFTRAP RD IENNA, VA 22180		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
W 475	admitted to [Name of diagnoses that included profound intellectual disorder [2], mild ceres self-injurious behavious on 08/27/2020 at approbation was condining area at [Name # 1 was seated in a reaction that it is diagnosable bowled and disposable bowl and disposable spoon to the POS [physician 08/01/20 To 08/31/20 documented in part, bowled spoon (marode eating. May use plate The "Aspiration Proto" 06/16/2020" documented (maroon spoon) The "Nutritional Assed dated, "03/24/2020" Skills. Adaptive Equipments and use (maroon spoon) to entire the entire that is the professional of the selection of	A6 year old female, who was a Group Home] with led but were not limited to: disability [1], impulse ebral palsy [3] and or [4]. Proximately 6:59 a.m., an educted of Individual # 1 in the legular straight back chair at a DSP [direct support evided and placed a clothing eal # 1, then provided eitr breakfast in a paper provided a white plastic eat with. Proceed a white plastic eat with. Proceder sheet] dated "From "Treatment Orders: Small flat on spoon) to enhance safe the guard during meal." Procol" for Individual # 1 dated ented in part, "Adaptive the guard/use small flat on) for safe eating." Pessment" for Individual # 1 documented in part, "Dining ipment: 03/2020 scoop dish es a small flat bowled spoon inhance safe eating."	W	475			
		oximately 8:30 a.m., an					

	MENT OF HEALTH AN	ID HUMAN VICES MEDICAID SERVICES			\bigcirc	FOF	ED: 09/07/2020 M APPROVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		49G014	B. WING			0.0	3/27/2020
	ROVIDER OR SUPPLIER FISHER HALL GROUP H	OME		820	REET ADDRESS, CITY, STATE, ZIP CODE 07 WOLFTRAP RD ENNA, VA 22180	,	_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
W 475	stated that Individual is spoon. When asked is adaptive equipment for no. On 08/27/20 at approximatery was conducted from the above stated that Individual is adaptive equipment disadaptive equipment disadaptive equipment disadaptive staff manager, and ASM # Intellectual Disabilities aware of the findings. No further information References: (1) Refers to a group of by a limited mental can adaptive behaviors suschedules and routine This information was chitps://www.report.nih.ctSheet.aspx?csid=10 (2) Impulse control disan inability to resist the action that is harmful to information was obtain http://medical-dictionalpulse+Control+Disorder.	dishes and utensils eat their meals, DSP # 2 # 1 used a dish, cup and if Individual # 1 used or eating, DSP # 2 stated ximately 12:10 p.m., an ted with ASM [administrative orgam manager. When observation, ASM # 1 # 1 should have been using uring their meal. roximately 12:30 p.m., ASM member] # 1, program 2, the QIDP [Qualified orgam provided prior to exit. of disorders characterized pacity and difficulty with ch as managing money, as, or social interactions. obtained from the website: agov/NIHfactsheets/ViewFa 10 corders are characterized by the impulse to perform an to one's self or others. This med from the website: ry.thefreedictionary.com/Im	w	475			

	~~
DEPARTMENT OF HEALTH AND HUMAN)VICES
CENTERS FOR MEDICARE & MEDICAID S	SEÉVICES



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G014	B. WING_			08/27/2020	
NAME OF PROVIDER OR SUPPLIER MINERVA FISHER HALL GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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	X (EACH CORRECTIVE CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 475			W		(CIENCI)		