PRINTED: 06/09/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCT		' '	(X3) DATE SURVEY COMPLETED	
		49G005	B. WING		10	0/26/2020		
	ROVIDER OR SUPPLIER	IING			ESS, CITY, STATE, ZIP CODE GSTONE SQUARE (E, VA 23320	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTI ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E	00				
W 000	survey was conducte and 10/26/20. The facompliance with 42 C Condition of Participal Facilities for Individual Disabilities. No emergeomplaints were investigated in the Intervention of Participal Facilities for Individual Disabilities. No emergeomplaints were investigated in the Intervention of Participal Facilities for Individual Participal Particip	gency preparedness stigated during the survey. Indamental Medicaid was conducted 10/21/20 I 10/26/20. The facility was	W	00				
W 206	Individuals with Inteller. The Life Safety Code complaints were invector. The census in this 85 at the time of the sun consisted of 6 Individual through #6). INDIVIDUAL PROGRE	ermediate Care Facilities for ectual Disabilities (ICF/IID). survey/report will follow. No stigated during the survey. I certified bed facility was 75 yey. The survey sample ual reviews (Individuals #1	W2	06				
	developed by an interepresents the professareas that are releval (i) Identifying the clithe comprehensive for required in paragraph	e an individual program plan rdisciplinary team that sions, disciplines or service						
LABORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

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

11/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G005	B. WING		10/26/2020	
	ROVIDER OR SUPPLIER	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
W 206	Based on observation reviews, and facility of facility staff failed to oparameters for the usul ndividuals (Individuals ample. The findings include: 1. The facility staff failed to expend the use of Individuals (Individuals ample). The findings include: 1. The facility staff failed plan developed that inform the use of Individuals (Individuals and Individuals and Individuals (ICF/IID) included severe IID, shistory of falls with the pneumothorax (collapteractures, osteopenials joint disease (DJD), included severe IID, shistory of falls with the pneumothorax (collapteractures, osteopenials joint disease (DJD), included severe IID, shistory of falls with the pneumothorax (collapteractures, osteopenials joint disease (DJD), included severe Individuals and blinesecondary to hitting hobjects, high blood presidence. The following observation of the following observation in the real observed in his residence wheelchair with seat the breakfast meal. He meal by a Direct state of the presidence of the presidenc	not met as evidenced by: ans, staff interviews, record documentation review, the develop a specific plan with se of a soft helmet for 2 of 6 Is #4 and #3) in the survey filed to ensure there was a indicated clear parameters and #4's soft helmet. mitted to the Intermediate dividuals with Intellectual facility with diagnoses that schizophrenia, unsteady gait, ead trauma, rib fractures with besed lung), tibia and fibula dosteoporosis, degenerative coursitis, myositis ossificans side muscle and other soft significant visual dness in his left eye his head into walls and ressure and seizures. and	W 20			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		49G005	B. WING _			10/26/2020
	ROVIDER OR SUPPLIER	NING	•	STREET ADDRESS, CITY, STATE, ZIP CO 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 206	table. He wore socks able to propel himse using both feet. Staf supervised for meals supervised" at all tim to attempts to rise an Obsessive Compuls with destruction of puse and hand washi wearing his soft helm On 10/22/20, Individ following four times of At 1:15 p.m., this surhallway at a corner of door and observed liminated wheelchair seat belt himself on the commisame manner, transically wheelchair, re-bucklid dried his hands using towels. At 1:25 p.m., Individuation of the count paper towel washed and dried his to count paper towel At 1:28 p.m., Individuation of the living room from visible to staff at this screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the staff at the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of the screened porch with 1 minute later, Directive of t	eled himself away from the s and tennis shoes and was of freely in the wheelchair by a stated that he was only 1:1 s, and had to be "in sight ness otherwise for safety due and walk or during his over Disorder (OCD) behaviors roperty, repetitive bathrooming. Individual #4 was not net. The wall #4 was observed the pout of sight of the staff: The veyor was standing in a wall to the left of the bathrooming and unsteadily transferred node, after which he, in the ferred himself back in his ed his seat belt, washed and grapproximately 10-15 paper and #4 wheeled into the same in his wheelchair, again shands using too numerous	W2	206		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		49G005	B. WING			0/26/2020	
	ROVIDER OR SUPPLIER	IING		STREET ADDRESS, CITY, STATE, ZIP COD 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
W 206	Individual #4 propels his wheelchair and redue to escalation of Chis wheelchair and deensure is safety and asked when he wore "We put it on from tirneeds it, especially if against the wall, but r She stated that Indivi was very unsteady, hremained at high risk staff keep eyes on Inchome to maintain his manage his OCD and stated when in bed as mandatory every (q)1 safety because he wo the bathroom and not constantly wash his home to maintain his manage his OCD and stated when in bed as mandatory every (q)1 safety because he wo the bathroom and not constantly wash his home to maintain his manage his OCD and stated 10/22/20 for And the OCD behavior that seat belt of his wheel and or frequent hand a note in the AM on 1 Individual #4 banged shaking hand while so On 10/23/20 at 1:40 puckled in his wheeld quickly down a hallway were located in the liventered the living roo	himself "very, very fast" in quired "in sight supervision" DCD behaviors, rising out of estructive tenancies to safety of others. When the soft helmet, she stated, ne to time, if we think he he starts banging his head no real times otherwise." dual #4 could ambulate, but ad a fall history and for falls. She stated all the dividual #4 throughout the safety and assist him to didestructive behaviors. She sleep, the staff implemented 5 minute checks for his build get out of bed to go to a always to use it, but to lands. Inpleted by the assigned DSP of and PM did not indicate at included unbuckling the chair, going to the bathroom washing events. There was 0/22/20 that indicated his head on the wall and queezing tightly. D.m., Individual #4 was thair propelling himself ay, out of view of staff that wing room area. Once he m, DSP #8, who was where he came from and	W 20	06			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G005	B. WING				0/26/2020
	ROVIDER OR SUPPLIER ASTERN VIRGINIA TR	AINING		2100 STEP	DRESS, CITY, STATE, ZIP CODE PINGSTONE SQUARE EAKE, VA 23320	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 206	building #29 for day wheelchair at a take watching a movie. With four other indid DSP #7 stated all sindividuals, but he Individuals, but he Individual #4. The "speedily" and not the staff. He state and heads out of he to bathroom. DSP bathroom he likes hands and could seall and possibly his before. He comes chance of falls and coming out of the limitudes when he is specifically give parequired application. Another DSP#6 and be used when the of banging his hear reserved the right it was necessary for there were several involved Individual pacing up and down grabbing staff, run bathroom, throwing the living room, agreview of the recer reports presented individual was have jumped off his bed and hit his head or	30 a.m., Individual #4 was in y programing, sitting in his ole with his model trains and He was in the room with along viduals from the same home. Staff in the room watch the was regularly assigned DSP stated could walk, but safe without assistance from d, he unbuckles his seat belt is chair or gets out of bed to go #7 said, "When he is in the to compulsively wash his plash water on the floor, slip, this head which he has done out of bed quick too, also a has injured himself in the past bed. We watch him every 15 is in bed." The DSP could not arameters the staff followed that an of Individual #4's soft helmet. Ided that the soft helmet could individual started the behavior diagainst the wall, but they to use it whenever they thought	W	206			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G005	B. WING _		10	/26/2020
	ROVIDER OR SUPPLIER	AINING		STREET ADDRESS, CITY, STATE, ZIP C 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	•	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCY	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 206	dresser drawers a of the structure of dresser drawers were top of the dresser potential danger of without a behavior 10/26/20 at 10:40. Individual #4 in but movie time. She sweeks ago and I rebuildings and groundrawers." She starplaced in a storage to get them fixed. stacked drawers observed throughout the professional (QID She stated the individual because he could he was cycling he sometimes escalar sweating, repetitive tightly and agitating asked what parameters were a storage of the stated there we order in place for the parameters were at the structure of the stated there we order in place for the parameters were at the structure of the structure of the stated there we order in place for the parameters were at the structure of the structur	age 5 n out of his room, kicking the nd knocking three of them out the dresser. Two of these were stacked on each other on structure which posed a f falling on the Individual with or ral outburst of OCD events. On a.m., DSP #6 was with hilding #29 for activities and stated, "He did that about 2 meant to get (name of the unds person) to fix these ted one of the drawers was e area, but she is calling today. The condition of the broken on top of the dresser was out all days of the survey. 25 p.m., an interview was e Qualified Intellectual Disability P) assigned to Individual #4. lividual remains at high risk for all assessment and after the ch of his falls. She stated based his spine, if he fell again, he d. She continued to say he has running with a tendency to fall. preferred to use his wheelchair get around quickly, but when moves even quicker ting his behaviors with rely squeezing others hands too ag other individuals. When neters were in place that the value for the helmet, was a consent and physician's the use of the helmet, but no addressed with the Specially nittee SCC. She stated the soft	W 2	206		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		49G005	B. WING _			10/26/2020	
	ROVIDER OR SUPPLIER	NING		STREET ADDRESS, CITY, STATE, ZIP 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 206	bang head on wall, a helmet when other of destructive behavior injury. She stated the the soft helmet, but of documentation. She the use of the soft he interdisciplinary team at Individual #4's upo QIDP stated she explicated individual #4 in sight OCD behaviors in act Support Plan (BSP) 5/20/20) and his Indi (dated 5/20/20 throus) on 10/26/20 at approaforementioned obsewere shared with the Director of Complian clear understanding further information por The Individual Support Individual Support Plan (BSP) 19/21 identification in the Individual Support Plan (BSP) 19/21 identification in the Individual axonal myopathy, at conditions that affect coordination. There is 9/6/18, "Encourage of Management Plan dothe individual could reference on the Individual could reference in the In	en the individual starts to and should probably wear the DCD, cycling, agitated and a start to escalate to prevent elindividual at times refused did not present the refusal stated she plans to address elmet with the infollowed by a presentation coming SCC review. The sected the staff to have kept for his safety and to monitor cordance with his Behavioral (dated as reviewed on vidual Support Plan (IPP) gh 5/19/21). Eximately 3:30 p.m., the ervations, staff interviews efacility Administrator and the ce. They stated there was of the presented issues. No rovided prior to survey exit. Fort Plan (ISP) dated 5/20/20 diffied adaptive equipment logy supports to include soft parameters for its use. The #4 was prone to falls due to exic gait and other chronic in his balance and were physician's orders dated use of helmet." The Physical ated 5/14/20 soft helmet that remove. There was an ted 3/12/20 for the soft ensure safety and protection	W2	206			
	coordination. There of 9/6/18, "Encourage of Management Plan do the individual could rinformed consent day helmet with straps to during falls and there	were physician's orders dated use of helmet." The Physical ated 5/14/20 soft helmet that emove. There was an ted 3/12/20 for the soft					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G005	B. WING		10/26/2020		
	ROVIDER OR SUPPLIER ASTERN VIRGINIA TRAI	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION		
W 206	this surveyor for the The Behavioral Suppindicated, "(Individual used in accordance BSP identified Self Inicluded using his howalls with such force 2. The facility's staff which defined paramand for how long to Individual #3. Individual #3 was ad Care Facility for Individual #3. Individual #3 was ad Care Facility for Individual Bisabilities (ICF/IID) diagnoses that including bisability, epilepsy, Individual and two D (DSP). Individual #3 was observed un Individual and two D (DSP). Individual #3 was obapproximately 3:30 phe was seated in and down. A neck napkineck and covering helmet was on his helindividual and assist gait belt. The staff nindividual #3 unsteal	no SCC review presented to soft helmet. port Plan (BSP) dated 5/20/20 al #4's name) helmet will be with physician orders." The njurious Behavior (SIB) that ead to hit objects, windows or e to potentially cause injury. failed to develop a program neters including why, when, use a soft helmet for mitted to the Intermediate viduals with Intellectual facility on 5/8/19 with ded profound Intellectual legal blindness, a, and hypothyroidism. oximately 3:45 p.m. Individual der the pavilion with another irect Service Personnel 8 was seated in a wheel chair as if asleep. He was wearing	W 20	6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		49G005	B. WING _	-		10/26/2020	
	ROVIDER OR SUPPLIER	NING	•	STREET ADDRESS, CITY, STATE, ZIF 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
W 206	assisted to sit in the remained on his head on his head on his head on his head on his neck and a soft be interview was conducted therefore, activity prodeveloped around the At approximately 12: observed seated in a table for the midday in neck napkin and a soft interview was conducted approximately 12:13 removal of the helmes stated the helmet is remained on his helmes to his helmes to help the stated the helmes to help the remained on his helmes to help the help the helmes to help the help the helmes to help the helmes to help the he	to the living room, he was wheel chair and the helmet d. eximately 11:00 a.m., ain observed under the eck napkin donned around lack on his head. An otted Activity staff #1. Activity dual #3 reads braille ogramming for him was e use of braille and music. 07 p.m., Individual #3 was wheel chair at the dining meal. He was wearing a off black helmet. An	W 2	206			
	equipment for use; fluseat belt, bed alarm, blocks to elevate the chair with safety strain handle coated spoon sectional plate, dycer Stimulation (VNS) mathe ISP revealed und know to support me" soft shell helmet. The October 2020, p contained an order displayed to the section of the secti	cor mats, wheel chair with Therarest mattress with head of the bed, shower ps, soft shell helmet, built up in, nosey cup, high side im mat, Vagus Nerve agnet, and a gait belt. Also ler; "what others need to in, (name of individual) has a hysician order summary ated 9/27/19 which read; soft on could be located in the lying when or when not to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER STERN VIRGINIA TRAIN	IING		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 206	Continued From page 9		w	206			
W 242	interview was conducted Intellectual Disabilities QIDP stated Individual helmet when walking parameters for use because specifics were to all staff. On 10/26/20 at approabove information was Administrator and the The Administrator state was absent from the ensure the necessary and made available for INDIVIDUAL PROGRECER(s): 483.440(c)(6)	e Director of Compliance. Ited she understood what record and she would Information was acquired or staff. IAM PLAN	W	242			
	those clients who lack skills essential for printing including, but not limb personal hygiene, de bathing, dressing, groof basic needs), until	k them, training in personal vacy and independence					
	Based on observation reviews, and facility of facility staff failed to its Support Plan (ISP) for	survey sample. The facility					

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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W 242	and deter any inapper. The findings included Individual #4 was at Care Facilities for Irr Disabilities (ICF/IID included severe IID history of falls with	didual #4 to maintain his safety propriate behaviors. dmitted to the Intermediate adividuals with Intellectual placification facility with diagnoses that propriet sealing sealing and fibula and fibula and fibula and fibula and sealing propriet so sufficant visual and other soft propriet single single field walls and pressure and seizures. and	W 2-	42		
	areas: On 10/21/20 at 7:40 observed in his resiwheelchair with sea the breakfast meal. the meal by a Direct Following his meal, backed up and whe table. He wore sock able to propel himse using both feet. Stasupervised for meal supervised" at all tir to attempts to rise at Obsessive Compuls	a.m., Individual #4 was dence positioned in his t belt at the dining table for He was 1:1 supervised during t Support Professional (DSP). Individual #1 independently eled himself away from the as and tennis shoes and was self freely in the wheelchair by ff stated that he was only 1:1 s, and had to be "in sight mes otherwise for safety due and walk or during his sive Disorder (OCD) behaviors property, repetitive bathroom				

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		49G005	B. WING _		10/2	6/2020	
	ROVIDER OR SUPPLIER	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	1 1372		
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W 242	use and hand washin wearing his soft helm On 10/22/20, Individe following four times of At 1:15 p.m., this sur hallway at a corner we door and observed limits wheelchair seat belt himself on the commisame manner, transf wheelchair, re-buckled dried his hands using towels. At 1:25 p.m., Individe bathroom, remained washed and dried his to count paper towel. At 1:28 p.m., Individe above behavior. At 1:30 p.m., Individed the living room from visible to staff at this screened porch with 1 minute later, Direct #6 headed into the stee individual #4 propels his wheelchair and redue to escalation of	ng. Individual #4 was not net. ual #4 was observed the out of sight of the staff: veyor was standing in a wall to the left of the bathroom ndividual #4, unbuckling his and unsteadily transferred node, after which he, in the ferred himself back in his ed his seat belt, washed and g approximately 10-15 paper ual #4 wheeled into the same in his wheelchair, again is hands using too numerous	W 2-	42			
	that Individual #4 columnsteady, had a fall	safety of others. She stated uld ambulate, but was very history and remained at high ated all the staff keep eyes on					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 242	Individual #4 through safety and assist hir destructive behavior asleep, the staff imp (q)15 minute checks would get out of bed not always to use it, hands. The Data Forms, condated 10/22/20 for And the OCD behavior the seat belt of his wheel and or frequent hand a note in the AM on Individual #4 bangers shaking hand while On 10/23/20 at 1:40 buckled in his wheel quickly down a hallow were located in the lentered the living rocharting, asked him "what were you up to the condition of the individual #29 for day wheelchair at a table watching a movie. How with four other individuals, but he will individual #4. The Dispeedily" and not sithe staff. He stated.	hout the home to maintain his in to manage his OCD and is. She stated when in bed elemented mandatory every is for his safety because he if to go to the bathroom and but to constantly wash his impleted by the assigned DSP in Mand PM did not indicate that included unbuckling the elechair, going to the bathroom dwashing events. There was 10/22/20 that indicated in the head on the wall and squeezing tightly. p.m., Individual #4 was chair propelling himself way, out of view of staff that iving room area. Once he om, DSP #8, who was where he came from and on?" 0 a.m., Individual #4 was in programing, sitting in his ele with his model trains and the was in the room with along duals from the same home. The was regularly assigned in the room watch the was regularly assigned in the washing the without assistance from the unbuckles his seat belt	W 2-	42			
	Individual #4 banger shaking hand while On 10/23/20 at 1:40 buckled in his wheel quickly down a hallw were located in the lentered the living rocharting, asked him "what were you up to the content of the living and heads out of his to bathroom. DSP #7 stated and heads out of his to bathroom.	d his head on the wall and squeezing tightly. p.m., Individual #4 was chair propelling himself vay, out of view of staff that iving room area. Once he om, DSP #8, who was where he came from and o?" 0 a.m., Individual #4 was in programing, sitting in his e with his model trains and le was in the room with along duals from the same home. aff in the room watch the vas regularly assigned SP stated he could walk, but afe without assistance from					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		49G005	B. WING	·····		0/26/2020	
	ROVIDER OR SUPPLIER	NING	•	STREET ADDRESS, CITY, STATE, ZIP COD 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 242	fall and possibly hit hefore. He comes of chance of falls and he coming out of the beaminutes when he is in. There were several of involved Individual #-pacing up and down grabbing staff, running bathroom, throwing he the living room, aggreview of the recent preports presented to 8/18/20, the individual event when he jumpe bathroom, slipped and On 10/17/20, while elindividual #-4 was throom, kicking the dreathree of them out of the Two of these dresser each other on top of posed a potential dar Individual with or with OCD events. On 10/2 was with Individual #-and movie time. She weeks ago and I meabuildings and ground drawers." She stated	ash water on the floor, slip, is head which he has done at of bed quick too, also a as injured himself in the past d. We watch him every 15 in bed." documented incidents that 4 behaviors to included hallways, pushing and ing back and forth to the himself on the bed, running in essively pushing staff. A coast three months of incident this surveyor identified on all was having a bad OCD and off his bed to run to the aid hit his head on the floor. Exhibiting OCD behaviors, owing toys from out of his asser drawers and knocking the structure of the dresser. If drawers were stacked on the dresser structure which inger of falling on the mout a behavioral outburst of 26/20 at 10:40 a.m., DSP #6 4 in building #29 for activities a stated, "He did that about 2 ant to get (name of the is person) to fix these one of the drawers was	W 24	,			
	to get them fixed. The stacked drawers on to observed throughout On 10/26/20 at 1:25	rea, but she is calling today ne condition of the broken op of the dresser was all days of the survey. p.m., an interview was qualified Intellectual Disability					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		49G005	B. WING	 	10/26/2020
	ROVIDER OR SUPPLIER	INING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	10.20.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
W 242	She stated the individals at each annual assessment of each on the issues with h could be paralyzed. had injuries from rur. She the individual p because he could g he was cycling he m sometimes escalatir sweating, repetitivel tightly and agitating stated she expected Individual #4 in sigh OCD behaviors in a Support Plan (BSP) 5/20/20) and his Individual #4 in Sigh OCD behaviors in a Support Plan (BSP) 5/20/20 and his Individual 5/20/20 thrown of the Individual Support Plan (BSP) in	assigned to Individual #4. idual remains at high risk for assessment and after the of his falls. She stated based is spine, if he fell again, he She continued to say he has nning with a tendency to fall. referred to use his wheelchair et around quickly, but when noves even quicker ng his behaviors with y squeezing others hands too other individuals. The QIDP If the staff to have kept t for his safety and to monitor ccordance with his Behavioral (dated as reviewed on lividual Support Plan (IPP)	W 24	12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G005	B. WING		10	/26/2020	
	ROVIDER OR SUPPLIER STERN VIRGINIA TRAIN	IING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 242	individuals and group supervision and supp needs and within para Individual Support pla supervision: Visual of a minimum of one sta member may be enga	d 10/19/17 indicated that is are to receive staff ort consistent with individual ameters determined by the	W 24	42			
W 262	monitor individual pro inappropriate behavio	o(i) d review, approve, and orgrams designed to manage or and other programs that, committee, involve risks to	W 26	52			
	Based on observation interviews, the Special (SCC) failed to ensure for a restrictive device obtained prior to granthe helmet for 2 (Individuals in the survival).	iting approval for the use of vidual #3 and #4) of 6 vey sample.					
	Care Facility for Indiv Disabilities (ICF/IID) of that included profoun	; admitted to the Intermediate iduals with Intellectual on 5/8/19 with diagnoses d Intellectual Disability, ess, hypercholesterolemia,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		49G005	B. WING _			10/26/2020
	ROVIDER OR SUPPLIER	NING	1	STREET ADDRESS, CITY, STATE, 2100 STEPPINGSTONE SQUAR CHESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
W 262	#3 was observed und Individual and two Di (DSP). Individual #3 with his head down a a black soft helmet or Individual #3 was observed approximately 3:30 p. He was seated in a widown. A neck napkin neck and covering his helmet was on his helmet was in the was a sisted to sit in the was remained on his head. On 10/23/20 at approximately 12:07 observed seated in a table for the midday in neck napkin and a so interview was conduct approximately 12:13 removal of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet, gait belt, should be the solution of the helmet is revealed the plan was afety and specialized helmet.	der the pavilion with another rect Service Personnel was seated in a wheel chair is if asleep. He was wearing in his head. Served again on 10/22/20 at it.m., in the living room area. Wheel chair with his head in was donned around his is chest area and a soft black ead. A staff came over to the ead him to stand utilizing a member instructed the inhim to the bathroom. Upon to the living room, he was wheel chair and the helmet in the donned around lack on his head. At p.m., Individual #3 was a wheel chair at the dining meal. He was wearing a oft black helmet. An	W	262		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G005	B. WING _				10/26/2020	
	ROVIDER OR SUPPLIER	NING		2100	ET ADDRESS, CITY, STATE, ZIP CODE STEPPINGSTONE SQUARE SAPEAKE, VA 23320	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 262	Continued From pag chair secured to the alarm	e 17 wall, bed alarm and an audio	W2	262				
	restraint form was signed the facility's staff with authorized represent stated the soft helmed the Individual was under remove the soft helmed hadn't identified an a similar benefits.	ant for medical and protective gned and dated 10/22/20 by a a verbal consent from the ative on 10/22/20. The form of was to ensure safety and hable to independently net and the facility's staff lternative to the helmet with ort Plan (ISP) dated 4/8/20 the following adaptive						
	equipment for use; fluseat belt, bed alarm, blocks to elevate the chair with safety strainandle coated spoon sectional plate, dyce Stimulation (VNS) mathe ISP revealed under the section of the section	oor mats, wheel chair with Therarest mattress with head of the bed, shower ps, soft shell helmet, built up n, nosey cup, high side						
	contained an order d helmet. No informati	hysician order summary ated 9/27/19 which read; soft on could be located in the ying when or when not to elmet.						
	interview was conduction intellectual Disabilities QIDP stated Individuction helmet when walking parameters for use be	oximately 2:40 p.m. an octed with the Qualified as Professional (QIDP). The al #3 was to wear the soft but he couldn't recall other out he would follow-up and a documented and available						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		49G005	B. WING		10/26/2020		
	ROVIDER OR SUPPLIER	INING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	10/20/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
W 262	read at procedure 3l approve and monito Plans and other plar Individual protection to plan implementing will include those whose psychoactive medical on community access restrictions on other determined by the coread; review and apprestraint devices, phonton the protection of the p	dated 6/29/20, on the SCC B; the SCC will review, r Individual Behavior Support ns that involve risks to and rights restrictions, prior g. At a minimum, such plans nich involve restraints, ations, time out, restrictions ss, or freedom at home and	W 26	52			
	above information w Administrator and th The Administrator st was absent from the ensure the necessal and made available 2. Individual #4 was Care Facilities for In Disabilities (ICF/IID) severe IID, schizoph of falls with head tra pneumothorax (colla fractures, osteopeni- joint disease (DJD), (bone tissue forms in tissue after injuries), impairments and blii	e Director of Compliance. ated she understood what record and she would ry information was acquired for staff. admitted to the Intermediate dividuals with Intellectual with diagnoses that included arenia, unsteady gait, history uma, rib fractures with apsed lung), tibia and fibula a/osteoporosis, degenerative bursitis, myositis ossificans nside muscle and other soft					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G005	B. WING _			10/26/2020
	ROVIDER OR SUPPLIER	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 262	seizures. On 10/21/20 at 7:40 observed in his resid wheelchair with seat the breakfast meal. If the meal by a Direct Following his meal, I backed up and wheetable. Individual #4 whelmet. At 1:30 p.m., Individual the living room from visible to staff at this screened porch with 1 minute later, Direct #6 headed into the sthe individual's medic Individual #4 propels his wheelchair and redue to escalation of this wheelchair and densure is safety and asked when he wore "We put it on from tineeds it, especially it against the wall, but She stated that Indiv was very unsteady, it remained at high risk staff keep eyes on Inhome to maintain his manage his OCD an stated when in bed a mandatory every (q) safety because he wish	a.m., Individual #4 was ence positioned in his belt at the dining table for de was 1:1 supervised during Support Professional (DSP). Individual #1 independently ded himself away from the was not wearing his soft he proceeded to the one sock on. Approximately support Professional (DSP) creened porch to administer cation. The DSP stated that himself "very, very fast" in equired "in sight supervision" DCD behaviors, rising out of estructive tenancies to safety of others. When the soft helmet, she stated, me to time, if we think he is he starts banging his head no real times otherwise." idual #4 could ambulate, but	W 2	262		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G005	B. WING			10/	26/2020
	ROVIDER OR SUPPLIER	IING		21	TREET ADDRESS, CITY, STATE, ZIP CODE 100 STEPPINGSTONE SQUARE HESAPEAKE, VA 23320		
(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 262	dated 10/22/20 for AM the OCD behavior that seat belt of his wheel and or frequent hands a note in the AM on 1 Individual #4 banged shaking hand while so On 10/26/20 at 10:30 building #29 for day powheelchair at a table watching a movie. He with four other individ DSP #7 stated all statindividuals, but he wa Individual #4. The DS "speedily" and not sat the staff. He stated, I and heads out of his of to bathroom. DSP #7 bathroom he likes to of hands and could splat fall and possibly hit his before. He comes out chance of falls and ha coming out of the bed minutes when he is in specifically give parant required application of Another DSP#6 adde be used when the ind of banging his head a	ands. Appleted by the assigned DSP M and PM did not indicated at included unbuckling the chair, going to the bathroom washing events. There was 0/22/20 that indicated his head on the wall and queezing tightly. a.m., Individual #4 was in programing, sitting in his with his model trains and a was in the room with along uals from the same home. If in the room watch the as regularly assigned as regularly assigned be stated could walk, but fe without assistance from the unbuckles his seat belt chair or gets out of bed to go of said, "When he is in the compulsively wash his sh water on the floor, slip, as head which he has done at of bed quick too, also a the sinjured himself in the past as injured himself in the past as injured himself in the past as injured himself followed that as infludividual #4's soft helmet and that the soft helmet could ividual started the behavior against the wall, but they use it whenever they thought his safety.	W	262			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		49G005	B. WING _		,	10/26/2020	
	ROVIDER OR SUPPLIER	NING		STREET ADDRESS, CITY, STATE, ZIP COE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 262	pacing up and down grabbing staff, running the living room, aggreeview of the recent preports presented to 8/18/20, the individual event when he jumped bathroom, slipped and On 10/17/20, while extend individual #4 was three of them out of the Two of these dresser each other on top of posed a potential dar Individual with or with OCD events. On 10/2 was with Individual #4 and movie time. She weeks ago and I mea buildings and ground drawers." She stated placed in a storage at the placed in a storage at t	A behaviors to included hallways, pushing and a back and forth to the himself on the bed, running in essively pushing staff. A bast three months of incident this surveyor identified on al was having a bad OCD and off his bed to run to the d hit his head on the floor. Exhibiting OCD behaviors, owing toys from out of his seer drawers and knocking the structure of the dresser. In drawers were stacked on the dresser structure which	W 2	62			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G005	B. WING			0/26/2020	
	ROVIDER OR SUPPLIER	NING	•	STREET ADDRESS, CITY, STATE, ZIP COL 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
W 262	he was cycling he mosometimes escalating sweating, repetitively tightly and agitating casked what parameters as a stated there was order in place for the parameters were adouted the soft helme individual starts to be probably wear the hecycling, agitated and to escalate to preven individual at times reinot present the refus stated she plans to a helmet with the interca presentation at Indireview. The QIDP state have kept Individual to monitor OCD behas Behavioral Support Freviewed on 5/20/20) Plan (IPP) (dated 5/2) On 10/26/20 at approaforementioned observers shared with the Director of Compliance clear understanding of that the SCC should use of the soft helme information provided.	t around quickly, but when oves even quicker g his behaviors with squeezing others hands too other individuals. When ers were in place that the e individual's soft helmet, a consent and physician's use of the helmet, but no dressed with the SCC. She t was used when the ang head on wall, and should elmet when other OCD, destructive behaviors start t injury. She stated the fused the soft helmet, but did all documentation. She ddress the use of the soft disciplinary team followed by ividual #4's upcoming SCC ated she expected the staff to #4 in sight for his safety and aviors in accordance with his plan (BSP) (dated as and his Individual Support 10/20 through 5/19/21). Eximately 3:30 p.m., the ervations, staff interviews facility Administrator and the ce. They stated there was of the presented issues and have approved and reviewed t for Individual #4. No further	W 26				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED	
		49G005	B. WING _			10/26/2020	
	ROVIDER OR SUPPLIER	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 262	ISP notes Individual axonal myopathy, ata conditions that affect coordination. There we 9/6/18, "Encourage of Management Plan dathe individual could minformed consent dathelmet with straps to during falls and there similar benefits ident consent. There was at this surveyor for the straightful the surveyor for	parameters for its use. The #4 was prone to falls due to axic gait and other chronic his balance and were physician's orders dated use of helmet." The Physical ated 5/14/20 soft helmet that emove. There was an ited 3/12/20 for the soft ensure safety and protection were no alternatives with ified at the time of the signed no SCC review presented to soft helmet. Fort Plan (BSP) dated 5/20/20 I #4's name) helmet will be with physician orders." The highrious Behavior (SIB) that had to hit objects, windows or to potentially cause injury. S Fride clients with nursing the with their needs. For which interviews, record documentation review, the provide 1 of 4 Individuals the pro	W				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G005	B. WING			10/	26/2020
	ROVIDER OR SUPPLIER	IING	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	, , , , ,	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 331	Care Facilities for Ind Disabilities (ICF/IID) fincluded severe IID, shistory of falls with he pneumothorax (collapfractures, osteopenia, joint disease (DJD), be (bone tissue forms instissue after injuries), simpairments and blind secondary to hitting hobjects, high blood property. The following observation in the following observed in his reside wheelchair with seat the breakfast meal. His physician ordered TE 10/21/20 at 1:30 p.m. wearing his TED hose on 10/22/20, at 1:15 wearing his right leg of the screened porch to staff to the screened porch to admedication. The DSF	mitted to the Intermediate ividuals with Intellectual facility with diagnoses that schizophrenia, unsteady gait, and trauma, rib fractures with beed lung), tibia and fibula fosteoporosis, degenerative pursitis, myositis ossificans side muscle and other soft significant visual dness in his left eye has head into walls and ressure and seizures. A.m., Individual #4 was ence positioned in his belt at the dining table for the was not wearing his D hose to the right leg. On the Individual #4 was not e. p.m., Individual #4 was not p.m., Individual #4 was not e. p.m., Individual #4 wheeled from from the hallway, now at this point. He proceeded in with one sock on the right	w	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		49G005	B. WING	·····	10/26/2020
	ROVIDER OR SUPPLIER	IINING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETIO
W 331	On 10/22/20 at 4:30 wearing his right leg On 10/23/20 at 1:40 white socks and ter a TED hose. DSP # removed his right leg On 10/26/20 at 10:3 observed wearing hand a tennis shoe. On 10/26/20 at 1:25 conducted with Ind Intellectual Disabilit was not able to conphysician was made not consistently we stated she knew he hose off, but expect TED hose or tell he she would ensure so nursing and the phy Individual #4 had phy to apply compressic leg during the daytin (facility staff to appl Administration Reconducted was applied in bedtime. No notes we	s, but no TED hose. D p.m., Individual #4 was not g TED hose. D p.m., the Individual had on an is shoe, but was not wearing to stated Individual #4 often to g TED hose. BO p.m., Individual #4 was as is black right leg TED hose D p.m., an interview was ividual #4's assigned Qualified its Professional (QIDP). She firm that nursing or the to aware that Individual #4 was aring the TED hose. She is sometimes took the TED ted the staff to re-apply the reconsistently refused so the addressed the issue with visician. In the consistent or detection or detection or detection or detection or detection. The profession or detection or detection or detection or detection or detection. The profession or detection or detection or detection or detection or detection. The profession or detection or detection or detection or detection or detection. The profession or detection or detecti	W 33	31	
	to apply compression leg during the dayting (facility staff to apply Administration Record hose was applied in bedtime. No notes was applied to TAR that indicated by removed the right Total Nursing	on hose (TED) to right lower me and take off at bedtime- y). The Treatment ord (TAR) indicated the TED on the AM and removed at were written on the back of the Individual #4 refused or			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		49G005	B. WING _			10/26/2020
	NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN VIRGINIA TRAINING (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 331 Continued From page 26 hose was a treatment for dependent edema to the right lower leg. There were no notes from either of the aforementioned assessments/documents that indicated Individual #4 removed or refused to wear the TED hose. The ISP also set a desired outcome that included the individual would maintain an optimal level of health and that nursing was responsible for implementing, monitoring and making the necessary changes that would impact this outcome. On 10/26/20 at approximately 3:30 p.m., the aforementioned observations and staff interviews were shared with the facility Administrator and the Director of Compliance. They stated there was clear understanding of the presented issues. No			STREET ADDRESS, CITY, STATE, ZIP 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	CODE	.0.20.2020
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 331	hose was a treatmenthe right lower leg. The either of the aforement assessments/document removed or refused the individual would realth and that nursing implementing, moniton necessary changes the outcome. On 10/26/20 at approaforementioned observers shared with the Director of Compliance	t for dependent edema to here were no notes from intioned ents that indicated Individual ed to wear the TED hose. esired outcome that included maintain an optimal level of any was responsible for oring and making the mat would impact this eximately 3:30 p.m., the revations and staff interviews facility Administrator and the one. They stated there was	W	331		
W 420	The policy titled Pers dated 8/12/20 indicte many core members specialized needs thr program planning that of programming responses are two of the shared participation in decision-making regard CLIENT BEDROOMS CFR(s): 483.470(b)(4). The facility must provide functional furniture, an needs.	S -)(iv)	W	420		

_ ` '		1 ` ′	A. BUILDING (X3) DA		
	49G005	B. WING		10/26/2020	
ROVIDER OR SUPPLIER	NING	:	2100 STEPPINGSTONE SQUARE	,	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
reviews, and facility of facility staff failed to of (Individual #4) in the provided safe function dresser drawers were of the dresser structure. The findings include: Individual #4 was add Care Facilities for Incided Severe IID, history of falls with he pneumothorax (collar fractures, osteopenia joint disease (DJD), lone tissue after injuries), impairments and blind secondary to hitting I objects, high blood poseizures. On 10/21/20 at 8:00 Individual #4's room, observed stacked on On 10/22/20 at 1:45 10/23/20 at 1:40 p.m. drawers remained ur	documentation review, the ensure 1 of 4 Individuals survey summary was onal furniture. Individual #4's e broken and stacked on top are. mitted to the Intermediate dividuals with Intellectual facility with diagnoses that schizophrenia, unsteady gait, ead trauma, rib fractures with psed lung), tibia and fibula a/osteoporosis, degenerative bursitis, myositis ossificans aside muscle and other soft significant visual adness in his left eye his head into walls and aressure and seizures. and a.m., upon observation into two dresser drawers were a top of the dresser structure. p.m., 4:30 p.m. and on and the condition of the dresser and and the condition of the dresser and	W 420			
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCY REGULATORY OR Continued From pags reviews, and facility of facility staff failed to of (Individual #4) in the provided safe function dresser drawers were of the dresser structure. The findings included: Individual #4 was ad Care Facilities for Inc. Disabilities (ICF/IID) included severe IID, history of falls with he pneumothorax (colla fractures, osteopenia joint disease (DJD), (bone tissue forms in tissue after injuries), impairments and blin secondary to hitting Included severe IID, objects, high blood projects, and blin secondary to hitting Included severed stacked or Individual #4's room, observed Individual #4's room, o	A9G005 ROVIDER OR SUPPLIER STERN VIRGINIA TRAINING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 reviews, and facility documentation review, the facility staff failed to ensure 1 of 4 Individuals (Individual #4) in the survey summary was provided safe functional furniture. Individual #4's dresser drawers were broken and stacked on top of the dresser structure. The findings include: Individual #4 was admitted to the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facility with diagnoses that included severe IID, schizophrenia, unsteady gait, history of falls with head trauma, rib fractures with pneumothorax (collapsed lung), tibia and fibula fractures, osteopenia/osteoporosis, degenerative joint disease (DJD), bursitis, myositis ossificans (bone tissue forms inside muscle and other soft tissue after injuries), significant visual impairments and blindness in his left eye secondary to hitting his head into walls and objects, high blood pressure and seizures. On 10/21/20 at 8:00 a.m., upon observation into Individual #4's room, two dresser drawers were observed stacked on top of the dresser structure. On 10/22/20 at 1:45 p.m., 4:30 p.m. and on 10/23/20 at 1:40 p.m., the condition of the dresser drawers remained unchanged. There were several incidents documented that involved Individual #4's behaviors to included	A BUILDING 49G005 B. WING STERN VIRGINIA TRAINING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 reviews, and facility documentation review, the facility staff failed to ensure 1 of 4 Individuals (Individual #4) in the survey summary was provided safe functional furniture. Individual #4's dresser drawers were broken and stacked on top of the dresser structure. The findings include: Individual #4 was admitted to the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facility with diagnoses that included severe IID, schizophrenia, unsteady gait, history of falls with head trauma, rib fractures with pneumothorax (collapsed lung), tibia and fibula fractures, osteopenia/osteoporosis, degenerative joint disease (DJD), bursitis, myositis ossificans (bone tissue after injuries), significant visual impairments and blindness in his left eye secondary to hitting his head into walls and objects, high blood pressure and seizures. On 10/21/20 at 8:00 a.m., upon observation into Individual #4's room, two dresser drawers were observed stacked on top of the dresser structure. On 10/22/20 at 1:45 p.m., 4:30 p.m. and on 10/23/20 at 1:40 p.m., the condition of the dresser drawers remained unchanged. There were several incidents documented that involved Individual #4's behaviors to included	ROWIDER OR SUPPLIER STERN VIRGINIA TRAINING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 27 reviews, and facility documentation review, the facility staff failed to ensure 1 of 4 Individuals (Individual #4) in the survey summary was provided safe functional furniture. Individual #4's dresser drawers were broken and stacked on top of the dresser structure. The findings include: Individual #4 was admitted to the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facility with diagnoses that included severe IID, schizophrenia, unsteady gait, history of falls with head traumar, ib fractures with pneumothorax (collapsed lung), tibia and fibula fractures, osteopenia/osteoporosis, degenerative joint disease (DJD), bursilis, myositis ossificans (bone tissue after injuries), significant visual impairments and blindness in his left eye secondary to hitting his head into walls and objects, high blood pressure and seizures. On 10/21/20 at 8:00 a.m., upon observation into Individual #4's room, two dresser drawers were observed stacked on top of the dresser structure. On 10/22/20 at 1:40 p.m., 4:30 p.m. and on 10/23/20 at 1:40 p.m., the condition of the dresser drawers remained unchanged. There were several incidents documented that	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		49G005	B. WING _			10/26/2020
	ROVIDER OR SUPPLIER STERN VIRGINIA TRAIN	NING		STREET ADDRESS, CITY, STATE, ZIP CO 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 420	8/18/20, the individual (obsessive-compulsive jumped off his bed to and hit his head on the exhibiting OCD behas throwing toys from our dresser drawers and of the structure of the dresser drawers were top of the dresser structure of the dresser drawers were top of the dresser structure of the dresser drawers were top of the dresser structure of the dresser drawers were top of the dresser structure of the dresser drawers were top of the dresser structure of the dresser drawers were top of the dresser structure of the without a behavioral of the dresser structure of the without a behavioral of the dresser structure	this surveyor identified on al was having a bad OCD we disorder) event when he run to the bathroom, slipped he floor. On 10/17/20, while viors, Individual #4 was at of his room, kicking the knocking three of them out he dresser. Two of these is stacked on each other on a cucture which posed a hilling on the Individual with or outburst of OCD events. In a.m., DSP #6 was with hing #29 for activities and fed, "He did that about 2 and to get (name of the sperson) to fix these one of the drawers was rea, but she is calling today he condition of the broken op of the dresser was all days of the survey. In m., an interview was a cualified Intellectual Disability assigned to Individual #4. Invidual #4 displayed OCD hed destruction of property the dresser, breaking three he called the buildings and pair the dresser and drawers quired about them earlier in	W	420		
		facility Administrator and the				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49G005	B. WING			10/	26/2020
	ROVIDER OR SUPPLIER STERN VIRGINIA TRAIN	IING		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 420	The facility's policy ar for Buildings and Grodated 2/28/19 indicate their respective staff achecks of their areas safety hazards and mithe Building and Grou INFECTION CONTROCFR(s): 483.470(I)(1) The facility must provious to avoid sources and This STANDARD is represented by the staff failed to assist In hygiene prior to her mito appropriately wear equipment) to include that covered both the to utilize surgical mass Administration when operevent the development communicable diseased 15 facility homes. The findings included 1a. Facility staff failed hand hygiene prior to the control of the staff failed hand hygiene prior to the control of the staff failed hand hygiene prior to the control of the staff failed hand hygiene prior to the control of the staff failed hand hygiene prior to the control of the staff failed hand hygiene prior to the control of the staff failed hand hygiene prior to the staff fa	ce. No further information ey exit. Ind procedures titled Request unds Department Services ed each area supervisor and are responsible for frequent to identify and reports and raintenance deficiencies to unds Department. OL ide a sanitary environment transmission of infections. Inot met as evidenced by: In, staff interview, and facility was determined that facility adividual #1 with hand real on 10/22/20; And failed PPE (personal protective a face mask in a manner nose and mouth; And failed exis as directed by caring for individuals to ment and/or transmission of a see (COVID-19) for 4 out of		454			
		ses that included but were					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G005	B. WING		10/26/2020		
	ROVIDER OR SUPPLIER	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
W 454	unspecified neurocog #1 was documented intellectual disabilitie On 10/22/20 observa 3:26 p.m. until 6:04 p On 10/22/20 at 5:19 Member) #1, the Res take Individual #1 to (Direct Support Staff declined stating that #1 was sitting in her area watching the ne On 10/22/20 at 5:37 herself from the loun DSP staff were obse themselves prior to p On 10/22/20 at 5:42 served her meal. Ind herself with set up he evidence of staff ass hygiene prior to start On 10/23/20 at 12:30 conducted with DSP When asked if Individuals hand hygiene perforr stated, "Normally we before meals." When wipe Individuals hand writer a package of " that were kept in the protectors.	lerma, Bipolar disorder, and gnitive disorder. Individual as having moderate s. Intion was conducted from p.m. of Individual #1. Inp.m., OSM (Other Staff sidential Manager, offered to the bathroom with a DSP of member. Individual #1 her brief was dry. Individual wheelchair in the lounge ws. Individual #1 propelled ge to the dining room table. The reparing meals. Individual #1 was ividual #1 was able to feed the prom staff. There was no sisting Individual #1 with hand	W 45-	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	. ,	(X3) DATE SURVEY COMPLETED		
		49G005	B. WING _			10/26/2020	
	ROVIDER OR SUPPLIER	INING	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320		, .0.23,2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
W 454	Plan) Schedule and PMP schedule to clewe will clean hands on them." Review of Individua Plan did not addresher daily schedule. Review of Individua Plan) did not addresher daily schedule. Review of Individua Plan) did not addresher daily schedule. On 10/26/20 at 10:3 conducted with (Other Residential Manage how Individual #1 per program and the sink and that so faucet herself and the assist with turning of that Individual #1 can dispenser. OSM #1 use hand sanitizer whand by staff. OSM can wipe the sanitize independently. When program looked like hygiene program us instructions on how hand hygiene. When ot have a hand hygistated that not all Instructions on the sink and that and all instructions and hygistated that not all Instructions on the sink and hygistated	s PMP (Program Management stated, "It doesn't say in the ean hands prior to eating, but after meals if they have food I #1's Program Management shand hygiene anywhere in I #1's ISP (Individual Support shand hygiene. I #1's ISP (Individual Fl of house 103. When asked erformed hand hygiene, OSM boull her wheelchair right up to metimes she can turn on the mat other times the staff will shand on the faucet. OSM #1 stated an independently use the soap stated Individual #1 can also when it is squeezed into her #1 stated that Individual #1 er into her hands an asked what a hand hygiene of the individual was to perform the asked why Individual #1 did giene program; OSM #1 dividuals had a hand hygiene	W 4	,			
	When asked if Indiv #1 stated that she w wasn't sure why it w not have a hand hy	if they were not trainable. idual #1 was trainable, OSM vas. OSM #1 stated that she vas decided for Individual #1 to giene program. When asked her staff to perform hand					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49G005	B. WING _			10	/26/2020
	ROVIDER OR SUPPLIER	INING		2100 ST	ADDRESS, CITY, STATE, ZIP CODE EPPINGSTONE SQUARE PEAKE, VA 23320	·	
(X4) ID PREFIX TAG			ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 454	hygiene on Individual expected staff to perhygiene before and On 10/26/20 at 1:25 conducted with OSN Intellectual Disabilities #103. When asked if hand hygiene; OSM needed staff assista #6 stated that Individual #6 stated that Individual #6 could not some eded assistance wasked if she expected hygiene prior to measure would expect staff to prior to meals. When expect this, OSM #6 os stated between you and I be Individual #1 had a phygiene, OSM #6 stated to the work would expect this, OSM #6 stated between you and I be Individual #1 had a phygiene, OSM #6 stated to SM	als, OSM #1 stated that she form or assist with hand	W	154			
	assessment dated 3 washing was one of training was required On 10/26/20 at 2:54	#1's comprehensive /18/18 revealed that hand her strengths and that no d. p.m., ASM (Administrative ne Administrator and ASM #2,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		49G005	B. WING		10/26/2020		
	ROVIDER OR SUPPLIER ASTERN VIRGINIA TRAI	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC		
W 454	the Director of Comp the above concerns. Facility policy titled, documented in part, for individuals is the employees! Hands n eating food" No further information 1b. Facility staff failed manner to prevent the home #103. On 10/22/20 at 3:26 made of the houseked #103. OSM #5 was of sweeping the floor. Of mask right underned On 10/22/20 at 3:31 surgical mask down was still in the dining proximity to an individed in the dining proximity to an individed in the dining proximity to an individed in the dining proximity to an individed in the dining proximity at this time is On 10/22/20 at 3:35 observed to have he mouth; at this time is On 10/22/20 at 3:41 placing her surgical mose. On 10/26/20 at 10:33 conducted with OSM	"Personal Hygiene" the following: "Hand hygiene same as hand hygiene for nust be washed:Before on was presented prior to exit. In the to wear surgical masks in a me spread of infection in p.m., an observation was beeper (OSM #5) in house observed in the dining area DSM #5 had her surgical with her nostrils. p.m., OSM #5 had her by her mouth area. OSM #5 garea at this time in close idual who was using the	W 45	54			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		49G005	B. WING _			10/26/2020	
	ROVIDER OR SUPPLIER	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 454	cover their entire nos the above observation knows some of the strate, and it was hard bridge of the nose. On 10/26/20 at 1:05 proconducted with OSM Housekeeping. When his housekeeping state house 103, OSM #4 to wear a surgical mass mouth and nose. OSI staff to wear other PF quarantine or isolation COVID case. When a wearing PPE correctled #4 stated the purpose PPE was to prevent the from one person to at \$45\$ had been trained in stated that she was be date. On 10/26/20 at approximation (Administrator, present signature sheets show regarding PPE use woosm \$45\$ had signed the education.	and that she expected staff to be. OSM #1 was told about ans. OSM #1 stated that she curgical masks slide down the to keep the mask on the co.m., an interview was a #4, the Director of an asked what he expected off to don while working in stated that he expected staff ask covering the entire and was under an for a suspected/actual asked the purpose of y while in the houses, OSM are of wearing the appropriate of the spread of the contagion another. When asked if OSM in how to wear PPE; OSM #4 but could not recall the exact oximately 1:30 p.m., ASM Member) #1, the atted this writer a copy of staff	W 4	54			
	Staff Member) #1, the the Director of Comp	e Administrator and ASM #2, liance were made aware of No further information was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		49G005	B. WING		1	0/26/2020	
	ROVIDER OR SUPPLIER ASTERN VIRGINIA TRAI	NING		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	·	·	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 454	2. On 10/23/20 at apduring an observatio #204 Residence. Dir #2 was observed secueing an Individual the nose. At this tim with DSP #3; DSP # to make talking easie DSP #3's memory to surgical mask was reconversation was coremoval of the surgical adjusted the mask, I adjusting her surgical below her nose each with the meal. An interview was con approximately 12:25 stated the mask was the metal clip on the mask just wouldn't so observed attempting notifying anyone of the approximately 12:40 residential living roof surgical mask below. On 10/26/20 at approabove information would have read on he personal protective of the surgical mask and duty. The Director of they have random controls are the surgical mask and duty. The Director of they have random controls are the surgical mask and duty. The Director of they have random controls are the surgical mask and duty. The Director of they have random controls are the surgical mask and duty. The Director of they have random controls are the surgical mask and duty. The Director of they have random controls are the surgical mask and duty.	proximately 12:07 p.m., n of the midday meal in the ect Service Personnel (DSP) ated at the dining table with the surgical mask below e a conversation was started 3 lowered the surgical mask er, immediately after jogging keep the mask in place, the epositioned and the mpleted without further cal mask. As DSP #3 DSP #2 was also observed at mask but it continued to fall in time she cued the individual anducted with DSP #2 at p.m. on 10/23/20. DSP #2 donned appropriately with bridge of her nose but the tay in place. DSP #2 wasn't to don a new mask or the concern. At p.m., DSP #2 was still in the m with an individual with the the nose.	W 45	4			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		49G005	B. WING			10/26/2020	
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN VIRGINIA TRAINING			•	2100 S	TADDRESS, CITY, STATE, ZIP CODE TEPPINGSTONE SQUARE APEAKE, VA 23320	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 454	wearing a personal their chin. A second positioned below the The following observed on 3/22/20 at 7:40 a surgical facemask b attempt to reposition was less than 6 feet interactions with the On 10/22/20 at 1:00 wear his surgical face #6 repeatedly told h facemask over his n On 10/22/20 at 1:35 home without a face the staff office twice staff without a facem came out of the staff facemask. The DSP shift at 2:00 p.m., bushift.	e DSP was observed with facemask positioned under DSP wore a surgical mask eir nose. vations were made in #305: a.m., DSP #10 wore his elow his nose and did not a the facemask. The DSP physical distance during his facility's individuals and staff. p.m., DSP #10 continued to the temask below his nose. DSP im to pull his surgical	W	154	DEFICIENCY)		
	wore his personal fa appeared that the fa	cemask below his nose. It cemask was too small which aintain over both mouth and					
	was sitting in a chair charting where othe He specifically atten	40 p.m. to 2:10 p.m., DSP #8 in the living room area r individuals were located. ded to several individuals oned under his chin and less distance.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		49G005	B. WING		10/26/2020
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN VIRGINIA TRAINING				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	10.20.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
W 454	Continued From page	e 37	W 4	54	
	Intellectual Disabilities observed during the awith a personal one lastightly under the tip of On 10/26/20 at 1:25 p Manager/QIDP was it personal facemask the mouth and nose. She facemask she previous				
W 455	aforementioned obset were shared with the Director of Compliant Compliance stated shall staff to wear a sure contact and attending She provided inservice signatures on the Conthat addressed proper that surgical facemass the care and in the prindividuals, other wish acceptable. No further to survey exit. INFECTION CONTRUCTR(s): 483.470(I)(1)	ne instructed and educated gical facemask when in g to the facility's individuals. See records with originals staff ronavirus/Pandemic Plan er wearing of facemask and sk were to be worn during resence of the facility's e personal facemask were er information was provided OL tive program for the nd investigation of infection	W 4:	55	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		49G005	B. WING		,	10/26/2020	
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN VIRGINIA TRAINING				STREET ADDRESS, CITY, STATE, ZIP CO 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 455	Based on observation facility's staff failed to measures were imple development and/or diseases during the robservation on 10/21. The findings included On 10/21/20 at appro 2:10 p.m., medication observations were of Personnel (DSP) #1 pudding, apple sauce and a glass measuring blue plate. The plate a low profile feeding provide nutrition to a centimeter syringe at was observed around time. At no point did or apply a barrier. At approximately 2:2 conducted with DSP tubing and syringe at specific individual sirtake medications to hinto the medication for required to do. DSP nervous and it was a especially containing individual. On 10/26/20 at approabove information was Administrator and the	not met as evidenced by: ons and staff interviews the of ensure infection control emented to prevent the transmission of infectious medication pour and pass //20. d: coximately 1:00 p.m., through in pour and pass oserved. Direct Service was observed placing e, water, medication cups ing cup on a round plastic in held an extension tubing for tube (medical device used to in individual), a 60 cubic ind a liquid white substance id the rim of the plate at all DSP #1 clean the blue plate 3 p.m., an interview was #1, who stated the plate, I belonged to another ince sometimes they have to inim instead of him coming from as most residents are #1 stated she was extremely mistake to use the plate used products from another	W 4	55			

l ` '		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		49G005	B. WING _		10	0/26/2020	
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN VIRGINIA TRAINING				STREET ADDRESS, CITY, STATE, ZIP CO 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	TE, ZIP CODE JARE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 474	MEAL SERVICES CFR(s): 483.480(b)(2 Food must be served developmental level	I in a form consistent with the	W 4	174			
	Based on observation interviews, the facility Individual Support Plorders were implement	not met as evidenced by: on, record review, and staff y staff failed to ensure the an (ISP) and physician ented for thickened liquids to dration for 1 of 6 individuals e survey sample.					
	Care Facility for Indiv Disabilities (ICF/IID) diagnoses that include Disability, epilepsy, le	mitted to the Intermediate viduals with Intellectual facility on 5/8/19 with led profound Intellectual					
	Individual #3 was ob- chair at the dining tal was wearing a neck helmet and kept his had a high rimmed so- meal but staff fed hin interaction from the in was consumed Direct #4 introduced a red to Individual #3's mouth repeatedly lifted his h	eximately 12:07 p.m., served seated in a wheel cole for the midday meal. He mapkin and a soft black nead lowered. Individual #3 sectional plate holding his may with no attempted andividual. After all the food at Service Personnel (DSP) hin liquid in a nosy cup to a. Individual #3 quickly and nead, and pushed the cup iquid touched his lips without					
	On 10/23/20 at appro	oximately 12:12 p.m., an					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		, ,	ATE SURVEY DMPLETED		
49G005		B. WING _			10/26/2020		
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN VIRGINIA TRAINING			STREET ADDRESS, CITY, STATE, ZIP C 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320	•			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 4	174				
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page interview was conduct determine if use of ext be implemented to ext accept the red liquid stated another Individual liquids. DSP #3 over provided a beverage point it required a spe beverage was still a fra and Individual #3's fluids discarded by the staff A nursing summary of dehydration risk assel lacks understanding causes of dehydratio plan. The diet plan in refused, then thicken consistency, Serve a breakfast, skim milk a dinner. May add cho lunch and dinner, one and p.m., snacks and syrup by spoon to inc The physician's orde revealed the following arrives too runny/thir potato flakes as need texture for all foods. meal plan - large/dou liquids but may thicke refused and consume The Registered Dieti also stated if thin liquid	A9G005 ROVIDER OR SUPPLIER STERN VIRGINIA TRAINING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 interview was conducted with DSP #4 to determine if use of extremely thick liquids would be implemented to encourage Individual #3 to accept the red liquid in the nosey cup. DSP #4 stated another Individual consumed thickened liquids but Individual #3 didn't consume thickened liquids. DSP #3 overheard the interview and provided a beverage thickened but not to the point it required a spoon to scoop up. The beverage was still a thinner drinkable consistency and Individual #3 still wouldn't consume it. Individual #3's fluids were left at the table and discarded by the staff. A nursing summary dated 4/8/20 read: dehydration risk assessment summary 3/18/20, lacks understanding about fluid needs and causes of dehydration, fluids calculated in diet plan. The diet plan included thin liquids unless refused, then thicken liquids to pudding consistency, Serve 4 ounces of prune juice at breakfast, skim milk at breakfast, lunch and dinner. May add chocolate syrup to milk with lunch and dinner, one serving of jell-o for a.m., and p.m., snacks and shaved ice with flavored syrup by spoon to increase fluid intake. The physician's order summary for October 2020 revealed the following undated diet orders: if food arrives too runny/thin staff may thicken with potato flakes as needed. Minced and moist texture for all foods. No added salt, 2500 calorie meal plan - large/double portions, offer thin liquids but may thicken to extremely thick if	A BUILDIN A BOOTS ROVIDER OR SUPPLIER STERN VIRGINIA TRAINING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 interview was conducted with DSP #4 to determine if use of extremely thick liquids would be implemented to encourage Individual #3 to accept the red liquid in the nosey cup. DSP #4 stated another Individual Consumed thickened liquids but Individual #3 didn't consume thickened liquids. DSP #3 overheard the interview and provided a beverage thickened but not to the point it required a spoon to scoop up. The beverage was still a thinner drinkable consistency and Individual #3 still wouldn't consume it. Individual #3°s fluids were left at the table and discarded by the staff. 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The Registered Dietitian summary dated 10/1/20 also stated if thin liquids are refused by cup to	ROUDER OR SUPPLIER STERN VIRGINIA TRAINING SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 40 Interview was conducted with DSP #4 to determine if use of extremely thick liquids would be implemented to encourage individual #3 to accept the red liquid in the nosey cup. DSP #4 stated another Individual and interview and provided a beverage thickened but not to the point it required a spoon to scoop up. The beverage was still a thinner drinkable consistency and Individual #3 still wouldn't consume it. Individual #3	A BUILDING 499005 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320 SUMMARY STATEMENT OF DEPICIENCES (EACH DEFICIENCY MIST EPERCEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 Interview was conducted with DSP #4 to determine if use of extremely thick liquids would be implemented to encourage Individual #3 to accept the red liquid in the nosey cup. DSP #4 stated another Individual Consumed thickened liquids but Individual #3 dividual Consumed thickened liquids but mad \$5 alli wouldrh consume it. Individual #3's fluids were left at the table and discarded by the staff. A nursing summary dated 4/8/20 read: dehydration fixed assessment summary 3/18/20, lacks understanding about fluid needs and causes of dehydration, fluids calculated in diet plan. The diet plan included thin liquids unless refused, then thicken liquids to pudding consistency, Serve 4 ounces of prune pice at breakfast, skim milk at breakfast, lunch and dinner. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NC	(X3) DATE SURVEY COMPLETED	
49G005		49G005	B. WING			10/26/2020	
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN VIRGINIA TRAINING					SS, CITY, STATE, ZIP CODE GSTONE SQUARE E, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E SS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
W 474	allow him to spoon from of prune juice at breat may add chocolate symeals, plain milk with of clear fluids (not Gacontents) should be of a.m., and 3:00 p.m., of chocolate milk served are to served at room. The Individual Support through 4/7/21 included optimal nutritional state interventions including-like consister it from a bowl becaus challenging for Individual Con 10/26/20 at approabove information was Administrator and the The Director of Componeysician's orders should be a supposed in the control of the componeysician's orders should be a supposed in the control of the control of the componeysician's orders should be a supposed in the control of the c	om a bowl. Serve 4 ounces kfast, skim milk at all meals, vrup to milk given with cereal. Additional 8 ounces torade due to its sodium offered twice daily at 10:00 daily. Individual #3 likes I cold but other beverages temperature. In the Plan (ISP) dated 4/8/20 ded problem #28 Maintain trus which was partially met. Sudded: if thin liquids are liquids thickened to may and allow him to spoon de drinking fluids are flual #3.	W	74			