PRINTED: 06/01/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE COMF	PLETED
		49G070	B. WING _		05/	27/2021
BURKE IC	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 9332 BURKE ROAD BURKE, VA 22015	ODE	
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 000	survey was conducted 05/27/2021. The factor compliance with 42 complia	g-Term Care Facilities.	E 0	The Program Manager program staff on accurate on the data collection she individual #2's involvement Goals. The Program Manager program staff on accurate on the data collection she individuals' ISP goals.	ely collecting data eet to reflect nt in his/her ISP will retrain ely collecting data	7/2/21
	Intermediate Care F Intellectual Disabilition 05/25/2021 through not in compliance with Requirements for Intellectual Retards survey report will follow. The census in this state of the survey.	ermediate Care Facilities for ed. The Life Safety Code		 3. The Program Manager individuals' ISP data collection accuracy on a Monthly ba 4. The Clinical Director with quarterly audits to ensure collection sheets reflect actinformation. 	ction sheets for sis. Ô	
W 111		velop and maintain a m that documents the client's eatment, social information,	W	111		
	Based on staff inter review it was determ failed to ensure the and accurate for one survey sample, Indiv					
		sheet dated April 2021 failed			-12	
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITI F		(X6) DATE

Terell Jones, CD

Sull Jones

6/1//21

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.

AMBEOF PROVIDER OR SUPPLIER BURKE ICF ID STREETADDRESS, CITY, STATE, ZIP CODE 9322 BURKE ROAD BURKE, VA 22015 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 111 Continued From page 1 to accurately reflect individual # 2's involvement in their community integration program. The findings include: Individual # 2 was admitted to [Name of Group Horne] with diagnoses that included but were not limited to: severe intellectual disability [1], encephalopathy [2] and epilepsy [3]. "Desired Outcome: 6A. I will participate in (2) one-on-one community outings of my choice twice per month at 100% accuracy for 12 months. Start Date: 08/10/22020. End Date: 07/31/2021.* Support Activities & Instructions: 1, Individual #2] will be encouraged to participate in CR outing or community organized events. 2. [Individual #2] will be accompanied by staff, assisted to fully participate in the activity and with any paperwork. 4. [Individual #2] will be ractivity. 6. Monthly data will be reviewed by the QIDP. 7. [Individual #2] by Instructions and the end of the activity, 5. Staff will praise [Individual #2] to rhis efforts during the activity, 6. Monthly data will be reviewed by the QIDP. 7. [Individual #2] will be accompanied by staff, assisted to fully participate in the activity and with any paperwork. 4. [Individual #2] will be received and the activity and the angelored back to the house at the end of the activity, 5. Staff will praise [Individual #2] to rhis efforts during the activity wice per month for 12 consecutive months. Frequency: Monthly." Review of the data collection dated April 2021		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
BURKE ICF ID SIMMARY STATEMENT OF DEFICIENCIES 10 10 10 10 10 10 10 1			49G070	B. WING		05/27/2021
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) W 111 Continued From page 1 to accurately reflect Individual # 2's involvement in their community integration program. The findings include: Individual # 2 was admitted to [Name of Group Home] with diagnoses that included but were not limited to: severe intellectual disability [1], encephalopathy [2] and epilepsy [3]. "Desired Outcome: 6A. I will participate in (2) one-on-one community outings of my choice twice per morth at 100% accuracy for 12 months. Start Date: 08/01/2020. End Date: 07/31/2021." Support Activities & Instructions: 1, [Individual #2] will be encouraged to participate in CR outing or community organized events: 2. [Individual #2] will be transported back to the house at the end of the activity, 3. [Individual #2] participate in the activity and with any paperwork. 4. [Individual #2] will be transported back to the house at the end of the activity. 5. Staff will praise [Individual #2] of the activity. 6. Monthly data will be reviewed by the QIDP. 7. [Individual #2] will have achieved this goal when he has participated in a 11: community activity twice per month for 12 consecutive months. Frequency: Monthly."					9332 BURKE ROAD	
to accurately reflect Individual # 2's involvement in their community integration program. The findings include: Individual # 2 was admitted to [Name of Group Home] with diagnoses that included but were not limited to: severe intellectual disability [1], encephalopathy [2] and epilepsy [3]. "Desired Outcome: 6A. I will participate in (2) one-on-one community outings of my choice twice per month at 100% accuracy for 12 months. Start Date: 08/01/2020. End Date: 07/31/2021." Support Activities & Instructions: 1. [Individual #2] will be encouraged to participate in CR outing or community organized events. 2. [Individual #2] will be transported back to the house at the end of the activity. 3. [Individual #2] will be accompanied by staff, assisted to fully participate in the activity and with any paperwork. 4. [Individual #2] will be transported back to the house at the end of the activity. 5. Staff will praise [Individual #2] for his efforts during the activity. 6. Monthly data will be reviewed by the QIDP. 7. [Individual #2] will have achieved this goal when he has participated in a 1:1 community activity twice per month for 12 consecutive months. Frequency: Monthly."	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
documented plus signs [+] on 04/03/2021, 04/04/2021 and on 04/08/2021. The data sheet further documented, "LEGEND: + = support provided." On 05/26/2021 at approximately 1:30 p.m., an interview was conducted with ASM [administrative staff member] # 1, program manager. When	W 111	to accurately reflect in their community in The findings include Individual # 2 was at Home] with diagnost limited to: severe intencephalopathy [2] a "Desired Outcome: 6 one-on-one community one per month at 1 Start Date: 08/01/20 Support Activities & will be encouraged to community organize will be transported by of the activity. 3. [Inaccompanied by star in the activity and will [Individual #2] will be house at the end of praise [Individual #2] activity. 6. Monthly of QIDP. 7. [Individual goal when he has paractivity twice per momonths. Frequency: Review of the data of documented plus signored." On 05/26/2021 at apinterview was conductive two seconds.	Individual # 2's involvement integration program. Individual # 2's involvement integration program. Individual # 2's involvement integration program. Individual # 2's involvement included but were not ellectual disability [1], and epilepsy [3]. Individual # 2] indiv	W 1	11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G070	B. WING	esta per 15	05/27/2021
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID		- T - T - T	STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	
PREFIX (EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
home had gone ou if they had gone ou ASM # 1 stated no 2's data collect she community integra dates listed above sheet was marked On 05/26/2021 at a (administrative sta Manager, and OSI QIDP [Qualified Integration of the professional] were No further information of the professional were lightly a limited menta adaptive behaviors schedules and rou Intellectual disabilities and may result autism or cerebral causes, such as la responsiveness. If from the website: https://www.report.ctSheet.aspx?csid [2] A term for any of alters brain function was obtained from http://www.ninds.n.y/encephalopathy.	duals who resided at the group at to any community activities or an outings since January 2021, a. After reviewing Individual # eet dated April 2021 for the tion program regarding the ASM # 1 stated that the data in error. approximately 2:05 p.m. ASM ff member) #1, Program M [other staff member] # 1, tellectual Disabilities a made aware of the findings. tion was provided prior to exit. up of disorders characterized I capacity and difficulty with a such as managing money, tines, or social interactions. It originates before the age of from physical causes, such as palsy, or from nonphysical ck of stimulation and adult This information was obtained chih.gov/NIHfactsheets/ViewFa = 100 diffuse disease of the brain that in or structure. This information the website: ih.gov/disorders/encephalopath	W 11		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
		49G070	B. WING		05/27/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	1 (A)
(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 BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
W 111	send out the wrong si strange sensations ar strangely. They may he or lose consciousness obtained from the well https://medlineplus.go QIDP CFR(s): 483.430(a) Each client's active traintegrated, coordinate qualified intellectual do This STANDARD is not Based on staff intervireview and facility do determined that the Qualities Profession monitor the individuals for two of five individuals. 1. The QIDP failed to [person centered planthealthy life style skills] The findings include: 1. The QIDP failed to [person centered planthealthy life style skills]	gnals. People may have and emotions or behave nave violent muscle spasms as. This information was osite: ov/epilepsy.html. eatment program must be ad and monitored by a isability professional. The and clinical record cument review, it was aligned and is active treatment programs als in the survey sample, 2. ensure Individual #1's PCP of I for money management, adaptive living skills were limited to the survey sample, and and the survey sample, and the s		1. The Program Manager will train prograted for the frequency of implementing the goals as well as how to accurately document the data collection sheets for individuals number 1 and 2. 2. The Program Manager will train programs from the frequency of implementing the goals as well as how to accurately document the data collection sheets for all individuals. The Program Manager will review the collection sheets Monthly for accuracy ensuring staff are documenting per the frequency specified in each individuals. The Clinical Director will audit the CR Records Quarterly ensuring the data coll sheets are completed accuracy and per the frequency specified in each individuals.	he ISP nent on gram he ISP nent on ials. e data ISP. linical ection ne

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G070	B. WING		05/27/2021
NAME OF PE	ROVIDER OR SUPPLIER		9332	EET ADDRESS, CITY, STATE, ZIP CODE BURKE ROAD RKE, VA 22015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
W 159	Individual # 1 was ad Home] with diagnose limited to: moderate is swallowing difficulties. Individual #1's PCP of 06/30/2021 documer will increase my mon I sort out coins by nuthand support by staff 06/30/2021. Support [Individual #1's Initial engage in money mawill support [Individual mixture of coins (penquarters) on [Individual ptray for him to sow will be prompted to some numeric value. 4. Staff's Initials] progress needed. Frequency: "Desired Outcome: 4 independence by mastaff support once as consecutive months. Activities & Instruction #1] will identify the mor assist with preparicontaining preferred Individual #1] will revidentify the items need of Individual #1] will chosen for his select Individual #1] will par	mitted to [Name of Group is that included but were not intellectual disability [1], and cerebral palsy [2]. Idated 07/01/2020 through ited, "Desired Outcome: 2. I ey management skills when meric value with hand over fonce a week at 80% by Activities & Instructions: 1. is will be prompted by staff to nagement activity. 2. Staff al #1's Initials] by placing a nies, dimes, nickels and/or ital #1's Initials] wheelchair it. 3. [Individual #1's Initials] for the coins according to aff will document [Individual and provide support as Weekly." I will improve my king my preferred meal with week at 80% accuracy for 12 by 6/30/2021. Support ins: 1. [Name of Individual eal he would like to prepare ing using his picture board meals. 2. [Name of itew the grocery list and ited for his meal. 3. [Name item items that he has eed meal. 4. [Name of iticipate with hand over hand	W 159		
	assistance from staff [Name of Individual #	in preparing the meal. 5.			len

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G070	B. WING		05/27/2021
NAME OF PE	ROVIDER OR SUPPLIER	er egen er	5	STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 159	living skills by putting laundry basket using each day at 80% accomonths Start Date: 0 06/30/2021. Support [Name of Individual # the appropriate time support from staff. 2 hold his dirty clothes support from staff. 3 be verbally prompted into the laundry bask #1] will toss his clother using hand over hand [Name of Individual # Daily." Review of the data con 2021 through April 20 documentation of Individual # Daily." Review of the data con 2021 through 03/06/2021 and 04/30/2021. Further above revealed they offered]." Review of the data con 2021 through April 20 documentation of Individual # Daily." Review of the data con 2021 through 03/06/2021 and 204/30/2021. Further above revealed they offered]."	I will improve my adaptive my dirty clothes in the hand over hand assistance uracy for 12 consecutive 17/01/2020. End Date: Activities & Instructions: 1. Et] will remove his clothes at with the needed level of Individual #1] will using hand over hand Individual #1] will by staff to toss his clothes et. 4. [Name of Individual #1] will by staff to toss his clothes et. 4. [Name of Individual es into his laundry basket disupport. 5. Staff will praise et.] for his effort. Frequency: Dilection dated February Dilection dated Febru	W 15	9	
	04/17/2021. Further above revealed they offered]."	review of the dates listed			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMPI	
		49G070	B. WING		05/2	27/2021
NAME OF PI	ROVIDER OR SUPPLIER		18512	STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 159	documentation of Ir living skills program 03/24/2021, 03/28/203/31/2021. Further above revealed the offered]." On 05/26/2021 at an interview was condimember] # 1, QIDP collection sheets da April 2021 for the distated that Individual money managemer adaptive living skills When asked how or reviewed for accurate review them month month to make sure the program[s] corror The facility's docum QMRP/QIDP/QDDF "Principal Duties and evaluates, and recording to measure Service Plan."	2021 failed to evidence adividual # 1's and adaptive being implemented on 2021, 03/30/2021 and on a review of the dates listed y were coded "O = Other [not exproximately 2:30 p.m., an acted with OSM [other staff]. After reviewing the data ated February 2021 through ates listed above OSM # 1 al # 1's PCP programs of at, meal preparation and a were not implemented. Iften the data sheets are acy, OSM # 1 stated that they y close to the beginning of the eather staff are implementing eactly.	W 159	10		
	Manager, and OSM QIDP [Qualified Inter Professional] were No further informati	[other staff member] # 1,				
	References: [1] Refers to a grou	p of disorders characterized			8	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		49G070	B. WING		05/	27/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY 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	(X5) COMPLETION DATE
W 159	adaptive behaviors schedules and rout Intellectual disability 18 and may result if autism or cerebral progress, such as lad responsiveness. The from the website: https://www.report.ctSheet.aspx?csid=[2] A group of disordability to move and posture. This informability to move and posture. This informability to move and posture. This informability to move and posture. This information website: https://www.nlm.nih.y.html. 2. The QIDP failed [person centered plealthy life style skill limited to: severe in encephalopathy [2] "Desired Outcome: lifestyle by identifying starch, 1 vegetable a month at 100% at Date: 08/01/2020. Support Activities & will review the laming support. 2. [Individuation of the prompted by staff to select a proprompted by select a proprompted by select a proprompted by select a proprompted by sel	capacity and difficulty with such as managing money, ines, or social interactions. y originates before the age of rom physical causes, such as palsy, or from nonphysical ck of stimulation and adult his information was obtained with gov/NIHfactsheets/ViewFa endowners that affect a person's to maintain balance and mation was obtained from the agov/medlineplus/cerebralpals to ensure Individual #2's PCP and for laundry skills and lls were implemented. Individual #2's PCP and for laundry skills and lls were implemented. Individual #2's PCP and for laundry skills and lls were implemented.	W 15			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G	COMPLETED
		49G070	B. WING	·	05/27/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 159	Continued From page vegetable. 4. [Indivivocalizations, pointing indicate each time the selection. 5. Staff whis effort. 6. Data we QIDP and Program [Individual # 2] has it using the laminated consecutive months goal. Frequency: M. "Desired Outcome: 4 supported with compover hand support of accuracy for 12 consecutives & Instruction accuracy for 12 consecutives & In	ge 8 idual # 2] will use visual cues, ng or raising of eyebrows to hat he selects his food vill praise [Individual # 2] for vill be reviewed Monthly by the Manager. 7. When identified healthy food choices list twice a month for 12 is he would have achieved this	W 15	DEFICIENCY)	
	[Individual # 2] is ab week for 12 months achieved this goal.	am Manager. 7. When le to wash his clothes once a consecutively, he will have Frequency: Weekly."			
	through April 2021 fadocumentation of Inbeing implemented to 01/09/2021, 01/24/202/14/2021 through	collection dated January 2021 ailed to evidence dividual # 2's laundry program from 01/03/2021 through 2021 through 01/30/2021, 02/20/2021, 03/07/2021 and 03/21/2021 through			40 Pe

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		49G070	B. WING	<u> </u>	05/27/2021
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SUBVE V				9332 BURKE ROAD	* 1
BURKE IC	;FID			BURKE, VA 22015	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
W 159	Continued From page	e 9	W 15	59	
1	03/27/2021. Further	review of the dates listed			
		were coded "O = Other [not			
F.	through April 2021 fai		0		
		dividual # 2's healthy lifestyle mented from 01/24/2021 03/21/2021 through			
		1/2021 through 04/30/2021.			
		dates listed above revealed			
	Fig. Nation was recommended by the property of the party	= Other [not offered]."		a distance with the second second	-
	interview was conduct member] # 1, QIDP. collection sheets date April 2021 for the date agreed that Individual healthy life style skills	proximately 2:30 p.m., an oted with OSM [other staff After reviewing the data ed January 2021 through tes listed above OSM # 1 al # 2's PCP programs for s and laundry skills were not asked how often the data			
		for accuracy, OSM # 1			
		w they review them monthly			
11 197	the staff are implement correctly.	g of the month to make sure enting the program[s]			
	(administrative staff n	proximately 2:05 p.m. ASM member) #1, Program [other staff member] #1, lectual Disabilities			Sept 1
	Professional] were m	nade aware of the findings.			
	No further information	n was provided prior to exit.			4 2 4
	References:				. = 0.1
	[1] Refers to a group by a limited mental ca	of disorders characterized apacity and difficulty with uch as managing money,			

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		49G070	B. WING		5/27/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Intellectual disability 18 and may result fro autism or cerebral pa causes, such as lack responsiveness. Thi from the website: https://www.report.ni ctSheet.aspx?csid=1 [2] A term for any diffa alters brain function was obtained from th http://www.ninds.nih. y/encephalopathy.htm [3] A brain disorder th recurring seizures. T clusters of nerve cell send out the wrong s strange sensations a strangely. They may or lose consciousnes obtained from the we https://medlineplus.g PROGRAM IMPLEM CFR(s): 483.440(d)() As soon as the interest formulated a client's each client must rece treatment program c interventions and set and frequency to sup	les, or social interactions. originates before the age of om physical causes, such as alsy, or from nonphysical of stimulation and adult is information was obtained the description of the brain that or structure. This information he website: gov/disorders/encephalopath me. That causes people to have the seizures happen when so, or neurons, in the brain signals. People may have and emotions or behave thave violent muscle spasms as. This information was besite: gov/epilepsy.html. JENTATION Illisciplinary team has individual program plan, heive a continuous active		1. The Program Manager will retrain the QIDP on how to accurately complete monthly audits by reviewing the program data collection documentatic for accuracy on a Monthly basis to ensure all of individual number 1 and individual number 2's PCP goals are implemented correctly. 2. The Program Manager will retrain the QIDP on how to accurately complete the monthly audits by reviewing the program data collection documentation accuracy on a Monthly basis to ensure all individuals we serve at Burke Road's PCP goals are implemented correctly. 3. The Program Manager will review the Monthly QIDP data collection audits for accuracy on a Quarterly basis and provide additional training to the QIDP as needed. 4. The Program Manager will train program staff of the implementation of individual number 1 and individual number 2's ISP goals with an emphasis of ensuring staff understand how frequently they are to document and how to accurately document on the data collection sheet. 5. The Program Manager will train program staff of the implementation of all individuals' ISP goals with an emphasis of ensuring staff understand how to accurately document on the data collection sheet. 6. The QIDP will review all individuals' ISP data collection sheets on a monthly basis to ensure they are documented accurately per the frequency recommended in each individual's ISP. This process will be monitored by the Program Manager on a Quarterly basis. 7. The Clinical Director will audit the Clinical records on a Quarterly Basis to ensure the ISP data collection sheets are accurate per the frequency	

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B. WING	Section 1	05/27/2021
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ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I	BE COMPLET
W 249		
	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
		49G070	B. WING		05/27/2021
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
W 249	Continued From pa	ge 12	W 249		
	will support [Individ mixture of coins (pe quarters) on [Individed lap tray for him to se will be prompted to numeric value. 4.5	ual #1's Initials] by placing a cennies, dimes, nickels and/or dual #1's Initials] wheelchair ort. 3. [Individual #1's Initials] sort the coins according to Staff will document [Individual as and provide support as			
	independence by m staff support once a consecutive month. Activities & Instruct #1] will identify the or assist with prepa containing preferre. Individual #1] will re identify the items m of Individual #1] will chosen for his sele. Individual #1] will p assistance from sta [Name of Individual	4. I will improve my naking my preferred meal with a week at 80% accuracy for 12 is by 6/30/2021. Support ions: 1. [Name of Individual meal he would like to prepare uring using his picture board domeals. 2. [Name of eview the grocery list and eeded for his meal. 3. [Name II set up the items that he has coted meal. 4. [Name of articipate with hand over hand off in preparing the meal. 5. #1] will be praised for activity. Frequency: Weekly."			
	"Desired Outcome: living skills by putting laundry basket using each day at 80% at months Start Date 06/30/2021. Support [Name of Individual the appropriate time support from staff. hold his dirty clother support from staff. be verbally prompted."	5. I will improve my adaptive ng my dirty clothes in the g hand over hand assistance occuracy for 12 consecutive 07/01/2020. End Date: ort Activities & Instructions: 1. #1] will remove his clothes at with the needed level of 2. [Name of Individual #1] will susing hand over hand 3. [Name of Individual # 1] will ed by staff to toss his clothes sket. 4. [Name of Individual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		49G070	B. WING		05/27/2021
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	***	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
W 249	Continued From pag	e 13	W 24	19	2 4
	using hand over hand	es into his laundry basket d support. 5. Staff will praise f1] for his effort. Frequency:			
	2021 through April 20 documentation of Ind management program 02/07/2021 through 0	m being implemented from 02/13/2021, 02/28/2021			
	04/30/2021. Further	and 04/01/2021 through review of the dates listed were coded "O = Other [not			
	2021 through April 20 documentation of Ind	ollection dated February 021 failed to evidence ividual # 1's meal being implemented from			
	02/14/2021 through (through 03/31/2021 a 04/17/2021. Further	noting implemented from 2/20/20/2021, 03/15/2021 and 04/11/2021 through review of the dates listed were coded "O = Other [not			
	2021 through April 20 documentation of Ind living skills program b 03/24/2021, 03/28/20 03/31/2021. Further above revealed they offered]." On 05/26/2021 at appinterview was conducted staff member] # 1, progressively previewing the data confederation.	ollection dated February 221 failed to evidence ividual # 1's and adaptive being implemented on 221, 03/30/2021 and on review of the dates listed were coded "O = Other [not eroximately 1:30 p.m., an eted with ASM [administrative begram manager. After illection sheets dated gh April 2021 for the dates stated that according to the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	COMPLETED
		49G070	B. WING _	9.	05/27/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 249	Continued From pag	ne 14	W 2	49	
		# 1's PCP programs of t, meal preparation and that they were not			
	documented, "ISP In Engagement: Impler the time of its develor plan are fully implem receiving support, le active engagement r	4.1 Individual Service Plan" inplementation and Consumer mentation of the ISP begins at opment. Components of the mented, with the consumer arning environment and mecessary to reach his or her autcomes as defined in the			
	(administrative staff Manager, and OSM QIDP [Qualified Intel	proximately 2:05 p.m. ASM member) #1, Program [other staff member] # 1, lectual Disabilities nade aware of the findings.			
1180	No further information	n was provided prior to exit.		1 % 50 1 10 %	
	by a limited mental of adaptive behaviors is schedules and routin Intellectual disability 18 and may result for autism or cerebral pa causes, such as lack responsiveness. The from the website:	o of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. originates before the age of om physical causes, such as alsy, or from nonphysical to of stimulation and adult is information was obtained th.gov/NIHfactsheets/ViewFa			
		ers that affect a person's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		44 11000 0000 0000	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		49G070	B. WING	<u> </u>	05/27/2021
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 249	posture. This informative website:	e 15 ation was obtained from the gov/medlineplus/cerebralpals	W 24	19	
	#2's PCP [person cer style skills and laundre lindividual # 2 was ad Home] with diagnose limited to: severe interencephalopathy [2] at "Desired Outcome: 3/2 lifestyle by identifying starch, 1 vegetable) to a month at 100% according to 100% accord	Imitted to [Name of Group es that included but were not ellectual disability [1], and epilepsy [3]. A. I will improve my healthy the healthy meals (1 protein, 1 using my laminated list twice curacy for 12 months. Start and Date: 07/31/2021." Instructions: 1. [Individual #2] atted food list with staff all #2] will be prompted by in. 3. [Individual # 2] will be select a starch. 4. [Individual by staff to select a dual # 2] will use visual cues, gor raising of eyebrows to at the selects his food at the selects his food at the reviewed Monthly by the Manager. 7. When lentified healthy food choices ist twice a month for 12 he would have achieved this			
		A. [Individual # 2] will be leting his laundry using hand			* 2 (2 =)

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BURKE ICF ID				STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	1 032772021	
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W 249	08/01/2020. End Da Activities & Instruction supported in the every wash his clothes. 2. Supported with hand his dirty clothes from them in the washing will be supported by to the washing mach [Individual # 2] by set start the wash. 5. So for his effort. 6. Data the QIDP and Progra [Individual # 2] is about 12.	nce a week at 100% secutive months. Start Date: ste: 07/31/2021." Support sins: 1. [Individual #2] will be ning when it is time for him to [Individual #2] will be over hand support to remove the hamper and to place machine. 3. [Individual # 2] staff to add laundry detergent sine. 4. Staff will support electing the correct buttons to staff will praise [Individual # 2] a will be reviewed Monthly by am Manager. 7. When e to wash his clothes once a consecutively, he will have	W 24	9		
	through April 2021 fadocumentation of Indebeing implemented for 01/09/2021, 01/24/202/14/2021 through 03/13/2021 03/27/2021. Further above revealed they offered]." Review of the data of through April 2021 fadocumentation of Indeprogram being imple through 01/30/2021, 03/27/2021 and 04/0 Further review of the	dividual # 2's laundry program from 01/03/2021 through 021 through 01/30/2021, 02/20/2021, 03/07/2021 and 03/21/2021 through review of the dates listed were coded "O = Other [not collection dated January 2021 ailed to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dividual # 2's healthy lifestyle through growth of the dates listed were coded to evidence dates were coded to evidence dates listed were coded to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G070	B. WING		05/27/20	21
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMP	(X5) PLETION PATE
W 249	interview was condi- staff member] # 1, previewing the data of January 2021 through listed above, ASM # coding for Individual life style skills and lanot implemented. On 05/26/2021 at appropriate (administrative staff Manager, and OSM QIDP [Qualified Interprofessional] were reprofessional] were reprofessional were reprofess	proximately 1:30 p.m., an acted with ASM [administrative program manager. After collection sheets dated gh April 2021 for the dates if 1 stated that according to the I # 2's PCP programs healthy aundry skills, that they were approximately 2:05 p.m. ASM member) #1, Program [other staff member] # 1, ellectual Disabilities made aware of the findings. In was provided prior to exit. To of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. To originates before the age of comphysical causes, such as alsy, or from nonphysical k of stimulation and adult his information was obtained with gov/NIHfactsheets/ViewFa 100 If use disease of the brain that or structure. This information he website:	W 24	9		
	[3] A brain disorder t	that causes people to have				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G070	B. WING	<u> </u>	05/27/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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BUKKE IC	רוט			BURKE, VA 22015	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	clusters of nerve cells send out the wrong si	e 18 ne seizures happen when s, or neurons, in the brain ignals. People may have nd emotions or behave	W 24	1. The Nursing Coordinator will train the and all other ICF facility staff on infection control with an emphasis of ensuring staff understand when contamination occurs and ensure eating utensils are appropriately cle when contaminated for individual #4.	1
W 455	strangely. They may	have violent muscle spasms s. This information was bsite: ov/epilepsy.html. OL	W 45	2. The Nursing Coordinator will train the and all other ICF facility staff on infection control with an emphasis of ensuring staff understand when contamination occurs and ensure eating utensils are appropriately cle	1
	and communicable di	nd investigation of infection		when contaminated for all individuals supported. 3. The Program Manager will observe mealtime on a Monthly basis to ensure staffollowing the appropriate infection control practices.	
	facility staff failed to in practices for one of 5 sample, (Individual #4			4. The Clinical Director will audit the progon a quarterly by observing and ensuring the appropriate infection control practices are ladhered to.	ne
	Individual #4 an adap dropped on the floor a eat their lunch with. L	al nurse] # 1 provided stive spoon that had been and rinsed under water to PN #1 was not observed rior to providing to Individual			
	The findings include:				
	Home] with diagnose limited to: severe inte epilepsy [2] and quad				
	On our zorzoz i at app	John Marie Training and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G070	B. WING _		05/27/2021
NAME OF PROVIDER OR SUPPLIËR BURKE ICF ID			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015		
(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 CORRECTIV ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
W 455	observation of the lur Home) was conducted in their wheelchair to dayroom. LPN [licen observed in the kitcher # 4's plate of food, be While carrying the ite dayroom, LPN # 1 dronto the floor. LPN # spoon, went back to plate of food and bevon the water, placed water, rinsing it. Furt evidence LPN # 1 wa and a washing impler sponge or brush. LP plate of food, beverag placed them in front of 4 was observed using rinsed off to eat their. On 05/26/2021 at 1:2 conducted with LPN # the observation described they cleaned could be used, LPN # floor that long. I picket fingers on it while I rin On 05/26/2021 at 2:4 conducted with ASM member] # 1, progrand describe the proceduran Individual that was	ich meal at (Name of Group d. Individual # 4 was seated ward the center of the sed practical nurse] # 1 was en area picking up Individual everage and adaptive spoon. In stopped, picked up the he kitchen area, placed the erage on the counter, turned the spoon under the running ther observations failed to shing the spoon with soap, ment such as washcloth, N # 1 then picked up the ge and the rinsed spoon and of Individual # 4. Individual # 1 the spoon that LPN # 1 meal. 10 p.m., an interview was # 1. After being informed of the spoon properly so that it it 1 stated, "It wasn't on the end it right up and rubbed my used it."	W 4	155	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G070			-=	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		B. WING _	, 2° 18°	05/27/2021	
NAME OF P	ROVIDER OR SUPPLIER	The second of th	5	STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
W 455	Continued From pa	age 20	W 4	55	
	2.1	approximately 2:05 p.m. ASM		F 11 8	=
		ff member) #1, Program			-
		I [other staff member] # 1,	= 5		
		ellectual Disabilities			
	- [- [- [- [- [- [- [- [- [- [made aware of the findings.			
	, , , , , , , , , , , , , , , , , , , ,			e e	
	No further informat	ion was provided prior to exit.		1 1 1 1 1	
		,		and the second second	
	References:			the order	2 88.814
	[1] Refers to a grou	up of disorders characterized	Page		π h h h h
	by a limited mental	capacity and difficulty with			
		such as managing money,		19 := 2	15 19 31
	1 5 6	tines, or social interactions.	Age of		
		ty originates before the age of		U =,	La e
	18 and may result	from physical causes, such as	1	Tage	Established to the second
		palsy, or from nonphysical			•
	causes, such as la	ck of stimulation and adult		E	, a 100
	responsiveness. T	his information was obtained	100		
	from the website:			19 1	
	https://www.report.	nih.gov/NIHfactsheets/ViewFa			
	ctSheet.aspx?csid=	=100			1, 2
					9
	[2] A brain disorder	that causes people to have		E 22 - 10/10/21 - 1	100
	recurring seizures.	The seizures happen when			2.11
		ells, or neurons, in the brain			Also din
	send out the wrong	g signals. People may have			
		and emotions or behave			2 9 4
		ay have violent muscle spasms			× II = = = = = = = = = = = = = = = = = =
	Scottle redioents course as course average assessed actions	ess. This information was		The second secon	e m po F
	obtained from the				
	https://medlineplus	.gov/epilepsy.html.			× 15 =
		scle function in part of your			
		hen something goes wrong			
		ages pass between your brain	4 - 6 -		
		lysis can be complete or	4 4 3		A A STATE OF THE S
	· The second sec	r on one or both sides of your			Se seriel e 1850 - 1870 - 11 (1
		ccur in just one area, or it can			
	be widespread. Pa	ralysis of the lower half of your	and a second		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		49G070	B. WING _		05/	27/2021	
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID			STREET ADDRESS, CITY, STATE, ZIP CODE 9332 BURKE ROAD BURKE, VA 22015				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 455	Paralysis of the arm This information was https://medlineplus. On 05/26/2021 at a (administrative staff Manager, and OSM QIDP [Qualified Inte Professional] were No further informati References: [1] Refers to a grou by a limited mental adaptive behaviors schedules and routi Intellectual disability 18 and may result f autism or cerebral p causes, such as lac responsiveness. The from the website: https://www.report.r	n legs, is called paraplegia. Is and legs is quadriplegia. Is obtained from the website: gov/paralysis.html. pproximately 2:05 p.m. ASM member) #1, Program I [other staff member] # 1, ellectual Disabilities made aware of the findings. on was provided prior to exit. p of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. I originates before the age of rom physical causes, such as ealsy, or from nonphysical is of stimulation and adult his information was obtained	W 4	155			
	alters brain function was obtained from thttp://www.ninds.nihy/encephalopathy.h [3] A brain disorder recurring seizures. clusters of nerve cesend out the wrong strange sensations	ffuse disease of the brain that or structure. This information he website: n.gov/disorders/encephalopath					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		49G070	B. WING _			05	27/2021
NAME OF PROVIDER OR SUPPLIER BURKE ICF ID				STREET ADDRESS, 9332 BURKE ROAL BURKE, VA 2201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
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	or lose consciousnes obtained from the we https://medlineplus.g						
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