STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/20/21 through 7/22/21. The facility wwas in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	W125 **How corrective action will be accomplished for individual #1:** The facility staff suspected of restricting individual #1's freedoms of everyday life was immediately put on administrative leave upon discovery of the allegation pending the outcome of a human rights investigation (10/12/2020). Based on confirmed findings that the alleged staff had indeed restricted individual #1 from getting out of his wheelchair, the staff member was separated from employment with the agency on 10/27/2020. Facility staff will continue to support individual #1's choice to get out of his wheelchair as he wishes, providing him assistance as needed, to ensure that freedoms of everyday life are maintained. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will support all individuals in the home with exercising and maintaining their choices, providing appropriate supports as needed, to ensure freedoms of everyday life are maintained. Consequent of this incident, all staff have been re-trained on person-centered practices, human rights, and principles of therapeutic options. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP and ICF Management will continue to monitor facility staff adherence to promoting and honoring individual choice to ensure freedoms of everyday life are maintained and restrictive practices are not being implemented. Monitoring will consist of onsite spot checks and supervision as well as randomized checks via program camera surveillance. **How the facility plans to monitor its performance to make sure that solutions are sustained:** ICF Management will monitor and document various randomized shift checks to ensure that freedoms of everyday life are being promoted and not restricted for all individuals. Additionally, the Quality team is completing random site checks and camera checks to ensure freedoms of everyday life are being honored and choices are being offered. **Date of Completion:** 10/27/2020	10/27/2020 and ongoing
W 000	INITIAL COMMENTS An unannounced annual Medicaid ICF/ID Health Care Certification survey was conducted 7/20/21 through 7/22/21. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Mentally Retarded. The Life Safety Code survey report will follow. The census in this four bed facility was four at the time of the survey. The survey sample consisted of two current individual reviews (Individuals #1 and #2).	W 000		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff restricted the freedoms of everyday life for one of two individuals in the survey sample, Individual #1. The facility staff prevented Individual #1 from getting out of his wheelchair on 10/12/20.	W 125		

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

DD Residential Coordinator 8/4/2021

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

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W 125	Continued From page 1 The findings include: Individual #1 was a 54 year old male admitted to the group home with diagnoses including Cornelia de Lange syndrome (1) and profound intellectual disability. A review of facility documents revealed an incident report dated 10/13/20. The report documented: "Supervisor Comments: Last evening at 10:30 p.m., I received a phone call from [DSP (direct support professional) #2] reporting a bruise on [Individual #1]'s left arm...When I called and spoke to [DSP #3] about the bruise, I asked her if anything happened during the time she was sitting in his room with him and she stated, 'Oh, I forgot to tell [RN (registered nurse) #1] before she left, but [Individual #1] slipped and fell in his room after leaving the shower. He wouldn't stay still for me to dry his feet and when he fell, he hit his left arm on his dresser.' It was also reported to me that [DSP #3] had been sitting in [Individual #3]'s room with him for a period of time and it sounded like he was trying to come out of his room, but [DSP #3] was not letting him. Staff reported that they believe she was sitting in front of the door in his room. At this time, we are unsure of where the bruise originated...This has been referred to the QA (quality assurance) department for investigation..." A review of the document, "Human Rights Investigation - [Individual #1]" revealed, in part: "Review of Camera Footage...6:04 p.m. [Individual #1] get (sic) in wheel chair. [DSP #3] appears to buckle him in and then she sits on the ottoman. While sitting on the ottoman she leans the wheel chair back onto the back two wheel and	W 125		

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W 125	Continued From page 2	W 125		

rest (sic) the top of the wheel chair on her legs. [Individual #1] attempts to get out of the chair. At one point he raises his hands above his head and [DSP #3] pushes his hands back down to his side. [Individual #1] continues to try and get out of the chair by twisting and turning in the chair. He turns the chair on its side and slides out head first. The entire time he is attempting to get out of the chair [DSP #3] continues to hold the chair back on two wheels. 6:06 p.m. [Individual #1] is in the wheel chair and [DSP #3] pushes him to his room. 6:27 p.m. [DSP #2] goes to [Individual #1]'s bedroom door for the second time. The first time she was unable to open the door. This time as she was able to open the door, [Individual #1] comes out of the room. He is crawling on the floor... [OSM (other staff member) #1, a QA staff member] and OSM #2, a QA staff member completed a face to face interview with [DSP #3]. [DSP #3] provided an overview of the afternoon/evening of October 12, 2020. She reported that she assisted [Individual #1] with his shower. She stated, he usually takes long showers. However, on this particular day he took a short shower, and did not want to get his feet dried, so when he went into his bedroom he slipped and fell due to his wet feet. He fell into the dresser and then fell onto the floor. [DSP #3] stated she helped him up and he then sat in the chair in his room where she was able to assist him in drying his feet. She assisted him in putting on socks; however, he took them off shortly after they were put on. [DSP #3] then reported that she did not work with him after dinner and that two other staff took him for a ride. When asked is remembers (sic) pushing around in the wheel chair, she stated, 'Oh yeah, I did that.' She was asked to elaborate on what happened. She reported that she was pushing him in the wheel

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W 125	Continued From page 3 chair and at one point, she sat on the ottoman and leaned the wheel chair back onto her lap. When asked why she leaned the wheel chair back, she stated, 'probably to keep him from getting up or falling out of the chair.' She stated he likes to slip out of the chair. She reported that after she leaned him back, he slid out of the wheel chair; however, she stated she did not see him sliding because she was paying attention to another client. She stated once he slide (sic) out another staff checked him for injuries. She stated she then put him back in the chair and rolled him down to his room. She states that [Individual #1] got onto his bed and then got back up and went back to the living room. This writer informed [DSP #3] of what was observed with the video footage. She then reported that while she and [Individual #1] were in his bedroom, [DSP #2] tapped on the door to see if [DSP #3] needed any assistance, as staff have been told that if they become frustrated or need a break they should ask other staff to assist. [DSP #3] reported this is why she thinks [DSP #2] came to the door. [DSP #3] also reported that when [DSP #2] came to the door, it was also to take [Individual #1] for a ride... [OSM #1] and [OSM #2] completed a face to face interview with [DSP #2]. [DSP #2] provided an overview of the afternoon/evening of October 12, 2020. [DSP #2] reported that when she arrived [Individual #1] was out of the home. She begin (sic) prepping dinner. Around 4 or 5, [DSP #3] reported to [DSP #2]...that [Individual #1] would not need a plate as he was sleeping. Later [DSP #2] states she saw [DSP #3] sitting on the ottoman with [Individual #1]'s wheel chair tilted backward. [Individual #1] was in the process of coming out of the chair and before [DSP #2] could get to him, he had fallen out. [DSP #2] reported that once [Individual #1] stood up, he got	W 125		

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W 125	Continued From page 4 back into the chair and [DSP #3] had buckled him in and took him to his room. [DSP #2] stated when she went down the hall to go to the restroom she could hear [DSP #3] telling [Individual #1] to stop, and at one point she heard his dresser drawer slam. [DSP #2] reported that she heard [DSP #3] telling [Individual #1] that he was not going out of his room and 'you need to stop, I don't know what the hell you (sic) doing, you are not going out there.' [DSP #2] reports she went to [Individual #1]'s bedroom door; however she could not open it. She reported that she believed that [DSP #3] was sitting in front of the door blocking [Individual #1] from leaving. [DSP #2] reports that she contacted [ASM (administrative staff member) #1, the supervisor], who advised her to go to [Individual #1]'s bedroom door and inform [DSP #3] that she...would be taking [Individual #1] for a ride. Conclusion: In consideration of information collected and recorded herein, the investigators substantiate the claim that [DSP #2] restricted [Individual #1]'s freedom of everyday life on two instances during the evening of October 12, 2020." DSP #3, OSM #1, and OSM #2 were unavailable for interview during the survey. On 7/21/21 at 1:50 p.m., ASM #1 was informed of these concerns. She stated as a result of the investigation referenced above, DSP #3 was terminated as an employee. When asked what specifically DSP #3 had done wrong, she stated DSP #3 had restricted Individual #1's freedom to get out of the wheelchair. She stated DSP #3 was suspected to have restricted Individual #1's freedom to leave his room when he wanted to, but this suspicion had not been proven. ASM #1	W 125		

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W 125	Continued From page 5 provided a copy of a section from the state's administrative code regarding intermediate care facilities for individuals with intellectual disabilities. This section documented: "Restrictions on freedoms of everyday life. From admission until discharge from a service, each individual is entitled to: 1. Enjoy all the freedoms of everyday life that are consistent with his need for services, his protection, and the protection of others, and that do not interfere with his services or the services of others. These freedoms include: a. Freedom to move within the service setting, its grounds, and the community." On 7/21/21 at 2:18 p.m., DSP #2 was interviewed. She verified the facts as documented in the human rights investigation report of her interview. She stated DSP #3 never told her for sure that DSP #3 had blocked [Individual #1] from exiting his bedroom. She added: "[DSP #3] definitely kept him that wheelchair when she had it leaned back on her lap." She stated when DSP #3 and Individual #1 went into the bedroom, the door was shut, and she heard DSP #3 screaming at Individual #1. She stated she does not like conflict, and she called her supervisor (ASM #1). She stated her supervisor advised her to go to Individual #1's bedroom door and tell DSP #3 that she was going to take him for a ride. She stated she followed this advice, and reported the events of the evening formally in the above referenced incident report. A review of the facility's resident rights revealed, in part: "These regulations are not intended to place unreasonable or undue restrictions on the resident during his/her life in the group home...I will be treated with dignity and respect at all times...I am adult and will expect to be treated as	W 125		

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W 125	Continued From page 6 such...I will have choices regarding my activities and I will exercise that choice." No further information was provided prior to exit. REFERENCES (1) "Cornelia de Lange syndrome is a developmental disorder...characterized by slow growth before and after birth, leading to short stature; intellectual disability that is usually moderate to severe; and abnormalities of bones in the arms, hands, and fingers. Most people with Cornelia de Lange syndrome also have distinctive facial features, including arched eyebrows that often meet in the middle..., long eyelashes, low-set ears, small and widely spaced teeth, and a small and upturned nose. Many affected individuals also have behavior problems." This information is taken from the website https://medlineplus.gov/genetics/condition/cornelia-de-lange-syndrome/.	W 125		