STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G065	A. BUILDING _____ B. WING _____	07/22/2021

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ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 07/20/2021 through 07/22/2021. The facility was in compliance with 42 CFR Part 483.73, Requirement for Intermediate Care Facilities for Persons with Intellectual Disabilities.	E 000	W127 **How corrective action will be accomplished for individual #1:** The staff member suspected of abuse of individual #1 was immediately put on administrative leave (effective 6/28/2021) pending the outcome of a human rights investigation. Based on a confirmed finding of the abuse that resulted in bruising, the responsible staff member was separated from employment with the agency on 7/28/2021. All facility staff will be re-trained no later than 8/15/21 on the following facets of human services expectations: assuring person-centered interactions with individual #1, retrained on individual #1's service plan, and receive remedial training on mandated reporting and human rights to ensure individual #1 is free from abuse. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will be re-trained no later than 8/15/2021 on assuring person centered interactions with all individuals, retrained on all individuals service plans, and receive remedial training on mandated reporting and human rights to ensure all individuals served are free from abuse. **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 monitor facility staff adherence to Human Rights policies and person centered practices to ensure compliance in the facility. This will be accomplished through direct observation, supervision, and monitoring via facility cameras. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Residents' Human Rights will be reviewed at mandatory staff meetings at least annually. Resident person centered plans will be reviewed with all staff at a minimum of annually, with staff signing off on their understanding of them. ICF Management will monitor and document various shift checks to ensure that individuals' Human Rights are being protected. The Quality Assurance team will also monitor at random via onsite visits and through camera checks to ensure that staff are providing person-centered supports and that human rights are being protected. Date of Completion: 7/28/2021	7/28/2021 and ongoing
W 000	INITIAL COMMENTS An unannounced annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted onsite on 07/20/2021 through 07/22/2021. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. 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 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on staff interviews and clinical record review and facility document review it was determined that the facility staff failed to ensure an Individual was free from abuse for one of two individuals in the survey sample, Individual # 1.	W 127		

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 127	Continued From page 1 The facility staff failed to implement proper interventions to prevent and deescalate Individual # 1's behavior while interacting with them which left Individual # 1 with bruising to their arm and shoulder. The findings include: Individual # 1 was admitted to [Name of Group Home] with diagnoses that included but were not limited to: moderate intellectual disability (1), and autistic disorder (2). The facility's "Annual Psychological Review" for Individual # 1 dated 10/25/2020 documented in part, "[Individual #1's] Behavior Support Plan which was revised in 2016, provides staff with additional guidance on how to manage [Individual #1's] behavior. However, the major emphases of the plan remain unchanged - provide sensory stimulation, engage [Individual] # 1] in activities he enjoys and avoid situations he dislikes." Individual # 1's ISP [individual support plan] dated 10/29/2020 to 10/28/2021documented, "Goal 15. Outcome Important To/for: [Individual # 1] follows his behavior support plan. List the actions/supports needed: [Individual # 1] is supported to follow his behavior support plan so that he can have the best possible interactions with those around him. Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found: The ICF psychologist has evaluated [Individual # 1] and felt that a behavior support plan would be beneficial to support him as outlined below: Staff Provided Sensory Interventions: Providing head, neck and back massage; Carrying/fidgeting with items; Walking	W 127		

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(possible a long walk), Swings in the park and Swing in the [Name of Group Home] basement. Staff Actions to prevent target behaviors: Use short simple sentences to allow adequate time to process request; Utilize structured and consistent schedule throughout the day; Inform in advance of any changes to his schedule; Consistently reinforce positive behaviors and successes; Allow transition time between activities for [Individual # 1] to process the next steps; Continually provide opportunities for leisure activities and alone time and Keep him engaged in preferred and offer new activities." How often or by when? Daily."

The facility's "Incident Report" completed by ASM [administrative staff member] # 1, program manager for Individual # 1 dated 06/28/2021 at 5:00 p.m. documented, "Provide a Detailed Description of the Incident: As I was watching video from Friday evening at [Name of Group Home], I noticed an incident between [DSP (direct support professional) # 1] and [Individual # 1]. While in the, [sic] [Individual # 1] was sitting on the floor which he does a lot) [sic] [DSP # 1] walked in and threw her hands up in what looked like frustration. She then took a dish towel from the floor that [Individual # 1] had with him. [Individual # 1] then picked up a plate from the counter and a physical struggle ensued which was initiated by [DSP # 1]. She put her hands on him in a non-therapy approved manner to push him out of the way. This continued for approximately 13 minutes." Under "Coordinator/Supervisor Review" it documented, "After reviewing the video, I contacted my supervisor and she contacted QA [quality assurance]. [DSP # 1] was sent to [Name of Location, Main Office] to meet with QA for an interview. [Individual # 1] does not appear to be

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W 127	Continued From page 3 injured from the incident." The facility's "Human Rights Investigation" with a completion date of 07/02/2021 documented in part, "Complaint: On the morning of 6/28/2021 [OSM [other staff member] # 2], director of compliance and human rights, received a call from [OSM # 3], assistant director of developmental disabilities residential coordinator, with an allegation of abuse. [OSM # 3] reported that [Name of Group Home] ICF staff reported that staff member [DSP # 1] did not perform job duties during the weekend of June 25. During the review of cameras to confirm staff's report, there was an incident that occurred between [DSP # 1] and [Individual # 1]. [OSM # 3] stated that the video footage would forwarded via email. The video footage showed [DSP # 1] pushing [Individual # 1] forcefully, evident by [DSP #3] stance and her taking [Individual # 1's] plate of food from him. The Director of Compliance and Human Rights immediately notified the Executive Director, [ASM # 4]. [ASM # 4] appointed [OSM # 2], Director of Compliance and Human Rights and [OSM # 4], Compliance Specialist, to initiate an investigation in compliance with the Human Rights Regulations concerning allegation of abuse." The text message sent to ASM # 1, supervisor from ASM # 3, assistant supervisor on June 26, 2021 at 8:54 a.m., documented, ASM # 3 -"Hey I hate to bother you but [DSP #2] had some complaints about [DSP #1] shift on Friday night (6/25).. even [DSP # 3] was complaining to [DSP #2] that night that he does not want to work with her." ASM # 1 - "Yep." ASM # 3 - up and t "[DSP # 2] said she was in the office on her phone when she came in at 7pm [7:00 p.m.] on yesterday and	W 127		

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W 127	Continued From page 4 [Individual # 1's Initials] was in the kitchen eating with blood coming out his mouth and blood on his shirt." ASM # 1 - "Why was be [sic] bleeding." ASM # 3 - "The kitchen was a mess and [DSP # 2] was the one to clean [Individual # 1's Initials] while [DSP # 1] went next door..didn't tell them that she went next door..when she came back [DSP # 2] asked her when she leaves to tell staff so they know..[DSP # 1] gave her attitude and told her don't start..[DSP # 2] then told me that [DSP] # 3] did all the showers and most of the cleaning..and [DSP #2] did the rest while [DSP #1] left at 8pm [8:00 p.m.] not helping." On 07/21/2021 at 8:50 a.m., an interview was conducted with ASM [administrative staff member] # 1, ICF (intermediate care facility) supervisor. When asked about the incident report dated 06/28/2021 regarding DSP # 1 and Individual # 1 on June 28, 2021, ASM # 1 stated that ASM # 3, assistant supervisor, received a complaint about DSP # 1 not completing their work on the evening of June 25, 2021. ASM # 1 further stated that they reviewed the camera footage for the evening in question to determine what DSP # 1 was doing during the shift and when they observed the "altercation between Individual # 1 and DSP # 1" they initiated an investigation of abuse. When asked if ASM # 3 reported any concerns regarding abuse when they contacted them, ASM # 1 stated no. On 07/21/2021 at 8:50 a.m., an interview was conducted with ASM [administrative staff member # 4, ICF (intermediate care facility) assistant supervisor. ASM # 4 stated that DSP # 2 told her at the end of their shift, Saturday Morning [06/26/2021] that she had concerns about DSP # 1's interactions with Individual # 1, the cause of	W 127		

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Individual # 1's bleeding and the blood on Individual # 1's shirt." When asked to explain DSP # 2's comment about DSP # 1's interactions with Individual # 1, ASM # 4 stated that DSP # 2 stated that DSP # 1 was rough with Individual # 1, pushing him aggressively and gripping his arm instead of redirecting Individual # 1. ASM # 4 further stated that they contacted ASM # 1, ICF supervisor after they were informed by DSP # 2.

On 07/21/2021 at 11:50 a.m., an interview was conducted with OSM # 1, Qualified Intellectual Disabilities Professional [QIDP]. When asked if he was aware of the confrontation that occurred on 06/25/2021 between DSP # 1 and Individual #1 they stated that they had but was at another group home at the time. After reviewing the incident report OSM # 1 was asked if there were other interventions that DSP # 1 should have used with Individual # 1, OSM # 1 stated yes. When asked what those interventions would be, OSM # 1 referred to Individual # 1's ISP [individual support plan] dated 10/29/2020 to 10/28/2021, goal # 15, behavior support plan. OSM # 1 identified the following interventions; Provided Sensory Interventions: Walking (possible a long walk), Staff Actions to prevent target behaviors: Use short simple sentences to allow adequate time to process request; Consistently reinforce positive behaviors and successes; and Allow transition time between activities for [Individual # 1] to process the next steps."

On 07/21/2021 at 1:05 p.m., an interview was conducted with ASM [administrative staff member # 1, ICF (intermediate care facility) supervisor. When asked how they received the information regarding DSP # 1 and Individual # 1 from ASM #

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W 127	Continued From page 6 4, ASM #1 stated that she received a text from ASM # 4 on the morning of 06/25/2021. ASM # 1 provided this surveyor with a copy of the text message. When asked what they observed on the video footage they reviewed in regard to the interaction(s) between DSP # 1 and Individual # 1, ASM #1 stated they observed "Mishandling" of Individual # 1 by DSP # 1. ASM # 1 stated that DSP # 1 was pushing and pulling Individual # 1 in the kitchen, pulling his arm, not leaving Individual # 1 [giving them space]. ASM # 1 further stated, "The acts [by DSP # 1] appeared forceful and not following [Individual # 1's] plan." On 07/21/201 at 3:42 p.m., an interview was conducted with DSP # 2. When asked to describe the incident between Individual # 1 and DSP # 1 during the overnight shift on 06/25/2021, DSP # 2 stated, "She [DSP # 1] was trying to pull [Individual # 1's] dinner plate out of his hand and it still had his dinner on it. After she took the plate [Individual # 1] tried to get the plate back and grabbed at [DSP # 1] and she was pushing him back." When asked if pushing Individual # 1 was part of their intervention plan, DSP #2 stated no. When asked about the blood on Individual # 1's face and shirt, DSP # 2 stated that Individual # 1 had a scab on their lip and that Individual # 1 scratched it and opened it up and it bled. DSP # 2 further stated that they saw Individual # 1 in that condition when they arrived for their shift and that DSP # 1 did not clean Individual # 1. DSP # 2 stated that they cleaned Individual # 1. When asked if they informed anyone regarding the altercation between DSP # 1 and Individual # 1, DSP # 2 stated that she told the assistant supervisor [ASM # 4] in the morning. The facility's policy "Client Protection Section 2-3:	W 127		

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W 127	Continued From page 7 Abuse and Neglect" documented,"9. Abuse and Neglect includes the following but is not limited to this list. Any of these events will lead to an investigation; all of these are prohibited: b. Abuse: any act or failure to act by an employee or other person responsible for the care of an individual, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person." On 07/21/2021 at approximately 4:00 p.m. ASM (administrative staff member) # 1, ICF supervisor, was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html.	W 127		

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W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interviews and clinical record review and facility document review it was determined that the facility staff failed to report an allegation of abuse in a timely manner for one of two individuals in the survey sample, Individual # 1. The facility staff failed to convey complete information regarding an allegation of abuse in a timely manner. The findings include: Individual # 1 was admitted to [Name of Group Home] with diagnoses that included but were not limited to: moderate intellectual disability (1), and autistic disorder (2). The facility's "Annual Psychological Review" for Individual # 1 dated 10/25/2020 documented in part, "[Individual #1's] Behavior Support Plan which was revised in 2016, provides staff with additional guidance on how to manage [Individual #1's] behavior. However, the major emphases of the plan remain unchanged - provide sensory stimulation, engage [Individual] # 1] in activities he enjoys and avoid situations he dislikes."	W 153	W153 **How corrective action will be accomplished for individual #1:** The staff members responsible for failing to convey complete information regarding an allegation of abuse in a timely manner are receiving ongoing corrective action to ensure their understanding of reporting policies and protocols for moving forward. They will continue to be evaluated and receive coaching to ensure reporting accuracy and timeliness meets expectations. Further issue will result in further corrective disciplinary action. All facility staff will be re-trained no later than by 8/15/2021 on mandated reporting requirements to ensure timely and accurate reporting for any further allegations of abuse for individual #1. **Assurance that other residents are protected from the possibility of the deficiency:** All facility staff will be re-trained no later than by 8/15/2021 on mandated reporting requirements to ensure timely and accurate reporting for any allegations of abuse for any individual receiving services. **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 oversee facility staff adherence with mandated reporting requirements. This will be accomplished through review, coaching, and discussion of policies and requirements for both mandated reporting as well as incident reporting processes. This will be completed at least annually in team meetings and in regular discussions during 1:1 staff supervision. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Incident reporting time lines and reporting mandates/requirements will be monitored through daily checks by a collective team consisting of the Quality Assurance team, the ICF supervisor, and the DD Residential Coordination team to ensure staff provide complete and timely information for all incidents. **Date of Completion:** 8/15/2021	8/15/2021 and continuing

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W 153	Continued From page 9 Individual # 1's ISP [individual support plan] dated 10/29/2020 to 10/28/2021documented, "Goal 15. Outcome Important To/for: [Individual # 1] follows his behavior support plan. List the actions/supports needed: [Individual # 1] is supported to follow his behavior support plan so that he can have the best possible interactions with those around him. Describe how this will be provided based on individual preferences. (support instructions) and location where program strategy can be found: The ICF psychologist has evaluated [Individual # 1] and felt that a behavior support plan would be beneficial to support him as outlined below: Staff Provided Sensory Interventions: Providing head, neck and back massage; Carrying/fidgeting with items; Walking (possible a long walk), Swings in the park and Swing in the [Name of Group Home] basement. Staff Actions to prevent target behaviors: Use short simple sentences to allow adequate time to process request; Utilize structured and consistent schedule throughout the day; Inform in advance of any changes to his schedule; Consistently reinforce positive behaviors and successes; Allow transition time between activities for [Individual # 1] to process the next steps; Continually provide opportunities for leisure activities and alone time and Keep him engaged in preferred and offer new activities." How often or by when? Daily." The facility's "Incident Report" completed by ASM [administrative staff member] # 1, program manager for Individual # 1 dated 06/28/2021 at 5:00 p.m. documented, "Provide a Detailed Description of the Incident: As I was watching video from Friday evening at [Name of Group Home], I noticed an incident between [DSP (direct support professional) # 1] and [Individual # 1]. While in the, [sic] [Individual # 1] was sitting	W 153		

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W 153	Continued From page 10 on the floor which he does a lot) [sic] [DSP # 1] walked in and threw her hands up in what looked like frustration. She then took a dish towel from the floor that [Individual # 1] had with him. [Individual # 1] then picked up a plate from the counter and a physical struggle ensued which was initiated by [DSP # 1]. She put her hands on him in a non therapy approved manner to push him out of the way. This continued for approximately 13 minutes." Under "Coordinator/Supervisor Review" it documented, "After reviewing the video, I contacted my supervisor and she contacted QA [quality assurance]. [DSP # 1] was sent to [Name of Location, Main Office] to meet with QA for an interview. [Individual # 1] does not appear to be injured from the incident." The facility's "Human Rights Investigation" with a completion date of 07/02/2021 documented in part, "Complaint: On the morning of 6/28/2021 [OSM [other staff member] # 2], director of compliance and human rights, received a call from [OSM # 3], assistant director of developmental disabilities residential coordinator, with an allegation of abuse. [OSM # 3] reported that [Name of Group Home] ICF staff reported that staff member [DSP # 1] did not perform job duties during the weekend of June 25. During the review of cameras to confirm staff's report, there was an incident that occurred between [DSP # 1] and [Individual # 1]. [OSM # 3] stated that the video footage would forwarded via email. The video footage showed [DSP # 1] pushing [Individual # 1] forcefully, evident by [DSP #3] stance and her taking [Individual # 1's] plate of food from him. The Director of Compliance and Human Rights immediately notified the Executive Director, [ASM # 4]. [ASM # 4] appointed [OSM #	W 153		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 11 2], Director of Compliance and Human Rights and [OSM # 4], Compliance Specialist, to initiate an investigation in compliance with the Human Rights Regulations concerning allegation of abuse." The text message sent to ASM # 1, supervisor from ASM # 3, assistant supervisor on June 26, 2021 at 8:54 a.m., documented, ASM # 3 -"Hey I hate to bother you but [DSP #2] had some complaints about [DSP #1] shift on Friday night (6/25).. even [DSP # 3] was complaining to [DSP #2] that night that he does not want to work with her." ASM # 1 - "Yep." ASM # 3 - up and t "[DSP # 2] said she was in the office on her phone when she came in at 7pm [7:00 p.m.] on yesterday and [Individual # 1's Initials] was in the kitchen eating with blood coming out his mouth and blood on his shirt." ASM # 1 - "Why was be [sic] bleeding." ASM # 3 - "The kitchen was a mess and [DSP # 2] was the one to clean [Individual # 1's Initials] while [DSP # 1] went next door..didn't tell them that she went next door..when she came back [DSP # 2] asked her when she leaves to tell staff so they know..[DSP # 1] gave her attitude and told her don't start..[DSP # 2] then told me that [DSP] # 3] did all the showers and most of the cleaning..and [DSP #2] did the rest while [DSP #1] left at 8pm [8:00 p.m.] not helping." On 07/21/2021 at 8:50 a.m., an interview was conducted with ASM [administrative staff member # 1, ICF (intermediate care facility) supervisor. When asked about the incident report dated 06/28/2021 regarding DSP # 1 and Individual # 1 on June 28, 2021, ASM # 1 stated that ASM # 3, assistant supervisor, received a complaint about DSP # 1 not completing their work on the evening of June 25, 2021. ASM # 1 further stated that	W 153		

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	49G065	A. BUILDING _____ B. WING _____	07/22/2021

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W 153	Continued From page 12 they reviewed the camera footage for the evening in question to determine what DSP # 1 doing during the shift and when they observed the "altercation between Individual # 1 and DSP # 1" they initiated an investigation of abuse. When asked if ASM # 3 reported any concerns regarding abuse when they contacted them ASM # 1 stated no. On 07/21/2021 at 8:50 a.m., an interview was conducted with ASM [administrative staff member # 4, ICF (intermediate care facility) assistant supervisor. ASM # 4 stated that DSP # 2 told her at the end of their shift, Saturday Morning [06/26/2021] that she had concerns about DSP # 1's interactions with Individual # 1, the cause of Individual # 1's bleeding and the blood on Individual # 1's shirt." When asked to explain DSP # 2's comment about DSP # 1's interactions with Individual # 1, ASM # 4 stated that DSP # 2 stated that DSP # 1 was rough with Individual # 1, pushing him aggressively and gripping his arm instead of redirecting Individual # 1. ASM # 4 further stated that they contacted ASM # 1, ICF supervisor after they were informed by DSP # 2. On 07/21/2021 at 11:50 a.m., an interview was conducted with OSM # 1, Qualified Intellectual Disabilities Professional [QIDP]. When asked if he was aware of the confrontation that occurred on 06/25/2021 between DSP # 1 and Individual #1 they stated that they had but was at another group home at the time. After reviewing the incident report OSM # 1 was asked if there were other interventions that DSP # 1 should have used with Individual # 1, OSM # 1 stated yes. When asked what those interventions would be OSM # 1 referred to Individual # 1's ISP [individual support plan] dated 10/29/2020 to	W 153		

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W 153	Continued From page 13 10/28/2021, goal # 15, behavior support plan. OSM # 1 identified the following interventions; Provided Sensory Interventions: Walking (possible a long walk), Staff Actions to prevent target behaviors: Use short simple sentences to allow adequate time to process request; Consistently reinforce positive behaviors and successes; and Allow transition time between activities for [Individual # 1] to process the next steps." On 07/21/2021 at 12:28 p.m., a telephone interview was conducted with OSM [other staff member] # 2, director of compliance and human rights. After reviewing portions of their report, "Human Rights Investigation" regarding DSP # 1 and Individual # 1, OSM # 2 was asked about the delay in reporting the allegation of abuse and the initiation of the investigation. OSM # 2 agreed that the investigation should have started earlier and that they had concerns regarding a staff member not reporting complete and timely information regarding allegations of abuse and that corrective action was in process. On 07/21/2021 at 1:05 p.m., an interview was conducted with ASM [administrative staff member # 1, ICF (intermediate care facility) supervisor. When asked how they received the information regarding DSP # 1 and Individual # 1 from ASM # 4, ASM #1 stated that she received a text from ASM # 4 on the morning of 06/25/2021. ASM # 1 provided this surveyor with a copy of the text message. When asked what they observed on the video footage they reviewed in regard to the interaction(s) between DSP # 1 and Individual # 1, they stated they observed "Mishandling" of Individual # 1 by DSP # 1. ASM # 1 stated that DSP # 1 was pushing and pulling Individual # 1 in	W 153		

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W 153	Continued From page 14 the kitchen, pulling his arm, not leaving Individual # 1 [giving them space]. ASM # 1 further stated, "The acts [by DSP # 1] appeared forceful and not following [Individual # 1's] plan." On 07/21/2021 at 3:35 p.m., an interview was conducted with ASM [administrative staff member # 4, ICF (intermediate care facility) assistant supervisor. When asked how they informed ASM # 1 of the incident on 06/25/2021 between DSP # 1 and Individual # 1, ASM # 4 stated that they sent a text. After reviewing the text message ASM # 4 verbally confirmed that it was the message they sent to ASM # 1. When asked if the information they conveyed to ASM # 1 contained any information regarding an allegation of abuse or the actions observed and told to them by DSP # 2, ASM #4 stated no. ASM # 4 further stated, "It should have been reported at the time I sent the text." When asked to describe the facility's policy about reporting abuse ASM # 4 stated, "It should be reported immediately." When asked if there was a delay in reporting the allegation of abuse, ASM # 4 stated yes. On 07/21/201 at 3:42 p.m., an interview was conducted with DSP # 2. When asked to describe the incident between Individual # 1 and DSP # 1 during the overnight shift on 06/25/2021 DSP # 2 stated, "She [DSP # 1] was try to pull [Individual # 1's] dinner plate out of his hand and it still had his dinner on it. After she took the plate [Individual # 1] tried to get the plate back and grabbed at [DSP # 1] and she was pushing him back." When asked if push Individual # 1 was part of their intervention plan DSP #2 stated no. When asked about the blood on Individual # 1's face and shirt DSP # 2 stated that Individual # 1 had a scab on their lip and that Individual # 1	W 153		

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W 153	Continued From page 15 scratched it and opened it up and it bled. DSP # 2 further stated that they saw Individual # 1 in that condition when they arrived for their shift and that DSP # 1 did not clean Individual # 1 or change their Individual # 1's. DSP # 2 stated that they cleaned Individual # 1. When asked if they informed anyone regarding the altercation between DSP # 1 and Individual # 1, DSP # 2 stated that she told the assistant supervisor [ASM # 4] in the morning. The facility's policy "Client Protection Section 2-3: Abuse and Neglect" documented in part, "Any employee who witnesses any behavior prohibited by RACSB's Human Rights Plan is required to complete an incident report and immediately inform the supervisor and RACSB's Human Rights Advocate in accordance with RACSB's Code of Ethics and Corporate Compliance Plan. Failure to do so violates RACSB's Human Rights Plan and Corporate Responsibility Resolution." The RACSB's "Code of Ethics" documented in part, "C. Employees will not engage in any activity that is physically, emotionally, or verbally abusing to individuals receiving services, their family members, or guardians. Employees will be aware of and avoid personal and professional circumstances that may cause conflict of interest and hinder making judgements in the best interests of an individual receiving services, her/his family member(s) or guardian(s)." The RACSB's Resident Rights documented in part, "To be treated with dignity and respect." On 07/21/2021 at approximately 4:00 p.m. ASM (administrative staff member) # 1, ICF supervisor,	W 153		

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W 153	Continued From page 16 was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html.	W 153		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview it was determined that the QIDP [Qualified Intellectual Disabilities Professional] failed to coordinate and monitor the individual's active treatment programs for one of two	W 159		

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W 159	Continued From page 17 individuals in the survey sample, Individual # 2. The findings include: The QIDP failed to review "PCP [person centered plan] Outcome Data Collection" sheets for Individual # 2 dated 07/01/2021. Individual # 2 was admitted to [Name of Group Home] with diagnoses that included but not limited to: profound intellectual disabilities [1] and bipolar disorder [2]. Individual # 2's current ISP (Individual Support Plan) date 04/09/21 through 04/08/22 documented: "Goal 3. Outcome Important To/for: [Individual # 2] dries his hands after washing. List the actions/supports needed: [Individual # 2] is verbally prompted 2x [two times] to dry his hands after washing them. [Individual # 2] will complete this outcome if he is successful 90% of the attempts each month for 9 [nine] of 12 months. How often or by when? 2x [two times] daily." "Goal 5. Outcome Important To/for: [Individual # 2] puts his dish in the dishwasher after eating. List the actions/supports needed: With 2 [two] verbal prompts [Individual # 2] places his dish in the dishwasher after eating. [Individual # 2] will complete this outcome if he is successful 70% of the attempts each month for 9 [nine] of 12 months. How often or by when? Daily." "Goal 6. Outcome Important To/for: [Individual # 2] identifies objects, colors letters or numbers on his books. List the actions/supports needed: With 2 [two] verbal prompts [Individual # 2] will correctly identify 1 [one] object, color letter or	W 159	W 159 **How corrective action will be accomplished for Individual #2:** The QIDP will review PCP outcome data sheets for individual #2 for all dates of services to ensure active treatment programs have been implemented and documented properly. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will review PCP outcome data sheets for all program individuals for all dates of services to ensure active treatment programs have been implemented and documented properly. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** To aid in oversight, the program supervisor and assistant manager will double check PCP outcome data sheets to ensure outcomes are being both implemented and documented on the data sheets accordingly. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Data collection and data collection review will be randomly monitored through periodic checks of the documentation conducted by the Quality Assurance team and the DD Residential Coordination team. **Date of Completion:** 8/15/2021	8/15/2021 and ongoing

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W 159	Continued From page 18 number on his books. [Individual # 2] will complete this outcome if he is successful 70% of all attempts each month for 9 [nine] of 12 months. How often or by when? Daily." "Goal 7. Outcome Important To/for: [Individual # 2] helps to make his bed. List the actions/supports needed: With 2 [two] verbal prompts and moderate hand over hand supports, [Individual # 2] helps to make his bed. [Individual # 2] will complete this outcome if he is successful 70% of all attempts each month for 9 [nine] of 12 months. How often or by when? Daily." The "PCP [person centered plan] Outcome Data Collection" sheets for Individual # 2 dated 07/01/2021 was reviewed. The "PCP Outcome Data Collection" documented goals #3, #5, #6, and #7 as documented above. Further review of the data collection revealed blanks on 07/16/2021 for goals #3 for the p.m. shift, #5, #6 and #7. On 07/22/2021 an interview was conducted with OSM [other staff member] # 1, QIDP. When asked how often they review an Individual's data collection OSM # 1 stated that they do random checks of the data sheets every week. When asked what they looked for when reviewing the data sheets OSM # 1 stated that they check for 'Holes' [missing data] and to make sure staff are on track for completing active treatment programs that are run monthly. After reviewing Individual # 2's "PCP Outcome Data Collection" goals #3, #5, #6, #7 for 07/16/2021 OSM # 1 agreed that there was a lack of documentation to indicate if the programs were implemented. OSM # 1 stated that the lack of documentation was not acceptable. The facility's policy "Qualified Intellectual	W 159		

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W 159	Continued From page 19 Disabilities Professional" documented in part, "f. Monitor and observe the individuals, their activities, the supports and services, progress notes and data." On 07/21/2021 at approximately 4:00 p.m. ASM # 1, ICF supervisor, was made aware of the findings. No further information was provided prior to exit. References: [1] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 [2] A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	W 159		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed	W 249		

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W 249	Continued From page 20 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility staff failed to implement the active treatment for one of two individuals in the survey sample, Individual # 2. The findings include: The facility staff failed to implement Individual # 2's daily active treatment programs for hand washing, putting dishes in the dishwasher, identifying objects, colors, letters or numbers in his books and making their bed. Individual # 2 was admitted to [Name of Group Home] with diagnoses that included but not limited to: profound intellectual disabilities [1] and bipolar disorder [2]. Individual # 2's current ISP (Individual Support Plan) date 04/09/21 through 04/08/22 documented: "Goal 3. Outcome Important To/for: [Individual # 2] dries his hands after washing. List the actions/supports needed: [Individual # 2] is verbally prompted 2x [two times] to dry his hands after washing them. [Individual # 2] will complete this outcome if he is successful 90% of the attempts each month for 9 [nine] of 12 months. How often or by when? 2x [two times] daily."	W 249	W 249 **How corrective action will be accomplished for Individual #2:** Facility staff will implement the active treatment programs for Individual #2 involving hand washing, putting dishes in the dishwasher, identifying objects, colors, letters or numbers in his books, and making his bed. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will ensure implementation of all active treatment programs from the ISPs for each individual. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will continue to monitor and ensure implementation of all active treatment programs from the ISPs for each individual. This will be achieved by the QIDP through re-educating all staff on all active treatment programs for each individual, re-educating all staff on the expected time frames for implementation of each active treatment program, and re-educating staff on properly documenting implementation on all active treatment programs . **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program supervisor and assistant manager will monitor through weekly direct supervision that all staff are consistently and correctly implementing and documenting all of the active treatment programs from the ISPs for each individual. **Date of Completion:** 8/15/2021	8/15/2021 and ongoing

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W 249	Continued From page 21 "Goal 5. Outcome Important To/for: [Individual # 2] puts his dish in the dishwasher after eating. List the actions/supports needed: With 2 [two] verbal prompts [Individual # 2] places his dish in the dishwasher after eating. [Individual # 2] will complete this outcome if he is successful 70% of the attempts each month for 9 [nine] of 12 months. How often or by when? Daily." "Goal 6. Outcome Important To/for: [Individual # 2] identifies objects, colors letters or numbers on his books. List the actions/supports needed: With 2 [two] verbal prompts [Individual # 2] will correctly identify 1 [one] object, color letter or number on his books. [Individual # 2] will complete this outcome if he is successful 70% of all attempts each month for 9 [nine] of 12 months. How often or by when? Daily." "Goal 7. Outcome Important To/for: [Individual # 2] helps to make his bed. List the actions/supports needed: With 2 [two] verbal prompts and moderate hand over hand supports, [Individual # 2] helps to make his bed. [Individual # 2] will complete this outcome if he is successful 70% of all attempts each month for 9 [nine] of 12 months. How often or by when? Daily." The "PCP [person centered plan] Outcome Data Collection" sheets for Individual # 2 dated 07/01/2021 was reviewed. The "PCP Outcome Data Collection" documented goals #3, #5, #6, #7 as stated above. Further review of the data collection revealed blanks on 07/16/2021 for goals #3 for the p.m. shift, #5, #6 and #7. Review of the progress note for Individual # 2 dated 07/16/2021 failed to evidence	W 249		

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W 249	Continued From page 22 documentation that Individual # 2's active treatment goals #3 for the p.m. shift, #4, #5, #6 and #7 were implemented on 07/16/2021. On 07/22/2021 at 8:10 a.m., an interview was conducted with ASM [administrative staff member] # 1, supervisor. After reviewing the "PCP Outcome Data Collection" goals #3, #5, #6, #7 and the progress note dated 07/16/2021 ASM # 1 agreed that the daily active treatment programs for hand washing, putting dishes in the dishwasher, identifying objects, colors, letters or numbers in his books and making the bed, were not implemented on 07/16/2021. The facility's policy "Active Treatment" documented in part, "4. Residents will receive Active Treatment as written in their Individualized Program Plan and in correlation with those services which RACSB [Rappahannock Area Community Services Board]is billing for." On 07/21/2021 at approximately 4:00 p.m. ASM # 1, ICF supervisor, was made aware of the findings. No further information was provided prior to exit. References: [1] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website:	W 249		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE ~~PRECEDED BY FULL~~ REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 23 https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 [2] A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	W 249		