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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/05/22 through 07/07/22. The facility was in substantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000	1. The QIDP will ensure all of individual number 3's ISP goals are accurately coded by immediately revising individual number 3's data collection sheets for all ISP goals by removing the legend code option (e. engaged in other activities). 2. The QIDP will review all other individual's data collection sheets legend code to ensure option (e. engaged in other activities) has been removed if present and only the approved CRi data collection sheet legend is being used.	8/11/22
W 000	INITIAL COMMENTS An unannounced annual Fundamental survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted 07/05/2022 through 07/07/2022. 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 six bed facility was six at the time of the survey. The survey sample consisted of four current individual reviews (Individuals #1, #2, #3 and #4).	W 000	3. The Program Manager will complete weekly audits for individual number 3 and all other individual's Clinical Records to ensure the data collection sheets are accurate and have not been altered but only includes the approved CRi form with the correct legend to prevent any further deficiencies. 4. The Program Manager will continue to monitor the data collection sheets of all individuals to ensure that the service needs of all individuals are accurately reflected through weekly operation meetings.	
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to maintain an accurate clinical record for one of four individuals in the survey sample, Individual #3.	W 111	5. The Clinical Director will complete quarterly audits to ensure the facility staff are accurately coding all individual's data collection sheets.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terell Jones	Clinical Director	7/15/22

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 111	Continued From page 1	W 111		

The findings include:

The facility staff failed to accurately code Individual #3's June 2022 data collection sheet for communication.

Individual #3 was admitted to the facility with diagnoses that included but not limited to: profound intellectual disability (1).

Individual #3's PCP (person centered plan) dated 01/01/2021 through 12/31/2022 documented, "Desired Outcome: 1A. To improve my communication skills, I will select the shirt of my choice in the morning by pointing to the desired shirt each day at 80% accuracy for 12 consecutive months. Support Activities & Instructions: 1. [Individual #3] will be escorted by staff to her closet and pull out two seasonal appropriate shirts. 2. [Individual #3] will be asked by staff to select the shirt of her choice out of two appropriate options. 3. [Individual #3] will touch the shirt of her choice. 4. Staff will praise [Individual #3] for her selection and ensure she wears the shirt of her choice. 5. Staff will document her progress via (by) progress notes. 6. [Individual #2] will be encouraged to hold towel and wipe his skin with staff support. Frequency: Daily."

Review of the facility's data collection sheets for Individual #3 dated July 2022 documented the outcome and support activities and instructions as stated above. Review of the data sheet for Outcome #1A coded Individual #3 as "E - (engaged in other activities)" on 07/02/2022, 07/03/2022 and on 07/04/2022.

On 07/06/2022 at 1:55 p.m., an interview and

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W 111	Continued From page 2 review of Individual #3's PCP and data collection sheets listed above was conducted with ASM (administrative staff member) #1, program manager. When asked how often Individual # 3's communication outcome number 1A should be implemented ASM #1 stated that it is implemented every morning. After reviewing the data collection sheet list above ASM #1 was asked why it was coded as "Engaged in Other Activities" on 07/02/2022, 07/03/2022 and on 07/04/2022. ASM #1 stated that the program was implemented and Individual #3 often refuses to participate. ASM #1 further stated that the data sheet should have been coded as "R - (refused)" and the staff failed to use the correct code. On 07/06/2022 at approximately 4:00 p.m. ASM # 1, program manager 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.	W 111		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)	W 125		

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W 125	Continued From page 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 observation, staff interview and facility document review, it was determined that the facility staff failed to allow an individual to exercise their rights for dignity during a meal, for one of four individuals in the survey sample, Individual #2. The findings include: OSM (other staff member) #2, community integration specialist for day program, stood next to Individual #2 while feeding them their lunch at (Name of Day Program). Individual #2 was admitted to the facility with diagnoses that included but were not limited to, severe mental retardation (1) and epilepsy (2). On 07/06/2022 at approximately 11:30 a.m., an observation was conducted of Individual #2 having lunch at (Name of Day Program). Individual #2 was observed sitting upright in their wheelchair, lap tray attached and positioned on the wheelchair in front of Individual #2 and their communication device attached to a supporting arm connected to the right side of the wheelchair, extending upward with a left bend so that the arm extended from Individual #2's right side, crossing in front of them to their left side. Observation of the communication device revealed it was attached to the support arm directly in front of Individual #2 and above the lap tray. Further	W 125	1. The Manager at the Day Program will retrain the staff at the day program during the staff meeting on the individual's rights as it pertains to dining with an emphasis on ensuring staff are sitting down assisting the individuals with meals and refraining from standing over individual #2 during all mealtimes. 2. The Manager at the day program will retrain the staff at the day program during the staff meeting on the individuals' rights as it pertains to dining with an emphasis on ensuring staff are sitting down assisting all individuals with meals and refraining from standing over all individuals during mealtimes. 3. The Program Manager, QIDP, and/or Program Nurse who work at the residence will complete monthly day support observations during mealtime to ensure day support staff are following the appropriate mealtime guidelines and ensuring the rights of individual #2 and all other individuals who reside at Burke Road ICF/IID. 4. The Clinical Director will monitor the completion of the monthly day support observations on a quarterly basis.	8/11/22

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observation revealed OSM #2 standing to Individual # 2's right side, holding a plate of Individual #2's food, and feeding Individual #2 until Individual #2 had finished their meal.

On 07/06/2022 at approximately 11:55 a.m., an interview was conducted with OSM #2. When asked to describe the procedure when feeding an Individual, OSM #2 stated that they should be sitting next to or in front of the Individual. When informed of the observation stated above OSM #2 stated that they stood when feeding Individual #2 because they would have to reach up to feed Individual #2 and they could not sit in front of Individual #2 because the communication device was in their way. When asked if the communication device could be removed or swiveled off to the side of Individual #2 to allow room to feed Individual #2, OSM #2 stated yes. When asked if it was dignified to stand and feed Individual #2, OSM #2 stated no.

On 07/06/2022 at approximately 2:45 p.m., an interview was conducted with ASM (administrative staff member) #1, program manager and OSM #1, QIDP (Qualified Intellectual Disabilities Professional). When informed of the observation described above ASM # 1 stated that it was not dignified for OSM #2 to stand and feed Individual #2. OSM #1 stated that they had visited Individual #2's day program a few weeks earlier and observed day program staff sitting in front of Individual # 2 while they fed Individual #2.
The facility's policy "2.1 Human Rights Plan" documented in part, "2.1.4 Dignity. Individuals shall be treated with dignity as a human being and free from abuse."

On 07/06/2022 at approximately 4:00 p.m. ASM #

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W 125	Continued From page 5 1, program manager 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 people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.	W 125		
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 who- This STANDARD is not met as evidenced by: Based on record reviews, staff interview and facility document review, it was determined that the QIDP (Qualified Intellectual Disabilities	W 159		

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Professional) failed to coordinate and monitor the individuals' active treatment programs for two of four individuals in the survey sample, Individuals #1 and #3.

1. The QIDP failed to define Individual #1's PCP (person-centered plan) outcome for medication and community outing in measurable terms.

2. The QIDP failed to define Individual #3's PCP (person-centered plan) outcome for community outing in measurable terms.

The findings include:

1. The QIDP failed to define Individual #1's PCP (person-centered plan) outcome for medication and community outing in measurable terms.

Individual #1 was admitted to the facility with diagnoses that included but were not limited to: moderate intellectual disability (1).

Individual #1's PCP (person centered plan) dated 07/01/2022 through 06/30/2023 documented in part,
"Desired Outcome: 1. I will prompt staff when it is time for my morning medication (8AM) (8:00 a.m.) and evening medication (8PM) using my communication board at 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #1) will be assisted by staff with attaching his lap tray securely to his wheelchair. 2. (Individual #1) will be reminded by staff to use his communication device or verbal/nonverbal prompts to communicate his needs with staff. 3. (Individual # 1) will prompt staff at 8am and 8pm when it is time for his medication. 4. Staff will praise

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W 159	Continued From page 7 (Individual #1) when he prompts staff at the appropriate times for his medications. Frequency: Daily." "Desired Outcome: I will engage in a (1:1) (one to one) individualized outing in the community or virtually once a month with 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #1) will be encouraged to participate in (Name of Corporation) or community organized events/community activity. 2. (Individual #1) will be transported in the program vehicle to the event. 3. (Individual # 1) will be supported by staff to fully participate and enjoy his time at the event/community activity. 4. (Individual #1) will be transported back to the house at the end of the activity. 5. (Individual #1) will receive praise for his efforts during the activity. Frequency: Monthly." On 07/06/2022 at approximately 1:55 p.m., an interview and review of Individual #1's PCP listed above was conducted with OSM # 1, QIDP. After reviewing Individual #1's outcome #1 the outcome for community outing as stated above OSM #1 was asked to identify Individual #1's method of communication that was being measured to prompt the staff, the use of the communication board or nonverbal prompts and how and what behavior was identified to measure Individual #1's engagement in a community outing. OSM #1 stated that the outcomes should be more specific to be measurable. When asked to describe their responsibility in regard to an individual's PCP, OSM #1 stated that they were to make sure the outcomes were written in measurable terms with the number and type of prompting, when and how often the outcome was to be implemented, the	W 159	1. The Program Manager will retrain the QIDP on writing individuals #1 and #3's ISP goals in measurable terms. The ISP for individual's #1 and #3 will be updated and amended and the ISP goals will be written in measurable terms. 2. The Program Manager will review all individuals' goals with the QIDP and ensure they are all written in measurable terms and update and amend the plans if necessary. 3. The Program Manager will review and monitor all new goals written by the QIDP to ensure they are all written in measurable terms. 4. The Clinical Director will audit the program Quarterly to ensure all goals are written in measurable terms.	8/11/22

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number of time the outcome was to be implemented such as two times per day, and determine the accuracy [quantitative values] to determine the level of progress.

On 07/06/2022 at approximately 4:00 p.m. ASM # 1, program manager 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. The QIDP failed to define Individual #3's PCP (person-centered plan) outcome for community outing in measurable terms.

Individual #3 was admitted to (Name of Group Home) with diagnoses that included but not limited to: profound intellectual disability (1).

"Desired Outcome: 3. I will engage in two (1:1) (one to one) individualized outing in the community twice a month with 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #3) will be consulted by staff when

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putting together the monthly activity calendar by making choices using pictures outline and past experiences. 2. If COVID-19 Pandemic is over (Individual # 3's Initials) has received the vaccine, she will be supported to select a date and location based on activity choices available. 3. (Individual # 3) will be assisted by staff into the community for the outing of her choice. For outings exceeding 30 minutes, (Individual # 3) will utilize a wheel chair per physician order. If (Individual # 3) is unable to go to the community for the month, she will be supported to engage in activities of interests at home. Frequency: Monthly."

On 07/06/2022 at approximately 1:55 p.m., an interview and review of Individual #3's PCP listed above was conducted with OSM # 1, QIDP. After reviewing Individual #3's outcome # 3 as stated above OSM # 1 was asked to identify how and what behavior was identified to measure Individual #3's engagement in a community outing. OSM # 1 stated that the outcomes should be more specific to be measurable. When asked to describe their responsibility in regard to an individual's PCP, OSM #1 stated that they were to make sure the outcomes were written in measurable terms with the number and type of prompting, when and how often the outcome was to be implemented, the number of time the outcome was to be implemented such as two times per day, and determine the accuracy [quantitative values] to determine the level of progress.

On 07/06/2022 at approximately 4:00 p.m. ASM #1, program manager was made aware of the findings.

No further information was provided prior to exit.

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W 159	Continued From page 10 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.	W 159	1. The Program Manager will retrain the QIDP on writing individuals #1 and #3's ISP goals in measurable terms. The ISP for individual's #1 and #3 will be updated and amended and the ISP goals will be written in measurable terms. 2. The Program Manager will review all individuals' goals with the QIDP and ensure they are all written in measurable terms and update and amend the plans if necessary. 3. The Program Manager will review and monitor all new goals written by the QIDP to ensure they are all written in measurable terms.	8/11/22
W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to develop outcomes in measurable terms for two of three individuals in the survey sample, Individuals #1 and #3. 1. The facility staff failed to develop Individual #1's residential PCP (person-centered plan) outcome for medication and community outing to define Individual #1's targeted response. 2. The facility staff failed to develop Individual #3's residential PCP outcome for community outing to define Individual #3's targeted response. The findings include:	W 231	4. The Clinical Director will audit the program Quarterly to ensure all goals are written in measurable terms.	

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1. The facility staff failed to develop Individual #1's residential PCP (person-centered plan) outcome for communication and community outing to define Individual #1's targeted response.

Individual # 1 was admitted to the facility with diagnoses that included but were not limited to: moderate intellectual disability (1).

Individual #1's PCP (person centered plan) dated 07/01/2022 through 06/30/2023 documented in part,
"Desired Outcome: 1. I will prompt staff when it is time for my morning medication (8AM) (8:00 a.m.) and evening medication (8PM) using my communication board at 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #1) will be assisted by staff with attaching his lap tray securely to his wheelchair. 2. (Individual #1) will be reminded by staff to use his communication device or verbal/nonverbal prompts to communicate his needs with staff. 3. (Individual #1) will prompt staff at 8am and 8pm when it is time for his medication. 4. Staff will praise (Individual #1) when he prompts staff at the appropriate times for his medications. Frequency: Daily."

"Desired Outcome: I will engage in a (1:1) (one to one) individualized outing in the community or virtually once a month with 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #1) will be encouraged to participate in (Name of Corporation) or community organized events/community activity. 2. (Individual #1) will be transported in the program vehicle to the event. 3. (Individual # 1) will be supported by

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staff to fully participate and enjoy his time at the event/community activity. 4. (Individual #1) will be transported back to the house at the end of the activity. 5. (Individual #1) will receive praise for his efforts during the activity. Frequency: Monthly."

Review of the facility's data collection sheets for Individual #1 dated July 2022 documented the outcome and support activities and instructions as stated above. Review of the data sheet for Outcome #1 coded Individual #1 as "Support provided" on 07/01/2022, 07/02/2022, 07/03/2022, at 8:00 a.m. and 8:00 p.m. and on 07/04/2022, 07/05/2022 at 8:00 p.m. Review of the data collection sheet for Individual #1's outcome for one-to-one individualized outing coded Individual # 1 1 as "Support provided" on 07/06/2022 in the evening.

On 07/06/2022 at approximately 1:55 p.m., an interview and review of Individual #1's PCP and data collection sheets listed above was conducted with ASM (administrative staff member) #1, program manager and OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing Individual #1's outcome # 1 as stated above ASM # 1 and OSM # 1 were asked to identify Individual #1's method of communication that was being measured to prompt the staff, the use of the communication board or nonverbal prompts ASM #1 stated that it was not clearly defined. OSM # 1 stated that the support instructions should have specified the use of Individual # 1's communication board. After reviewing Individual # 1's outcome for community outing as stated above, ASM #1 and OSM #1 were asked how and what behavior was identified to measure

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Individual # 1's engagement in a community outing. ASM # 1 stated that it was not clearly defined. OSM # 1 stated that the outcome should be more specific.

The facility's policy "4.1 Individual Service Plan (ISP)" documented, "4.1.3 Procedures: C. (Name of Corporation) ensures that an ISP will contain at a minimum: 4. Goals / outcomes and measurable objectives / desired outcomes for addressing each identified need. 4.1.4 Individual Service Plan (ISP) Development. E. Goals / Outcomes and Objectives/Desired Outcomes: The objectives / desired outcomes will be expressed in terms that are behavioral and provide measurable indexes of progress."

On 07/06/2022 at approximately 4:00 p.m. ASM #1, program manager 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. The facility staff failed to develop Individual #3's residential PCP outcome for community

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outing to define Individual #3's targeted response.

Individual #3 was admitted to the facility with diagnoses that included but not limited to: profound intellectual disability (1).

"Desired Outcome: 3. I will engage in two (1:1) (one to one) individualized outing in the community twice a month with 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #3) will be consulted by staff when putting together the monthly activity calendar by making choices using pictures outline and past experiences. 2. If COVID-19 Pandemic is over (Individual #3's Initials) has received the vaccine, she will be supported to select a date and location based on activity choices available. 3. (Individual #3) will be assisted by staff into the community for the outing of her choice. For outings exceeding 30 minutes, (Individual #3) will utilize a wheel chair per physician order. If (Individual #3) is unable to go to the community for the month, she will be supported to engage in activities of interests at home. Frequency: Monthly."

Review of the facility's data collection sheets for Individual #3 dated July 2022 documented the outcome and support activities and instructions as stated above.

On 07/06/2022 at approximately 1:55 p.m., an interview and review of Individual #3's PCP and data collection sheets listed above was conducted with ASM (administrative staff member) # 1, program manager and OSM (other staff member) #1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing Individual # 3's outcome for community outing as

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W 231	Continued From page 15 stated above, ASM #1 and OSM #1 were asked how and what behavior was identified to measure Individual #31's engagement in a community outing. ASM #1 stated that it was not clearly defined. OSM #1 stated that the outcome should be more specific. On 07/06/2022 at approximately 4:00 p.m. ASM #1, program manager 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.	W 231	1. The Program Nurse will retrain program staff during the staff meeting on individual number 4's fall protocol. 2. The Program Nurse will retrain program staff on all individuals' fall protocols. 3. The Program Manager will ensure all new staff are trained on individual number 4 and all other individual's fall protocols. The Program Manager will ensure the new hire orientation checklists include a review of the fall protocols and all new hires are trained accordingly. 4. The QIDP, Program Nurse, and Program Manager will provide weekly observations closely observing staff during shift during transfers to ensure staff are following individual number 4 and all other individual's fall protocols. Hands on training will be provided weekly as needed. 5. The Clinical Director will monitor the process to include ensuring all existing staff have been retrained on individual number 4 and all other individuals' fall protocols via the staff meeting agendas and the completion of the new hire orientation checklists.	8/11/22
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 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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This STANDARD is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined that the residential staff failed to ensure Individuals were receiving services consistent with the PCP (Person Centered Plan) for one of four individuals in the survey sample, Individuals #4.

The findings include:

The facility staff failed to implement Individual #4's transfer protocol according to the PCP to prevent a fall from their wheelchair.

Individual #4 was admitted to the facility with diagnoses that included but were not limited to: severe intellectual disability (1) and quadriplegia (2).

The facility's "Incident Report" for Individual #4 dated 01/26/2022 documented in part, "Incident Date: 01/26/2022. Antecedent (Describe What Was Happening With the Consumer BEFORE the Incident Occurred): Individual was in transition to her medical appointment for mammogram and pelvis ultra sound. Incident/Behavior (Describe the incident, WHAT happened and WHO was involved): Staff reported that individual slid from her wheelchair and rested on her knees in the van on her way to her appointment. Consequences (Describe how you evaluated the consumer AFTER the incident and what treatment you gave to the consumer): Staff report that the individual was supported back to her wheelchair and checked for signs of distress, pain and skin condition. Individual

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remains stable alert and verbally responsive. She denies any pain or discomfort. Staff assured her about her safety. Her PCP's (primary care physician's) office notified. PCP advised for individual to taken [sic] to her PCP's office for evaluation and not the ER (emergency room) since (Individual #4) was not bleeding, or appear to be in any pain. Program Manager Assessment: After talking with (Individual #4) and staff who secured (Individual #4) in the van this AM (a.m.), it appears (Individual # 4's) seat belt was not properly secured."

Individual #4's PCP (person centered plan) dated 10/01/2021 through 09/30/2022 documented in part, "Desired Outcome: 8L. I will be supported by staff who will follow my Fall Protocol. Please refer to Fall Protocol for Support Instructions. Frequency: Daily."

The "Protocol - Fall/Transfer" for Individual #4 initially dated 03/11/2021 and with a review date of 02/03/2022 documented in part, "(Individual #4) is at high fall risk due to her diagnosis of quadriplegia. She relies on wheelchair for mobility and uses a shower chair." Under "Adaptive Equipment" it documented in part, "Wheelchair with footrest and anti-roll back device ..." Under "Preventive measures" it documented in part, "Ensure that (Individual #4) is secure in her chair during transport by using her seat belt and securing the wheelchair to the floor."

On 07/06/2022 at 1:55 p.m., an interview and review of Individual #4's PCP and protocol for falls and transfers was conducted with ASM (administrative staff member) #1, program manager ASM #1 stated that the PCP was not

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implemented for the prevention of a fall during Individual #4's transportation to a medical appointment.

The (Name of Group Home's) policy "4.1 Individual Service Plan (ISP)" documented, "G. ISP Implementation and Consumer Engagement: Implementation of the ISP begins at the time of its development. Components of the plan are fully implemented, with consumer receiving the support, learning environment and active engagement necessary to reach his or her objectives/desired outcomes as defined in the ISP ...All staff working with consumers must be fully engaged in active treatment with the consumer."

On 07/06/2022 at approximately 4:00 p.m. ASM #1, program manager 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) The loss of muscle function in part of your body. This information was obtained from the

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W 249	Continued From page 19 website: https://medlineplus.gov/paralysis.html.	W 249	1. The Program Manager will retrain the QIDP on writing individuals #1's medication and community outing goals in measurable terms. The Program Manager will retrain the QIDP on writing individual #3's ISP goals for community integration in measurable terms. 2. The Program Manager will retrain the QIDP on writing all of individual #1 and all of individual #3's ISP goals in measurable terms. 3. The ISP for individuals' #1 and #3 will be updated and amended and the aforementioned ISP goals will be written in measurable terms. 4. The Program Manager will review all of the individuals' ISP goals to ensure they are all written in measurable terms and amend the ISPs if necessary. The Program Manager will retrain the QIDP on writing all of the individuals who live at Burke Road's ISPs in measurable terms. 5. The Program Manager will retrain the program staff on ISP data collection for individuals #1 and #3. 6. The Program Manager will retrain the program staff on ISP data collection for all individuals. 7. The Program Manager will review and monitor all new goals written by the QIDP to ensure they are all written in measurable terms moving forward and ensure the data collected is accurate and provide training as needed. The Program Manager will review the ISP goals and the data collection on a monthly basis for accuracy. 8. The Clinical Director will monitor/audit the program on a Quarterly basis to ensure all ISP goals are written in measurable terms and the ISP data collected is accurate and collected per the ISP. 9. The Quality Improvement and Compliance department will randomly review the program on an as needed basis unannounced to ensure the ISP goals are written in measurable terms and the ISP data is collected accurately.	8/11/22
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to collect data in measurable terms for three of three individuals in the survey sample, Individual # 1 and #3. 1. The facility staff failed to document the data collection of Individual #1's residential PCP (person-centered plan) outcome for medication and community outing in measurable terms. 2. The facility staff failed to document the data collection of Individual #3's residential PCP outcome for community outing in measurable terms. The findings include: 1. The facility staff failed to document the data collection of Individual #1's residential PCP (person-centered plan) outcome for medication and community outing in measurable terms. Individual #1 was admitted to the facility with diagnoses that included but were not limited to: moderate intellectual disability (1).	W 252		

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Individual #1's PCP (person centered plan) dated 07/01/2022 through 06/30/2023 documented in part,
"Desired Outcome: 1. I will prompt staff when it is time for my morning medication (8AM) (8:00 a.m.) and evening medication (8PM) using my communication board at 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #1) will be assisted by staff with attaching his lap tray securely to his wheelchair. 2. (Individual #1) will be reminded by staff to use his communication device or verbal/nonverbal prompts to communicate his needs with staff. 3. (Individual # 1) will prompt staff at 8am and 8pm when it is time for his medication. 4. Staff will praise (Individual #1) when he prompts staff at the appropriate times for his medications. Frequency: Daily."

"Desired Outcome: I will engage in a (1:1) (one to one) individualized outing in the community or virtually once a month with 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #1) will be encouraged to participate in (Name of Corporation) or community organized events/community activity. 2. (Individual #1) will be transported in the program vehicle to the event. 3. (Individual # 1) will be supported by staff to fully participate and enjoy his time at the event/community activity. 4. (Individual #1) will be transported back to the house at the end of the activity. 5. (Individual #1) will receive praise for his efforts during the activity. Frequency: Monthly."

Review of the facility's data collection sheets for

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Individual #1 dated July 2022 documented the outcome and support activities and instructions as stated above. Review of the data sheet for Outcome #1 coded Individual #1 as "Support provided" on 07/01/2022, 07/02/2022, 07/03/2022, at 8:00 a.m. and 8:00 p.m. and on 07/04/2022, 07/05/2022 at 8:00 p.m. Review of the data collection sheet for Individual # 1's outcome for one-to-one individualized outing coded Individual #1 a 1 as "Support provided" on 07/06/2022 in the evening.

On 07/06/2022 at approximately 1:55 p.m., an interview and review of Individual #1's PCP and data collection sheets listed above was conducted with ASM (administrative staff member) #1, program manager and OSM (other staff member) #1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing the data collection for Individual #1 dated July 2022, ASM # 1 was asked if the data for the medication and community outing outcome were documented in measurable terms. ASM # 1 stated, "No."

The facility's policy "4.1 Individual Service Plan (ISP)" documented, "4.1.4 Individual Service Plan (ISP) Development. H. Data Collection: Data collection is recorded on all objectives/desired outcomes in a format that accurately represents the consumer's progress. Data is tracked, documented in measurable terms and analyzed to ensure that appropriate objectives/desired outcomes and interventions/support strategies are in place for the consumer. On-going documentation is kept in the progress notes regarding the progress, changes or significant events relating to the functioning of the consumer."

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On 07/06/2022 at approximately 4:00 p.m. ASM #1, program manager 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. The facility staff failed to document the data collection of Individual #3's residential PCP outcome for community outing in measurable terms.

Individual #3 was admitted to the facility with diagnoses that included but not limited to: profound intellectual disability (1).

"Desired Outcome: 3. I will engage in two (1:1) (one to one) individualized outing in the community twice a month with 100% accuracy each day for 12 consecutive months by 06/30/2023. Support Activities & Instructions: 1. (Individual #3) will be consulted by staff when putting together the monthly activity calendar by making choices using pictures outline and past

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experiences. 2. If COVID-19 Pandemic is over (Individual # 3's Initials) has received the vaccine, she will be supported to select a date and location based on activity choices available. 3. (Individual # 3) will be assisted by staff into the community for the outing of her choice. For outings exceeding 30 minutes, (Individual # 3) will utilize a wheel chair per physician order. If (Individual # 3) is unable to go to the community for the month, she will be supported to engage in activities of interests at home. Frequency: Monthly."

Review of the facility's data collection sheets for Individual #3 dated July 2022 documented the outcome and support activities and instructions as stated above.

On 07/06/2022 at approximately 1:55 p.m., an interview and review of Individual #3's PCP and data collection sheets listed above was conducted with ASM (administrative staff member) #1, program manager and OSM (other staff member) #1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing the data collection for Individual # 1 dated July 2022, ASM # 1 was asked if the data for the community outing outcome was documented in measurable terms. ASM # 1 stated, "No."

On 07/06/2022 at approximately 4:00 p.m. ASM #1, program manager 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,

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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 252	Continued From page 24 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.	W 252	1. The Program Nurse will provide retraining on CRi's COVID-19 infection control policies and procedures in place to prevent the spread of communicable diseases in the facility with a focus on ensuring staff are wearing their face masks in the program during the staff meeting. 2. The Program Nurse will provide training to program staff anytime the COVID-19 infection control procedures are updated during the staff meetings.	8/11/22
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to implement infection control procedure to prevent the spread of communicable disease in the facility. The findings include: On 07/05/2022 at approximately 9:33 a.m., the surveyor rang the doorbell at the front door of the facility and DSP (Direct Support Professional) #1 opened the door, took the surveyor's credentials and stated that they would return and closed the door. Observation of DSP #1 revealed they were not wearing a face mask when they opened the door. At approximately 9:34 a.m., DSP #1 reopened the door, took the surveyor's temperature and allowed the surveyor to enter the ICF. Further observation revealed DSP #1 was not wearing a face mask. On 07/05/2022 at approximately 10:06 a.m., an	W 455	2. The Program Manager will ensure new staff are trained on CRi's most current COVID-19 infection control procedures via the completion of the new hire program orientation checklists. 3. The QIDP, Program Nurse, and Program manager will observe and ensure program staff are wearing their face masks per the COVID-19 infection control procedures in place by observing staff while on shift. 4. The RN supervisor will observe staff during monthly visits to the program ensuring staff are wearing their face masks and following all infection control procedures in place per the most current COVID-19 infection control procedures in place.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G070	A. BUILDING _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKE ICF ID	9332 BURKE ROAD BURKE, VA 22015

(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 455	Continued From page 25	W 455		

interview was conducted with LPN (licensed practical nurse) #1. When asked to describe the current infection control procedures staff at [Name of ICF] were to be following, LPN #1 stated that all staff were to wear a face mask all the time while in the ICF.

On 07/05/2022 at approximately 10:18 a.m., an interview was conducted with DSP #1. When asked to describe the current infection control procedures staff at [Name of ICF] they were to be following DSP #1 stated that all staff were to wear a face mask all the time while in the ICF. When asked if they were wearing a face mask when they answered the door or when they invited the surveyor into the home DSP #1 stated no. When asked if they should have been wearing a face mask DSP #1 stated yes. They further stated that they were eating at the time the door bell rang and was not wearing a mask while they were eating but forgot to put it back on when they went to answer the door and let the surveyor in.

The facility's policy "3.5.3 Face Covering and Other COVID Mitigating Procedures" it documented in part, "All [Name of Corporation] staff and visitors are mandated to wear a face mask in any [Name of Corporation] owned or operated facility."

On 07/06/2022 at approximately 4:00 p.m., ASM (administrative staff member) #1, program manager was made aware of the above findings.

No further information was provided prior to exit.