STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G073	A. BUILDING _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE STREET ICF ID	815 WOLFE STREET FREDERICKSBURG, VA 22401

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/18/2022 through 07/20/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 7/18/2022 through 7/20/2022. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 4 certified bed facility was 4 at the time of the survey. The survey sample consisted of three current Individual reviews (Individuals #1 through #3).	W 000		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to allow individuals to exercise their rights for dignity during a meal for one of three individuals in the survey sample, Individual # 3.	W 125	W125 **How corrective action will be accomplished for individual #3:** Facility staff will support individual #3 to exercise his right to dignity during a meal by sitting beside him (rather than standing) when feeding him. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will support all individuals to exercise their right to dignity during a meal by sitting beside them (rather than standing) when feeding them. **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 supporting all individuals to exercise their right to dignity during a meal by sitting beside them (rather than standing) when feeding them. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Dining protocols will be revised and then reviewed a minimum of annually with all staff and will include supporting all individuals to exercise their right to dignity during a meal by sitting beside them (rather than standing) when feeding them. ICF Management will monitor and document various shift checks to ensure that these protocols are being adhered to. **Date of Completion:** 8/26/22	8/26/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	DD Residential Coordinator	8/5/22

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 125	Continued From page 1 The findings include: ASM (administrative staff member) # 2, assistant ICF (intermediate care facility) manager, stood next to Individual # 3 while feeding them their dinner at the facility. Individual # 3 was admitted to the facility with diagnoses that included but were not limited to: profound mental retardation [1]. On 07/18/2022 at approximately 5:45 p.m., an observation was conducted of Individual # 3 having dinner at the facility. Individual # 3 was observed sitting upright in their wheelchair, positioned at the dining room table. Further observation revealed ASM # 2 standing to Individual # 3's left side, alternating in holding a plate of Individual # 3's food and their thickened beverage, feeding Individual # 3 until Individual # 3 had finished their meal. On 07/18/2022 at approximately 5:45 p.m., an interview was conducted with ASM # 1, ICF manager. When asked to describe the procedure when feeding an Individual ASM # 1 stated that they should be sitting next to the Individual. When informed of the observation stated above ASM # 1 stated that they noticed it and could not believe that ASM # 2 was standing while feeding Individual # 3. When asked if it was dignified to stand and feed Individual # 3, ASM # 1 stated no. On 07/19/2022 at approximately 3:04 p.m. an interview was conducted with ASM # 2. When asked about assisting Individual # 3 during the dinner meal the prior evening ASM # 2 stated that they were standing when they fed Individual # 3. When asked if it was appropriate to stand and	W 125		

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W 125	Continued From page 2 feed an individual ASM # 2 stated that no one had ever discussed it to them. When asked if it was dignified to stand and feed an individual ASM # 2 stated that no one had told them that it was not dignified to feed an individual that way. The facility's policy "Nutrition. Section 9-4: Dining" documented in part, "4. Support/assistance during meals: c. Staff will sit with the individual, assist them, and dine with them ..." On 07/18/2022 at approximately 5:45 p.m. ASM # 1 and ASM # 3, assistant residential coordinator were 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 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	W 159		

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W 159	Continued From page 3 facility document review, it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed coordinated and monitored the individuals' active treatment programs for two of three individuals in the survey sample, Individuals # 1 and # 2. 1a. The QIDP failed to define Individual # 1's ISP (individualized service plan) outcome for medication and community outing in measurable terms. 1b. The QIDP failed to ensure the data collection of Individual # 1's ISP outcome for community activity was in measurable terms. 2a. The QIDP failed to define Individual # 2's ISP outcomes for community outing in measurable terms. 2b. The QIDP failed ensure the data collection of Individual # 2's ISP outcomes for community outing, arts and crafts and day trips were in measurable terms. The findings include: 1a. The QIDP failed to define Individual # 1's ISP (individualized service plan) outcome for medication and community outing in measurable terms. Individual # 1 was admitted to the facility with a diagnosis that included but was not limited to: moderate intellectual disability (1). Individual # 1's ISP (individualized service plan) dated 01/11/2022 through 01/10/2023 documented in part, "Goal: 10. Actions/supports	W 159	W 159 1a **How corrective action will be accomplished for Individual #1:** The QIDP will ensure Individual #1's ISP outcomes for medication and community outing are re-defined in measurable terms in the ISP through revising both outcomes. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will ensure all individuals' ISP outcomes are defined in measurable terms by reviewing each outcome in each individual's ISP and revising any deficiencies. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will draft outcomes for each individual's annual ISP and review with the support team prior to the plan start date to help ensure that each is defined in measurable terms. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor ISP development to help ensure outcomes are measurable for each individual. **Date of Completion:** 8/26/22	8/26/2022

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W 159	Continued From page 4 needed: With maximum hand over hand supports, (Individual # 1) will help prepare a meal for his house. (Individual # 1) will complete this outcome if he is successful 2x (two times) a month for 9 (nine) of 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...(Individual # 1) should initially only be asked to help with smaller tasks to begin, such as pour a food item, stir a pot of food, or helping to set his place at the dining room table before building up to bigger tasks. (Individual # 1) should also participate for as long as he will tolerate and be praised for any attempts that he chooses to make. When (Individual # 1) chooses to participate in helping to prepare a meal in any way, a "+ (plus sign)" is recorded in his data book. If (individual #1) chooses not to participate, a "- (minus sign)" will be recorded ..." 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 #10 coded Individual #1 as "Outcome Offered & (and) Successful" on 07/04/2022, 07/09/2022, and on 07/11/2022. On 07/19/2022 at approximately 10:20 a.m., an interview and review of Individual # 1's ISP and data collection sheets listed above was conducted with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing Individual # 1's outcome # 10 as stated above OSM # 1 were asked to identify Individual # 1's act of participation that was being measured. OSM # 1 could not identify a specific act that was being measured and stated that the outcome should be	W 159	W 159 1b **How corrective action will be accomplished for Individual #1:** The QIDP will ensure data collection for Individual #1's ISP outcome for community outing is re-defined in measurable terms in the ISP through revising the outcome and updating the data collection form. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will ensure data collection for all individuals' ISP outcomes are defined in measurable terms by reviewing each outcome in each individual's ISP, revising any deficiencies in outcomes, and then updating data collection forms needing amendment. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will compile data collection forms for each individual's annual ISP and review with the support team to help ensure that each is defined in measurable terms. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor ISP development to help ensure outcomes and their associate data collection forms are measurable for each individual. **Date of Completion:** 8/26/22	8/26/2022

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W 159	Continued From page 5 more specific. When asked who was responsible for reviewing or monitoring the outcomes for measurable terms OSM # 1 stated that they were. On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, were 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. 1b. The QIDP failed to ensure the data collection of Individual # 1's ISP outcome for community activity was in measurable terms. 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 #10 coded Individual #1 as "Outcome Offered & (and) Successful" on 07/04/2022, 07/09/2022, and on 07/11/2022. On 07/19/2022 at approximately 10:20 a.m., an interview and review of Individual # 1's data	W 159	W 159 2a **How corrective action will be accomplished for Individual #2:** The QIDP will ensure Individual #2's ISP outcome for community outing is re-defined in measurable terms in the ISP through revising the outcome. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will ensure all individuals' ISP outcomes are defined in measurable terms by reviewing each outcome in each individual's ISP and revising any deficiencies. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will draft outcomes for each individual's annual ISP and review with the support team prior to the plan start date to help ensure that each is defined in measurable terms. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor ISP development to help ensure outcomes are measurable for each individual. **Date of Completion:** 8/26/22	8/26/2022

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W 159	Continued From page 6 collection sheets listed above was conducted with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing the data collection for Individual # 1 dated July 2022, OSM # 1 was asked if the data for the community activity outcome was documented in measurable terms. OSM # 1 stated, "No." When asked who was responsible for reviewing or monitoring the data collection for measurable terms OSM # 1 stated that they were. On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, were made aware of the findings. No further information was provided prior to exit. 2a. The QIDP failed to define Individual # 2's ISP outcomes for community outing in measurable terms. Individual # 2 was admitted to the facility with a diagnosis that included but was not limited to: severe intellectual disability (1). Individual # 2's ISP (individualized service plan) dated 02/21/2022 through 02/20/2023 documented in part, "Goal: 9. Actions/supports needed: With supervision, (Individual # 2) spends time in the community for at least 10 minutes participating in activities of his choosing at least 2x (two times) monthly at each location. (Individual # 2) will complete this outcome if he is successful for 9 of 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...(Individual # 2) is offered supervision to	W 159	W 159 2b **How corrective action will be accomplished for Individual #2:** The QIDP will ensure data collection for Individual #2's ISP outcomes for community outing, arts and crafts, and day trips are re-defined in measurable terms in the ISP through revising the outcomes and updating the data collection form. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will ensure data collection for all individuals' ISP outcomes are defined in measurable terms by reviewing each outcome in each individual's ISP, revising any deficiencies in outcomes, and then updating data collection forms needing amendment. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will compile data collection forms for each individual's annual ISP and review with the support team to help ensure that each is defined in measurable terms. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor ISP development to help ensure outcomes and their associate data collection forms are measurable for each individual. **Date of Completion:** 8/26/22	8/26/2022

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W 159	Continued From page 7 participate in activities in his community for at least 10 minutes. A "+ (plus sign)" is recorded for meeting outcome criteria per the indicated level of support. A "- (minus sign)" will be recorded for requiring a higher level of support, or if he declines to go at all." "Goal: 10. Actions/supports needed: With moderate hand over hand support, (Individual # 2) participates in an arts & crafts activity for at least 5 (five) minutes. (Individual # 2) will complete this outcome if he is successful for 9 of 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...When (Individual # 2) participates in a crafting activity for at least 5 minutes a "+ (plus sign)" is recorded in his data book. If (Individual # 2) does not meet that time frame, or if he chooses not to participate "- (minus sign)" will be recorded." "Goal: 12. Actions/supports needed: (Individual # 2) is supported to go on a solo day trip. (Individual # 2) will complete this outcome when he completes the task 2 (two) quarters in the plan year." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...Staff will work to explain to (Individual # 2) where he will be going and will present it in an exciting manner to increase the likelihood of (Individual # 2) participating. While on the outing, staff will remember all safety protocols while in the community and will continue to remain within an arm's reach of (Individual # 2) to prevent him from wandering. When (Individual # 2) completes a solo day trip with staff without incident, a "+ (plus sign)" is recorded in his data book. If (Individual # 2) chooses not to go, "- (minus sign)" will be recorded. Staff will record	W 159		

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W 159	Continued From page 8 (Individual # 2) reactions to his experience in daily notation so that further activities can be better customized to reflect (Individual # 2's) interest and preferences." Review of the facility's data collection sheets for Individual #2 dated July 2022 documented the outcome and support activities and instructions as stated above. Review of the data sheet for Outcome #9 coded Individual #2 as "Outcome Offered & Successful" on 07/01/2022, 07/02/2022, 07/08/2022 and on 07/12/2022; for Outcome # 10, Individual # 2 was coded as "Outcome Offered & Successful" on 07/01/2022 and for Outcome # 12, Individual # 2 was coded as "Outcome Offered & Successful" on 07/01/2022 and on 07/08/2022. On 07/19/2022 at approximately 10:20 a.m., an interview and review of Individual # 2's ISP and data collection sheets listed above was conducted with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing Individual # 2's outcomes # 9, # 10 and # 12 as stated above OSM # 1 was asked to identify Individual # 2's act of participation that was being measured for each of the outcomes. OSM # 1 could not identify a specific act that was being measured and stated that the outcomes should be more specific. When asked who was responsible for reviewing or monitoring the outcomes for measurable terms OSM # 1 stated that they were. On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, were made aware of the findings.	W 159		

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W 159	Continued From page 9 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. 2b. The QIDP failed ensure the data collection of Individual # 2's ISP outcomes for community outing, arts and crafts and day trips were in measurable terms. Review of the facility's data collection sheets for Individual #2 dated July 2022 documented the outcome and support activities and instructions as stated above. Review of the data sheet for Outcome #9 coded Individual #2 as "Outcome Offered & Successful" on 07/01/2022, 07/02/2022, 07/08/2022 and on 07/12/2022; for Outcome # 10, Individual # 2 was coded as "Outcome Offered & Successful" on 07/01/2022 and for Outcome # 12, Individual # 2 was coded as "Outcome Offered & Successful" on 07/01/2022 and on 07/08/2022. On 07/19/2022 at approximately 10:20 a.m., an interview and review of Individual # 1's data collection sheets listed above was conducted with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After	W 159		

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W 159	Continued From page 10 reviewing the data collection for Individual # 1 dated July 2022, OSM # 1 was asked if the data for the community outing, arts and crafts and day trip outcomes was documented in measurable terms. OSM # 1 stated, "No." When asked who was responsible for reviewing or monitoring the data collection for measurable terms OSM # 1 stated that they were. On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, were made aware of the findings. No further information was provided prior to exit.	W 159		
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 #2. 1. The facility staff failed to develop Individual # 1's residential ISP (individualized service plan) outcome for community activity to define Individual # 1's targeted act of participation. 2. The facility staff failed to develop Individual # 2's residential ISP outcome for community outing, arts and crafts and day trips to define Individual # 2's targeted act of participation.	W 231	W 231 (1) **How corrective action will be accomplished for Individual #1:** The QIDP will ensure Individual #1's ISP outcome for community activity is revised to define Individual #1's targeted act of participation. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will ensure all individuals' ISP outcomes are reviewed and revised as needed to ensure each individual's targeted act of participation is defined. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will draft outcomes for each individual's annual ISP and review with the support team prior to the plan start date to help ensure that each individual's targeted act of participation is defined for each outcome. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor ISP development to help ensure outcomes define each individual's targeted act of participation. **Date of Completion:** 8/26/22	8/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G073	A. BUILDING _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE STREET ICF ID	815 WOLFE STREET FREDERICKSBURG, VA 22401

(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 231	Continued From page 11 The findings include: 1. The facility staff failed to develop Individual # 1's residential ISP (individualized service plan) outcome for community activity to define Individual # 1's targeted act of participation. Individual # 1 was admitted to the facility with a diagnosis that included but was not limited to: moderate intellectual disability (1). Individual # 1's ISP (individualized service plan) dated 01/11/2022 through 01/10/2023 documented in part, "Goal: 10. Actions/supports needed: With maximum hand over hand supports, (Individual # 1) will help prepare a meal for his house. (Individual # 1) will complete this outcome if he is successful 2x (two times) a month for 9 (nine) of 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...(Individual # 1) should initially only be asked to help with smaller tasks to begin, such as pour a food item, stir a pot of food, or helping to set his place at the dining room table before building up to bigger tasks. (Individual # 1) should also participate for as long as he will tolerate and be praised for any attempts that he chooses to make. When (Individual # 1) chooses to participate in helping to prepare a meal in any way, a "+ (plus sign)" is recorded in his data book. If (individual #1) chooses not to participate, a "- (minus sign)" will be recorded ..." 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 #10 coded Individual #1 as "Outcome	W 231	W 231 (2) **How corrective action will be accomplished for Individual #2:** The QIDP will ensure Individual #2's ISP outcomes for community activity, arts and crafts, and day trips are revised to define Individual #2's targeted act of participation. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will ensure all individuals' ISP outcomes are reviewed and revised as needed to ensure each individual's targeted act of participation is defined. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will draft outcomes for each individual's annual ISP and review with the support team prior to the plan start date to help ensure that each individual's targeted act of participation is defined for each outcome. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor ISP development to help ensure outcomes define each individual's targeted act of participation. **Date of Completion:** 8/26/22	8/26/2022

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W 231	Continued From page 12 Offered & (and) Successful" on 07/04/2022, 07/09/2022, and on 07/11/2022. On 07/19/2022 at approximately 10:20 a.m., an interview and review of Individual # 1's ISP and data collection sheets listed above was conducted with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing Individual # 1's outcome # 10 as stated above OSM # 1 was asked to identify Individual # 1's act of participation that was being measured. OSM # 1 could not identify a specific act that was being measured and stated that the outcome should be more specific. The facility's policy "Active Treatment" documented in part, "6.c.iv. objectives expressed in behavioral terms that provide measurable indices of performance (the objective can be measured accurately in quantifiable data each time the treatment, procedure, intervention or interaction occurs) ..." On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, were 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	W 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 231	Continued From page 13 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 # 2's residential ISP outcome for community outing, arts and crafts and day trips to define Individual # 2's targeted act of participation. Individual # 2 was admitted to the facility with a diagnosis that included but was not limited to: severe intellectual disability (1). Individual # 2's ISP (individualized service plan) dated 02/21/2022 through 02/20/2023 documented in part, "Goal: 9. Actions/supports needed: With supervision, (Individual # 2) spends time in the community for at least 10 minutes participating in activities of his choosing at least 2x (two times) monthly at each location. (Individual # 2) will complete this outcome if he is successful for 9 of 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...(Individual # 2) is offered supervision to participate in activities in his community for at least 10 minutes. A "+ (plus sign)" is recorded for meeting outcome criteria per the indicated level of support. A "- (minus sign)" will be recorded for requiring a higher level of support, or if he declines to go at all." "Goal: 10. Actions/supports needed: With moderate hand over hand support, (Individual # 2) participates in an arts & crafts activity for at least 5 (five) minutes. (Individual # 2) will complete this outcome if he is successful for 9 of	W 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 231	Continued From page 14 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...When (Individual # 2) participates in a crafting activity for at least 5 minutes a "+ (plus sign)" is recorded in his data book. If (Individual # 2) does not meet that time frame, or if he chooses not to participate "- (minus sign)" will be recorded." "Goal: 12. Actions/supports needed: (Individual # 2) is supported to go on a solo day trip. (Individual # 2) will complete this outcome when he completes the task 2 (two) quarters in the plan year." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...Staff will work to explain to (Individual # 2) where he will be going and will present it in an exciting manner to increase the likelihood of (Individual # 2) participating. While on the outing, staff will remember all safety protocols while in the community and will continue to remain within an arm's reach of (Individual # 2) to prevent him from wandering. When (Individual # 2) completes a solo day trip with staff without incident, a "+ (plus sign)" is recorded in his data book. If (Individual # 2) chooses not to go, "- (minus sign)" will be recorded. Staff will record (Individual # 2) reactions to his experience in daily notation so that further activities can be better customized to reflect (Individual # 2's) interest and preferences." Review of the facility's data collection sheets for Individual #2 dated July 2022 documented the outcome and support activities and instructions as stated above. Review of the data sheet for Outcome #9 coded Individual #2 as "Outcome Offered & Successful" on 07/01/2022, 07/02/2022, 07/08/2022 and on 07/12/2022; for	W 231		

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W 231	Continued From page 15 Outcome # 10, Individual # 2 was coded as "Outcome Offered & Successful" on 07/01/2022 and for Outcome # 12, Individual # 2 was coded as "Outcome Offered & Successful" on 07/01/2022 and on 07/08/2022. On 07/19/2022 at approximately 10:20 a.m., an interview and review of Individual # 2's ISP and data collection sheets listed above was conducted with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing Individual # 2's outcomes # 9, # 10 and # 12 as stated above OSM # 1 was asked to identify Individual # 2's act of participation that was being measured for each of the outcomes. OSM # 1 could not identify a specific act that was being measured and stated that the outcomes should be more specific. On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, were 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		

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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 two of three individuals in the survey sample, Individual # 1 and #2. 1. The facility staff failed to document the data collection of Individual # 1's residential ISP (individualized service plan) outcome for community activity in measurable terms. 2. The facility staff failed to document the data collection of Individual # 2's residential ISP outcomes for community outing, arts and crafts and day trips in measurable terms. The findings include: 1. The facility staff failed to develop Individual # 1's residential ISP (individualized service plan) outcome for community activity to define Individual # 1's targeted act of participation. Individual # 1 was admitted to the facility with a diagnosis that included but was not limited to: moderate intellectual disability (1). Individual # 1's ISP (individualized service plan) dated 01/11/2022 through 01/10/2023	W 252	~~W 252 (1)~~ **How corrective action will be accomplished for Individual #1:** The QIDP will ensure Individual #1's ISP outcome and Individual #1's data collection form for community activity is revised into measurable terms. The QIDP will train facility staff on the revised outcomes and data collection forms, at which point staff will document in a fashion that reflects community activity data in measurable terms. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will ensure all individuals' ISP outcomes and data collection forms are reviewed and revised as needed into measurable terms. The QIDP will train facility staff on any revised outcomes and data collection forms, at which point staff will document in a fashion that reflects data in measurable terms. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will draft outcomes for each individual's annual ISP and review with the support team prior to the plan start date to help ensure that each individual's outcomes and data collection forms are developed in measurable terms. Facility staff will be trained in documenting each in measurable terms. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor ISP development to help ensure outcomes and data collection sheets are developed in measurable terms and that facility staff are documenting in a fashion that captures progress or regress. **Date of Completion:** 8/26/22	8/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 17 documented in part, "Goal: 10. Actions/supports needed: With maximum hand over hand supports, (Individual # 1) will help prepare a meal for his house. (Individual # 1) will complete this outcome if he is successful 2x (two times) a month for 9 (nine) of 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...(Individual # 1) should initially only be asked to help with smaller tasks to begin, such as pour a food item, stir a pot of food, or helping to set his place at the dining room table before building up to bigger tasks. (Individual # 1) should also participate for as long as he will tolerate and be praised for any attempts that he chooses to make. When (Individual # 1) chooses to participate in helping to prepare a meal in any way, a "+ (plus sign)" is recorded in his data book. If (individual #1) chooses not to participate, a "- (minus sign)" will be recorded ..." 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 #10 coded Individual #1 as "Outcome Offered & (and) Successful" on 07/04/2022, 07/09/2022, and on 07/11/2022. On 07/19/2022 at approximately 10:20 a.m., an interview and review of Individual # 1's data collection sheets listed above was conducted with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing the data collection for Individual # 1 dated July 2022, OSM # 1 was asked if the data for the community activity outcome was documented in measurable terms. OSM # 1 stated, "No."	W 252	**W 252 (2)** **How corrective action will be accomplished for Individual #2:** The QIDP will ensure Individual #2's ISP outcomes and Individual #2's data collection forms for community outing, arts and crafts, and day trips are revised into measurable terms. The QIDP will train facility staff on the revised outcomes and data collection forms, at which point staff will document in a fashion that reflects data in measurable terms. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will ensure all individuals' ISP outcomes and data collection forms are reviewed and revised as needed into measurable terms. The QIDP will train facility staff on any revised outcomes and data collection forms, at which point staff will document in a fashion that reflects data in measurable terms. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will draft outcomes for each individual's annual ISP and review with the support team prior to the plan start date to help ensure that each individual's outcomes and data collection forms are developed in measurable terms. Facility staff will be trained in documenting each in measurable terms. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor ISP development to help ensure outcomes and data collection sheets are developed in measurable terms and that facility staff are documenting in a fashion that captures progress or regress. **Date of Completion:** 8/26/22	8/26/2022

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W 252	Continued From page 18 The facility's policy "Active Treatment" documented in part, "9. Program Documentation: Accurate, systematic, behaviorally stated data about the individual's performance toward meeting the criteria stated in the PCP (person centered plan) objectives serves as the basis for necessary change and revision to the program." On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, were 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 # 2's residential ISP outcomes for community outing, arts and crafts and day trips in measurable terms. Individual # 2 was admitted to the facility with a diagnosis that included but was not limited to: severe intellectual disability (1). Individual # 2's ISP (individualized service plan)	W 252		

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W 252	Continued From page 19 dated 02/21/2022 through 02/20/2023 documented in part, "Goal: 9. Actions/supports needed: With supervision, (Individual # 2) spends time in the community for at least 10 minutes participating in activities of his choosing at least 2x (two times) monthly at each location. (Individual # 2) will complete this outcome if he is successful for 9 of 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...(Individual # 2) is offered supervision to participate in activities in his community for at least 10 minutes. A "+ (plus sign)" is recorded for meeting outcome criteria per the indicated level of support. A "- (minus sign)" will be recorded for requiring a higher level of support, or if he declines to go at all." "Goal: 10. Actions/supports needed: With moderate hand over hand support, (Individual # 2) participates in an arts & crafts activity for at least 5 (five) minutes. (Individual # 2) will complete this outcome if he is successful for 9 of 12 months." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...When (Individual # 2) participates in a crafting activity for at least 5 minutes a "+ (plus sign)" is recorded in his data book. If (Individual # 2) does not meet that time frame, or if he chooses not to participate "- (minus sign)" will be recorded." "Goal: 12. Actions/supports needed: (Individual # 2) is supported to go on a solo day trip. (Individual # 2) will complete this outcome when he completes the task 2 (two) quarters in the plan year." Under the heading "Describe how this will be provided based on individual preferences" it documented, in part " ...Staff will work to explain	W 252		

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W 252	Continued From page 20 to (Individual # 2) where he will be going and will present it in an exciting manner to increase the likelihood of (Individual # 2) participating. While on the outing, staff will remember all safety protocols while in the community and will continue to remain within an arm's reach of (Individual # 2) to prevent him from wandering. When (Individual # 2) completes a solo day trip with staff without incident, a "+ (plus sign)" is recorded in his data book. If (Individual # 2) chooses not to go, "- (minus sign)" will be recorded. Staff will record (Individual # 2) reactions to his experience in daily notation so that further activities can be better customized to reflect (Individual # 2's) interest and preferences." Review of the facility's data collection sheets for Individual #2 dated July 2022 documented the outcome and support activities and instructions as stated above. Review of the data sheet for Outcome #9 coded Individual #2 as "Outcome Offered & Successful" on 07/01/2022, 07/02/2022, 07/08/2022 and on 07/12/2022; for Outcome # 10, Individual # 2 was coded as "Outcome Offered & Successful" on 07/01/2022 and for Outcome # 12, Individual # 2 was coded as "Outcome Offered & Successful" on 07/01/2022 and on 07/08/2022. On 07/19/2022 at approximately 10:20 a.m., an interview and review of Individual # 1's data collection sheets listed above was conducted with OSM (other staff member) # 1, QIDP (Qualified Intellectual Disabilities Professional). After reviewing the data collection for Individual # 1 dated July 2022, OSM # 1 was asked if the data for the community outing, arts and crafts and day trip outcomes was documented in measurable terms. OSM # 1 stated, "No."	W 252		

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W 252	Continued From page 21 On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, were 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 252		
W 381	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(1) The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, facility document review and staff interview, it was determined that the facility staff failed to secure individual's medications in one of one facility medication rooms. The findings include: During the facility's medication administration observation, facility staff left individual's medications on the counter in the facility's	W 381	W 381 **How corrective action will be accomplished**: Facility staff will secure the medication room in the facility at all times by ensuring the door is shut and locked when they leave the room. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will secure all individuals' medications in the facility's medication room at all times by ensuring the door is shut and locked when they leave the room. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** A sign will be posted inside the medication room on the door reminding facility staff to secure the door by closing and locking it when exiting the room. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will monitor through randomized checks to ensure facility staff are securing the medication room door by closing it and locking it when they vacate the room. **Date of Completion:** 8/26/22	8/26/2022

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W 381	Continued From page 22 medication room and left the door open when they had left the room. On 07/19/2022 at approximately an observation was conducted of ASM (administrative staff member) # 2, assistant ICF (intermediate care facility) manager during the medication administration observation. At approximately 8:12 a.m., an observation revealed that ASM # 2 left the medication room, leaving the door open and an individual's medications laying on the counter and went into the day room to escort an individual to the medication room. At approximately 8:15 a.m., an observation revealed that ASM # 2 left the medication room again, leaving the door to the medication room open and medications laying out on the counter. Further observation revealed that when ASM # 2 left the medication room they stepped into the elevator to the third floor of the facility. On 07/19/2022 at approximately 9:57 a.m., an interview was conducted with ASM # 2. When asked to describe the procedure for securing the medication room when no one is in the room and securing an individual's medications ASM # 2 stated that the medication room should be closed and locked when it was not in use and that medications should not be left out on the counter. After informed of the above observations regarding the medication room and medications ASM # 2 stated that they had not secured individual's medications or the medication room. On 07/19/2022 at approximately 11:25 a.m., an interview was conducted with RN (registered nurse) # 1. When asked to describe the procedure for securing the medication room and an individual's medications RN # 1 stated that the	W 381		

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W 381	Continued From page 23 medication room should be closed and locked at all times when no one is in the room. RN # 1 further stated that medications could be left on the counter when they are being prepared and the staff member leaves the room to get an individual for their medications provided that the medication room door is closed and locked with the key removed from the door handle. After informed of the above observations RN # 1 stated that the staff member did not secure medications or the medication room. The facility's policy "Medication Administration" documented in part, "3. o. Lock the office (medication room) or closet door (medication closet) and go discreetly ask the individual if they are ready to take their medication and ask them to come to the medication room." On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, (Qualified Intellectual Disabilities Professional) were made aware of the findings. No further information was provided prior to exit.	W 381		
W 445	EVACUATION DRILLS CFR(s): 483.470(i)(2)(i) The facility must actually evacuate clients during at least one drill each year on each shift. This STANDARD is not met as evidenced by: Based on facility document review and staff interview, it was determined that the facility failed to conduct fire drills for each shift quarterly. The findings include:	W 445	W445 **How corrective action will be accomplished:** Facility staff will conduct fire drills for each shift at least quarterly. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will conduct and document evidence of fire drills at least quarterly for each shift of personnel. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The program supervisor will monitor to ensure that facility staff conduct and document fire drills at least quarterly for each shift of personnel. Copies of these drills will be submitted to the Quality Assurance team, whereupon they will be uploaded into an electronic repository for access to supervisors and auditors. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Director of Compliance and Human Rights, or designee, as well as members of the Developmental Disabilities Coordination team, will review to ensure that fire drills are conducted and documented at least quarterly for each shift of personnel and stored within the electronic repository **Date of Completion:** 8/26/22	8/26/2022

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W 445	Continued From page 24 Review of the facility's "Emergency Drill Forms" for fire drills dated 06/2021 through 06/2022 failed to evidence documentation of facility fire drills during the months of July, August and October 2021 and during the month of May 2022. On 07/18/2022 at approximately 11:55 a.m., an interview was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager. When asked about the missing fire drills for July, August and October 2021 and during the month of May 2022 ASM # 1 stated that due to changes in staffing some of the fire drill were not completed. The facility's policy "Section 8-6: Facility Inspections and Drills" documented in part, "3a. Fire drills will be done monthly." On 07/18/2022 at approximately 5:45 p.m. ASM # 1 and ASM # 3, assistant residential coordinator were made aware of the findings. No further information was provided prior to exit.	W 445		
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 procedures to prevent the spread of communicable disease in the facility, and failed to implement infection control procedures during medication administration.	W 455	W455 (1) **How corrective action will be accomplished:** Facility staff will wear a mask while in the facility to prevent the spread of communicable disease. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will be monitored by supervisor team to ensure compliance with mask wearing to assist in preventing the spread of communicable disease amongst all residents. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The Infection Control Policy will be reviewed, revised, and discussed at the next mandatory staff meeting to ensure mask compliance in order to prevent the spread of communicable disease. **How the facility plans to monitor its performance to make sure that solutions are sustained:** ICF Management will intermittently observe facility staff to ensure that they are being compliant with mask requirements. **Date of Completion:** 8/26/22	8/26/2022

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W 455	Continued From page 25 1. The facility staff failed to wear a mask while in the facility to prevent the spread of communicable disease. 2. The facility staff failed to implement hand hygiene and proper glove procedures when preparing and administering medications to facility individuals. The findings include: 1. The facility staff failed to wear a mask while in the facility to prevent the spread of communicable disease. On 07/18/2022 at approximately 12:10 p.m. ASM (administrative staff member) # 2, Assistant ICF manager, was observed on the third floor of the facility, walking down the hall toward an Individual's room, not wearing a mask. On 07/18/2022 at approximately 1:30 p.m., ASM # 2 was observed in the dining room sitting at the dining room table doing some paperwork, not wearing a mask. On 07/18 /2022 at approximately 1:40 p.m., OSM (other staff member) # 2, contracted cleaner, was on the third floor of the facility cleaning the elevator, not wearing a mask. On 07/18/2022 at approximately 2:30 p.m., ASM # 2 was observed on the second floor walking down the hallway not masked while Individuals were present on the second floor. On 07/18/2022 at approximately 3:10 p.m., as surveyor was walking off the facility elevator onto	W 455	W455 (2) **How corrective action will be accomplished:** Facility staff will implement hand hygiene and proper glove procedures when preparing and administering medications to facility individuals. This will include implementing hand hygiene and changing gloves between each task they are performing per standard infection control precautions during medication preparation and administration. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will implement hand hygiene and change their gloves between each task involved in medication preparation and administration for each individual in the facility per standard infection control precautions. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The Infection Control Policy will be reviewed and discussed at the next mandatory staff meeting. All facility staff will read and sign a statement of understanding of the policy and the expectations therein. **How the facility plans to monitor its performance to make sure that solutions are sustained:** ICF Management will intermittently observe facility staff to ensure that they are implementing hand hygiene and changing gloves per standard infection control precautions when preparing and administering medications for individuals. **Date of Completion:** 8/26/22	8/26/2022

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W 455	Continued From page 26 the second floor, DSP (direct support professional) # 3 was entering the elevator. Observations revealed that DSP # 3 was not wearing a mask. On 07/18 /2022 at approximately 3:04 p.m., an interview was conducted with OSM # 2. When asked if they were instructed to wear a mask while in the facility OSM # 2 stated that the ICF manager told them that they needed to be wearing a mask. When asked if they were informed as to why they needed to be wearing a mask OSM # 2 stated that the ICF manager told them that it was because the inspector was in the facility. When asked if they were wearing a mask when the surveyor observed them cleaning the elevator OSM # 2 stated no. On 07/18/2022 at approximately 5:45 p.m., an interview was conducted with ASM (administrative staff member) # 1, ICF (intermediate care facility) manager. When asked why staff should be wearing a mask while inside the facility ASM # 1 stated that it was to protect the staff and the individuals who resided at the facility. ASM # 1 further stated that wearing a mask was optional if the staff member was vaccinated. When asked where they obtained that information ASM # 1 stated that the information came from the CDC (Center for Disease Control and Prevention). The CDC document "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated 02/02/2022 documented in part, "Implement Source Control Measures. Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to	W 455		

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W 455	Continued From page 27 prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing ...Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission ..." On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, (Qualified Intellectual Disabilities Professional), were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to implement hand hygiene and proper glove procedures when preparing and administering medications to facility individuals. On 07/19/2022 at 7:55 a.m., an observation was conducted of ASM (administrative staff member) # 2, assistant ICF (intermediate care facility) manager, preparing and administering medications to individuals in the facility. At the start of the medication administration ASM # 2 was observed wearing gloves and taking the temperatures of three individuals seated at the dining room table. ASM # 2 then went into the medication room, wearing the same gloves, placed their hands on the counter, wrote down the individual's temperature in a book, opened the closet door in the medication room, removed a basket containing an individual's medications, removed the bubble pack of medications, opened	W 455		

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W 455	Continued From page 28 a book containing the individual's MARs (medication administration records), turned each page to verify the medications against the MAR, opened the bubble pack by peeling back the tab, placing their gloved thumb inside the bubble pack to hold it while continuing to remove the tab, poured out the tablets and capsules into a small plastic cup. ASM # 2 left the medication room, wearing the same gloves, walked down the hall to the day room, informed Individual # 1 it was time for their medication, escorted Individual # 1 to the medication room, gave the small cup of tablets and capsules to the individual. The individual was observed taking all the medications from the cup. ASM # 2 then removed their gloves and donned a new pair without sanitizing or washing their hands, left the medication room, went down the hall to the day room and verbally and physically prompted, by holding their hands and giving "high fives" with their gloved hands, another individual to come to the medication room. Observations of the individual's behavior when ASM # 2 prompted the individual, revealed that they had their hands over their nose and open mouth. ASM # 2 then escorted the individual to the medication room by holding the individual's hand. After entering the medication room, the individual sat down in a chair, ASM # 2 attempted to obtain the individual's blood pressure using a hand held blood pressure meter while wearing the same gloves. After several attempts ASM # 2 escorted the individual back to the day room. At approximately 8:25 a.m., ASM # 2 donned another pair of gloves without sanitizing or washing their hands, went back to the day room and physically prompted the same individual to get up from a sofa and escorted them to the	W 455		

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W 455	Continued From page 29 medication room by holding the individual's hand with their gloved hand. After entering the medication room, while still wearing the same gloves, ASM # 2 picked up the basket of medications from the previous individual, placed them in the closet and removed another basket of medications for the individual they brought into the medication room from the day room. Wearing the same gloves, ASM # 2 then removed a blood pressure cuff, placed it around the individual's arm, picked up the hand held blood pressure meter and obtained the individual's blood pressure, removed the bubble pack of medications from the basket, opened a book containing the individual's MARs, turned each page to verify the medications against the MAR, opened the bubble pack by peeling back the tab, placing their gloved thumb inside the bubble pack to hold it while continuing to remove the tab, poured out the tablets and capsules into a small plastic cup. ASM # 2 then removed a bubble pak card and pushed out a tablet. Observation revealed that the tablet landed on ASM # 2's glove and they pushed it off the glove into a small bowl. ASM # 2 then combined the medications from the bubble packs in the small bowl with applesauce and administered them to the individual. On 07/19/2022 at approximately 9:57 a.m., an interview was conducted with ASM # 2. When asked to describe the procedure for changing gloves ASM # 2 stated that gloves should be changed every time they come into contact with an individual or if they touch something else. ASM # 2 further stated that they should wash or sanitize their hands each time they change gloves. After informed of the observations as stated above regarding the use of gloves ASM #	W 455		

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W 455	Continued From page 30 2 stated that they did not follow proper hand hygiene or the correct procedure for glove use. On 07/19/2022 at approximately 11:25 a.m., an interview was conducted with RN (registered nurse) # 1. When asked to describe the procedure for using gloves during medication administration RN # 1 stated that gloves should be changed between each individual contact or when they come into contact with any surface such as door handles, counters, etc. RN # 1 further stated that after each glove change staff should use hand sanitizer or wash their hand with soap and water. After informed of the above observation RN # 1 stated that proper hand hygiene or the correct procedure for glove use was not followed. On 07/19/2022 at approximately 3:30 p.m. ASM # 3, assistant residential coordinator, RN (registered nurse) # 1 and OSM # 1, (Qualified Intellectual Disabilities Professional), were made aware of the findings. No further information was provided prior to exit.	W 455		