STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G065	A. BUILDING _____ B. WING _____	01/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/17/2023 through 1/18/2023. The facility was in 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		
W 000	INITIAL COMMENTS An unannounced Focused Fundamental Medicaid re-certification survey was conducted 1/17/2023 through 1/18/2023. 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 four certified bed facility was four at the time of the survey. The survey sample consisted of three individual reviews (Individuals #1, #2 & #3).	W 000		
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 observation, staff interview, facility document review and residential record review, it was determined that the QIDP (qualified intellectual disabilities professional) failed to coordinate and monitor individuals' active treatment program for two of three individuals in the survey sample, Individuals #2 and #3.	W 159		

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

DD Residential Coordinator 2/1/23

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 159	Continued From page 1 The findings include: 1. For Individual #2, the QIDP failed to ensure the individual's ISP (individualized service plan) for eating was implemented. Individual #2 was admitted to the facility on 11/28/14. Individual #2's diagnoses included but were not limited to severe intellectual disability and gastroesophageal reflux disease. Individual #2's ISP, signed by the QIDP (qualified intellectual disabilities professional) on 12/23/22, documented, "(Individual #2 Name) utilizes a suctioned plate to help prevent instances of him throwing his plate and eats with a spoon. As (Individual #2) has a history of throwing his food, often times without an identifiable trigger, staff will provide (Individual #2) with half of his meal at a time. When (Individual #2) finishes his first portion, he receives the rest of his meal. If (Individual #2) is expressing that he is finished eating, remove food from his reach. (Individual #2) is capable of feeding himself independently and is expected to do so at all times while being supervised by staff..." On 1/17/23 at approximately 5:05 p.m., DSP (direct support staff) #1 was observed feeding Individual #2 bite size pieces of pizza and salad with a spoon. On 1/17/23 at 5:09 p.m., an interview was conducted with DSP #1, regarding Individual #2's ability to feed self. DSP #1 stated Individual #2's ability to feed self depends on the individual's mood. DSP #1 stated sometimes (Individual #2) feeds self but sometimes when the individual is tired and doesn't want to feed self then staff feeds the individual. DSP #1 stated	W 159	**W159** **1.** **How corrective action will be accomplished for Individual #2:** The QIDP will monitor to ensure implementation of the PCP [person-centered plan] outcome/goal for eating for Individual #2. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will monitor to ensure implementation of all outcomes/goals in the active treatment plan/ PCP [person-centered plan] for each resident. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will review data to ensure outcome /goal implementation is being recorded accurately by staff. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will review all data collection at a minimum of monthly to ensure that implementation is being recorded accurately. **Date of Completion:** 2/1/2023	**2/1/2023**

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W 159	Continued From page 2 sometimes (Individual #2) pushes the plate of food away when staff puts the plate up to the individual. DSP #1 pushed the plate of food toward (Individual #2) and (Individual #2) pushed the plate away. On 1/18/23 at 1:23 p.m., an interview was conducted with ASM (administrative staff member) #2 (the QIDP). ASM #2 stated active treatment is collaborative and he is responsible for coordinating care. ASM #2 stated he writes the ISPs and is able to update them. ASM #2 stated that since he is in the facility, he can make sure staff is implementing the ISPs and explain to staff why they are supposed to do something the way they do it. ASM #2 stated he tries to ensure staff is implementing ISPs by making observations and correcting staff as soon as he sees they are doing something that does not align with the plan. ASM #2 stated he also communicates ISPs through monthly staff meetings and staff must sign off on individuals' ISPs. ASM #2 stated staff should not feed Individual #2 because the individual is capable of feeding self. ASM #2 stated Individual #2 should always be feeding self while physically capable because of dignity and staff does not want the individual's skill of feeding self to regress. ASM #2 stated when Individual #2 pushes the plate away then that is the individual's way of telling staff the individual does not want the plate. ASM #2 stated if Individual #2 pushes the plate away then staff should gauge the individual's mood, move the individual's plate and ask the individual if the individual wants to remain at the table. ASM #2 stated if Individual #2 indicates the individual wishes to remain at the table, then staff should put the plate back in front of the resident. ASM #2 stated that Individual #2 does not want	W 159	**W159** **2.** **How corrective action will be accomplished for Individual #3:** The QIDP will monitor to ensure implementation of the PCP [person-centered plan] outcome/goal for medication administration for Individual #3. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will monitor to ensure implementation of all outcomes/goals in the active treatment plan/ PCP [person-centered plan] for each resident. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will review data to ensure outcome /goal implementation is being recorded accurately by staff. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will review all data collection at a minimum of monthly to ensure that implementation is being recorded accurately. **Date of Completion:** 2/1/2023	**2/1/2023**

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W 159	Continued From page 3 the plate then staff should place the plate in the microwave and tray again in 30 minutes. On 1/18/23 at 1:35 p.m., ASM #1 (the residential coordinator) was made aware of the above concern. The facility policy titled, "Qualified Intellectual Disabilities Professional" documented, "It is the policy of (name of facility) that the Qualified Intellectual Disabilities Professional (QIDP) will provide comprehensive Active Treatment coordination, case management and oversight for the residents." No further information was presented prior to exit. 2. For Individual #3, the QIDP failed to ensure the individual's ISP (individualized service plan) for medication administration was implemented. Individual #3 was admitted to the facility on 3/9/15. Individual #3's diagnoses included but were not limited to intellectual disability and seizures. Individual #3's ISP, signed by the QIDP (qualified intellectual disabilities professional) on 4/1/22, documented, "(Individual #3 Name) takes his prescribed medications whole, in applesauce. After support staff prepare his medications, (Individual #3) is handed a spoon and is provided a gestural clue such as pointing to his medications and asked to take the final scoop of his medications. Support staff should hold the ramekin of applesauce underneath of (Individual #3's) spoon at all times to guard against any medications potentially hitting the floor..."	W 159		

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W 159	Continued From page 4 On 1/17/23 at 4:10 p.m., DSP (direct support staff) #2 was observed administering medications to Individual #3. DSP #2 held a ramekin containing pills and applesauce and fed four spoonfuls to Individual #3. DSP #2 did not gesture or ask Individual #3 to take the final scoop. On 1/18/23 at 1:26 p.m., Individual #3's ISP was reviewed with ASM (administrative staff member) #2 (the QIDP). ASM #2 stated active treatment is collaborative and he is responsible for coordinating care. ASM #2 stated he writes the ISPs and is able to update them. ASM #2 stated that since he is in the facility, he can make sure staff is implementing the ISPs and explain to staff why they are supposed to do something the way they do it. ASM #2 stated he tries to ensure staff is implementing ISPs by making observations and correcting staff as soon as he sees they are doing something that does not align with the plan. ASM #2 stated he also communicates ISPs through monthly staff meetings and staff must sign off on individuals' ISPs. ASM #2 stated the staff should began feeding Individual #3 the pills and applesauce then for the last scoop, the staff should give Individual #3 the spoon and prompt the individual to take what is left in the ramekin. On 1/18/23 at 1:35 p.m., ASM #1 (the residential coordinator) was made aware of the above concern. No further information was presented prior to exit.	W 159		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249		

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W 249	Continued From page 5 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. This STANDARD is not met as evidenced by: Based on observation, staff interview, facility document review and residential record review, the facility staff failed to implement active treatment for two of three individuals in the survey sample, Individuals #2 and #3. The findings include: 1. For Individual #2, the facility staff failed to implement the individual's ISP (individualized service plan) for eating. Individual #2 was admitted to the facility on 11/28/14. Individual #2's diagnoses included but were not limited to severe intellectual disability and gastroesophageal reflux disease. Individual #2's ISP, signed by the QIDP (qualified intellectual disabilities professional) on 12/23/22, documented, "(Individual #2 Name) utilizes a suctioned plate to help prevent instances of him throwing his plate and eats with a spoon. As (Individual #2) has a history of throwing his food, often times without an identifiable trigger, staff will provide (Individual #2) with half of his meal at a time. When (Individual #2) finishes his first portion, he receives the rest of his meal. If (Individual #2) is expressing that he is finished	W 249	**W 249** **1.** **How corrective action will be accomplished for Individual #2:** Facility staff will implement the active treatment outcome involving eating for Individual #2. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will implement the active treatment outcomes from the PCP's for each individual. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will continue to monitor and ensure implementation of the active treatment outcomes as described in each individual's PCP. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program supervisor and assistant manager will monitor to ensure the implementation of the active treatment outcomes as described in each individual's PCP. **Date of Completion:** 2/1/2023	2/1/2023

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W 249	Continued From page 6 eating, remove food from his reach. (Individual #2) is capable of feeding himself independently and is expected to do so at all times while being supervised by staff..." On 1/17/23 at approximately 5:05 p.m., DSP (direct support staff) #1 was observed feeding Individual #2 bite size pieces of pizza and salad with a spoon. On 1/17/23 at 5:09 p.m., an interview was conducted with DSP #1, regarding Individual #2's ability to feed self. DSP #1 stated Individual #2's ability to feed self depends on the individual's mood. DSP #1 stated sometimes Individual #2 feeds self but sometimes when the individual is tired and doesn't want to feed self then staff feeds the individual. DSP #1 stated sometimes Individual #2 pushes the plate of food away when staff puts the plate up to the individual. DSP #1 pushed the plate of food toward Individual #2 and Individual #2 pushed the plate away. On 1/18/23 at 1:23 p.m., an interview was conducted with ASM (administrative staff member) #2 (the QIDP). ASM #2 stated staff should not feed Individual #2 because the individual is capable of feeding self. ASM #2 stated Individual #2 should always be feeding self while physically capable because of dignity and staff does not want the individual's skill of feeding self to regress. ASM #2 stated when Individual #2 pushes the plate away then that is the individual's way of telling staff the individual does not want the plate. ASM #2 stated if Individual #2 pushes the plate away then staff should gauge the individual's mood, move the individual's plate and ask the individual if the individual wants to remain at the table. ASM #2 stated if Individual #2 indicates the individual wishes to remain at the	W 249	**W 249** **2.** **How corrective action will be accomplished for Individual #3:** Facility staff will implement the active treatment outcome involving medication administration for Individual #3. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will implement the active treatment outcomes from the PCP's for each individual. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will continue to monitor and ensure implementation of the active treatment outcomes as described in each individual's PCP. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program supervisor and assistant manager will monitor to ensure the implementation of the active treatment outcomes as described in each individual's PCP. **Date of Completion:** 2/1/2023	**2/1/2023**

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W 249	Continued From page 7 table, then staff should put the plate back in front of the resident. ASM #2 stated that Individual #2 does not want the plate then staff should place the plate in the microwave and tray again in 30 minutes. On 1/18/23 at 1:35 p.m., ASM #1 (the residential coordinator) was made aware of the above concern. The facility policy titled, "Active Treatment" documented, "5. Residents of (name of facility) will be provided with support which will assist them to function with as much self-determination and independence as possible while preventing the deceleration, regression, or loss of current optimal functional status through the development and direction of an individualized Person Center Plan." No further information was presented prior to exit. 2. For Individual #3, the facility staff failed to implement the individual's ISP (individualized service plan) for medication administration. Individual #3 was admitted to the facility on 3/9/15. Individual #3's diagnoses included but were not limited to intellectual disability and seizures. Individual #3's ISP, signed by the QIDP (qualified intellectual disabilities professional) on 4/1/22, documented, "(Individual #3) takes his prescribed medications whole, in applesauce. After support staff prepare his medications, (Individual #3) is handed a spoon and is provided a gestural clue such as pointing to his medications and asked to take the final scoop of his medications. Support	W 249		

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W 249	Continued From page 8 staff should hold the ramekin of applesauce underneath of (Individual #3's) spoon at all times to guard against any medications potentially hitting the floor..." On 1/17/23 at 4:10 p.m., DSP (direct support staff) #2 was observed administering medications to Individual #3. DSP #2 held a ramekin containing pills and applesauce and fed four spoonfuls to Individual #3. DSP #2 did not gesture or ask Individual #3 to take the final scoop. On 1/18/23 at 1:26 p.m., Individual #3's ISP was reviewed with ASM (administrative staff member) #2 (the QIDP). ASM #2 stated the staff should began feeding Individual #3 the pills and applesauce then for the last scoop, the staff should give Individual #3 the spoon and prompt the individual to take what is left in the ramekin. On 1/18/23 at 1:35 p.m., ASM #1 (the residential coordinator) was made aware of the above concern. No further information was presented prior to exit.	W 249		