		ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES					0. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		49G056	B. WING			07/13/2023		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
VINCES P	LACE/CHASES WAY				BOX 976, 4373/4395 PRUDEN BOULEVARD			
				SU	JFFOLK, VA 23439			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	<i>(</i>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE	
				\rightarrow	DEFICIENCY)			
W 000								
W 000	INITIAL COMMENTS		W 0	00				
	An unannounced Fur	v was conducted 7/11/23						
	through 7/13/23. The							
		FR Part 483 Requirements						
	for Intermediate Care	Facilities for Individuals						
		pilities (ICF/IID). The Life						
	Safety Code survey r	•						
	complaints were inve	stigated during the survey.						
	The census in this ter	n bed facility was eight at the						
		ne survey sample consisted						
	of six current individu	•						
W 153	STAFF TREATMENT	OF CLIENTS	W 1	53				
	CFR(s): 483.420(d)(2	!)						
	The facility must anal	is that all allocations of						
	mistreatment, neglect	ure that all allegations of						
	injuries of unknown s							
		ministrator or to other						
	officials in accordance	e with State law through						
	established procedure							
		not met as evidenced by:						
		iew, clinical record review, review, the facility staff						
	-	iry of unknown origin in a						
		e of six individuals in the						
	survey sample, Indivi							
	The findings include:							
	For Individual #6 (I6)	the facility staff failed to						
		s of unknown origin to						
		m 2/16/23 until 2/20/23.						
		• • • • • • • • •						
		's synopsis of events dated						
		oart: "On Thursday, February t support personnel) staff at						
		sapport personnen stan at						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	· F		TITLE		(X6) DATE	

08/05/2023

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/07/2023 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		49G056	B. WING			07	/13/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
VINCES P	LACE/CHASES WAY				PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 153	[name of facility] notic bruising around [I6]'s DSP staff saw the bru- who was on site provi- the nurse informed th describing the bruises (2/17/23), a DSP saw informed the house C Monday (2/20/23), the checked the bruises of informed by the DSP her legs. The nurse in ID/DD (intellectually of disabled) Residential DirectorThe Office of Reliability was inform services) report was in Allegation Report was [Name of facility] staff duties to support [I6] incident reporting pro- chose to assume it has or that their attempts despite not following in not aware of the deve days. Nevertheless, the indication that physical A review of the clinical evidence that I6 was visitors in February 20 record documented I6 walls and hard surface The facility staff provi-	ed what appeared to be breasts. By evening, other ising and informed a nurse ding a service. On Friday, e [name of facility]'s nurse, a soldOn Friday evening bruises on [I6]'s legs and ounselor on site. On a [name of facility]'s nurse on [I6]'s breasts and was that [I6] also had bruises on formed [I6]'s parent and the isabled/developmentally Supervisor and of Quality Healthcare and ed. An APS (adult protective nade, and an Abuse a enteredConclusion: properly performed their .but failed to follow proper tocols. Each staff involved ad been reported by another, to report were adequate protocol. Management was loping incident for several here is no evidence or al abuse occurred." I record revealed no abused by facility staff or 023. Multiple entries in the b as frequently bumping into es in the facility. ded credible evidence of a h, including staff interviews ysis.	W	153			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/07/2023 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G056		(X1) PROVIDER/SUPPLIER/CLIA	· /			(X3) DATE SURVEY COMPLETED		
		49G056	B. WING			07/	/13/2023	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
VINCES P	PLACE/CHASES WAY				PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 153	interviewed. When as she found new bruisir reasonable explanatio "I would tell the mana on-call manager." She protocol to be followe she would report ite immed be abuse, so we have On 7/12/23 at 2:35 p.1 interviewed. She state any visible injury to a a reasonable explana management as soon investigation can begi is important in order to On 7/13/23 at 9:45 a.1 staff member) #1, the disability professional stated an injury of un- ordinarily be reported She said timely report facility's program to pr On 7/13/23 at 10:33 a services administrator stated if a staff memb resident and the origin been reasonably doct the staff member shou immediately to manage should begin an invest possible.	sked what she would do if ng that did not have a on on a resident, she stated: ager, or, if it's after hours, the e stated the facility has set a ed. When asked how soon bruising, she stated she diately. She stated: "It could e to report it right away." m., DSP #2 was ed she has been taught that resident that does not have ation needs to be reported to n as possible so that an in. She stated this process to prevent resident abuse. m., ASM (administrative e QIDP (qualified intellectual I) was interviewed. She known origin should I as soon as it is discovered. ting is important in the revent abuse. a.m., ASM #3, the clinical r, was interviewed. She known origin is an injury to ot witnessed by anyone. She per observes bruising on a n of the bruising has not umented or communicated, uld report the injury gement, and management	W	153	3			

Facility ID: VAVINCPLA

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/07/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	
		49G056	B. WING		_	07/	13/2023
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
VINCES P	LACE/CHASES WAY			O BOX 976, 4373/4395 PI UFFOLK, VA 23439	RUDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 153	Individuals/Serious In "Any person having k involved in abuse or r reasonable cause to b place, or has taken pl make a report to his/h Director."	cidents," revealed, in part: nowledge of such individual leglect, or having believe the same is taking ace, shall immediately er Director/Executive	W 153				
W 159	QIDP CFR(s): 483.430(a) Each client's active tre integrated, coordinate qualified intellectual d This STANDARD is r Based on observation document review, and facility QIDP (qualified professional) failed to the IPP (individual pro- documentation of pro- in ADLs (activities of of individuals in the surv #2, #3, and #5. The findings include: 1. For Individual #1 (I the IPP identified objet independence in eatir On 7/12/23 at 5:08 p.1 in the recreation room member) #2, the cour was almost ready, an hands. I1 independent	isability professional who- to the as evidenced by: n, staff interview, facility I clinical record review, the d intellectual disability ensure implementation of bgram plan) and gress toward independence daily living) for four of six ey sample, Individuals #1, 1), the QIDP failed to ensure actives likely to promote	W 159				

Facility ID: VAVINCPLA

If continuation sheet Page 4 of 23

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/07/2023 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		49G056	B. WING _				07/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
VINCES P	LACE/CHASES WAY				O BOX 976, 4373/4395 PRU SUFFOLK, VA 23439	DEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
W 159	spot. 11 sat down at the served 11's plate in the down on 11's placema 11 independently fed h standard plate and sill eating, she pushed he and went back to the cleared 11's dishes, na the table, and put the A review of 11's IPP (In dated 12/20/22 reveal "GoalDietaryI will to ordered by my physic the dietician." The pla objectives toward inde or after mealtimes. On 7/13/23 at 9:45 a.r (qualified intellectual of interviewed. When as treatment, she stated and the goals should b personalized for each facility staff is "constat treatment by engaging other than what might told about the observa- for 11, she reviewed 11 stated: "[11] is probabl much more than sit do if interventions toward attempted despite the an individual might or stated those types of should be attempted. are saying. We at lease	 dining room table at I1's and dinner table. ASM #2 e kitchen, and set the plate at on the dining room table. herself dinner using a verware. When I1 finished er chair back from the table recreation room. ASM #2 apkin, and silverware from dishes in the dishwasher. Individual Program Plan) Ied, in part: follow my meal plan as ian and recommended by an contained no evidence of ependence before, during, m., ASM #1, the QIDP disability professional) was iked to define active it is different for everyone,	W	159				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/07/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		49G056	B. WING _			07/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VINCES P	LACE/CHASES WAY				20 BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 159	capable of accomplisit tasks like setting the t around mealtime. Wh she was ultimately rest the IPP development A review of the facility revealed in part: "The responsible for ensuri- provided in accordance No further information 2. For Individual #2 (I2 the IPP was written in implemented for medi- failed to identify object independence in bath On 7/11/23 at 3:22 p.1 in her wheelchair in th facility. DSP (direct su administered eye drop the physician's order. saying: "Are you read you. All done." DSP # else to the individual a administration. A review of I2's IPP (ii dated 12/21/22 revea "GoalMedication Su safe as agreed upon i [medications] as press information about the my medicationsDSF engaging in conversa facial expressions reg	hing more independent table and clearing the table en asked, ASM #1 stated sponsible for all aspects of and implementation. y policy, "Active Treatment," e designated [QIDP] is ing that active treatment is ce with this policy." h was provided prior to exit. 2), the QIDP failed to ensure a clear manner and was ication administration; and ctives likely to promote ing. m., I2 was observed sitting ne common area of the upport personnel) #3 ps to I2 in accordance with DSP #3 addressed I2 ly? One, two, three. Thank 43 did not say anything to at the time of the eye drop ndividual program plan) led, in part: upportI will be healthy and in my planDSP will apply cribed. I will learn side effects associated with	W	159			

Facility ID: VAVINCPLA

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 09/07/2023 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G056	B. WING		_	07/	13/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 PF SUFFOLK, VA 23439	RUDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 159	to bathe dailyI will re- bathingI will receive necessary supplies for receive support from I personnel) during my the washcloth when h my bath time." On 7/13/23 at 9:45 a.I staff member) #1, the disability professional asked who is ultimate sure interventions are she is ultimately respo- was not implemented the medication's side ultimately responsible written with clear instr stated: "I am." She sta IPP for medication ad clearly written. When toward independence whenever possible du living), she stated tho probably should be at what you are saying. When asked, ASM #1 responsible for all asp development and imp No further information 3. For Individual #3 (I the IPP was implement identify objectives like in toileting. On 7/11/23 at 1:35 p.I	eceive support with support with gathering r my bath/shower. I will DSP (direct support bath/shower. I will accept anded to me by DSP during m., ASM (administrative QIDP (qualified intellectual) was interviewed. When ly responsible for making implemented, she stated onsible. She stated the plan if the staff did not address effects. When asked who is for making sure the IPP is uctions for the DSP, she ated she could see how the ministration for I2 was not asked if interventions should be attempted ring ADLs (activities of daily se types of interventions tempted. She stated: "I see We at least need to try." stated she was ultimately pects of the IPP	W 159				

Facility ID: VAVINCPLA

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	-	ID HUMAN SERVICES				FORM): 09/07/2023 I APPROVED
							0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		49G056	B. WING			07/	13/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 PI SUFFOLK, VA 23439	RUDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 159	(direct support persor 13, and was feeding I3 #2 was not assisting I feeding in any way. On 7/11/13 at 5:47 p.1 in a wheelchair at the (direct support persor 13, and was feeding I3 #4 was not assisting I3 feeding in any way. A review of I3's IPP d part: "GoalDietary using hand over hand spoon independently. On 7/11/23 at 4:50 p.1 in her wheelchair in th behind the wheelchai "Let's go check you." back into her bedroor care. A review of I3's IPP d part: "GoalToileting. constipation and skin supported with my toi hours dailyDSP will movement each shift. checking her briefs to On 7/13/23 at 9:45 a. staff member) #1, the disability professional asked who is ultimate sure interventions are she is ultimately response	annel) #2 was sitting beside 3 using a soft spoon. DSP 13 with hand over hand m., 13 was observed sitting dining room table. DSP annel) #4 was sitting beside 3 using a soft spoon. DSP 13 with hand over hand ated 6/27/23 revealed, in .DSP will support me by a and allowing me to hold my "." m., 13 was observed reclined he day room. DSP #2 walked r, unlocked it, and said: DSP pushed the individual m and provided incontinence ated 4/26/23 revealed, in I like to remain free from breakdownI will be leting schedule every two	W 159				

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							FORM): 09/07/2023 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		49G056	B. WING				07/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
VINCES P	LACE/CHASES WAY			Ρ	PO BOX 976, 4373/4395 PRU	DEN BOULEVARD		
				S	SUFFOLK, VA 23439			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FFICIENCY)		(X5) COMPLETION DATE
W 159	individual to hold the stold about the observation 7/11/23, she review She stated: "[I3] is provindependent with toile interventions toward i attempted despite the an individual might or stated those types of should be attempted. are saying. We at least ASM #1 stated she we all aspects of the IPP implementation. No further information 4. For Individual #5 (I8 the IPP was written in implemented for medication for 7/11/23 at 6:04 p. If in a chair in the medication growth, and drank wat down. DSP #3 did not with 15 about the medication identify my pills and least a special and the medication is the information of the	ng assistance or allow the spoon independently. When ations regarding toileting I3 wed I3's IPP for toileting. bably not capable of being eting." When asked if independence should be e staff's expectation of what might not want to do, she interventions probably She stated: "I see what you st need to try." When asked, as ultimately responsible for development and in was provided prior to exit. 5), the QIDP failed to ensure a clear manner and was ication administration. m., I5 was observed sitting cation room. DSP (direct B prepared medications to . DSP #3 said to I5: "What's ne DSP her name. DSP #3 ins to I5, and I5 poured the medication cup into her ter to wash the medications t have any further discussion	W	159				

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	-	D HUMAN SERVICES					FORM): 09/07/2023 MAPPROVED). 0938-0391
CENTERS FOR MEDICARE 8 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G056	B. WING				07/	13/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZI	P CODE		
	LACE/CHASES WAY				O BOX 976, 4373/4395 PRUDEN	BOULEVARD		
					UFFOLK, VA 23439			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD B		(X5) COMPLETION DATE
W 159	Continued From page staff member) #1, the disability professional asked who is ultimate sure interventions are she is ultimately respo- was not implemented the medication's side resident on identifying asked who is ultimate sure the IPP is writter the DSP, she stated: ' see how the IPP for m I5 was not clearly write No further information INDIVIDUAL PROGR CFR(s): 483.440(c)(4 The individual program objectives necessary as identified by the co- required by paragraph This STANDARD is m Based on observation document review, and facility staff failed to id improve an individual' independently for three survey sample, Individ The findings include: 1. For Individual 11 (11	 9 QIDP (qualified intellectual) was interviewed. When ly responsible for making implemented, she stated onsible. She stated the plan if the staff did not address effects or work with the g the medications. When ly responsible for making with clear instructions for "I am." She stated she could nedication administration for ten. was provided prior to exit. AM PLAN m plan states the specific to meet the client's needs, omprehensive assessment n (c)(3) of this section. Not met as evidenced by: ns, staff interviews, facility a clinical record review, the dentify objectives likely to a sability to function se of six individuals in the duals #1, #2, and #3.), the facility staff failed to at objectives to promote 	W	227				
		m., I1 was observed sitting n. ASM (administrative staff						

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	-	ID HUMAN SERVICES				FORM): 09/07/2023 MAPPROVED
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE). 0938-0391 SURVEY LETED
		49G056	B. WING _			07/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				Р	O BOX 976, 4373/4395 PRUDEN BOULEVARD		
VINCES P	LACE/CHASES WAY			S	SUFFOLK, VA 23439		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
W 227	was almost ready, an hands. 11 independent and washed her hand and silverware on the spot. 11 sat down at th served 11's plate in the down on 11's placema 11 independently fed h standard plate and sil eating, she pushed he and went back to the cleared 11's dishes, na the table, and put the A review of 11's IPP (I dated 12/20/22 revea "GoalDietaryI will ordered by my physic the dietician." The pla objectives toward inde or after mealtimes. On 7/13/23, ASM #2 w interview. On 7/13/23 at 9:45 a. (qualified intellectual of interviewed. When as treatment, she stated and the goals should personalized for each facility staff is "constat treatment by engaging other than what might told about the observa for 11, she reviewed 11's tated: "[11] is probab	hselor, told 11 that dinner d instructed 11 to wash her titly walked to the bathroom ls. ASM #2 set a placemat dining room table at 11's he dinner table. ASM #2 e kitchen, and set the plate at on the dining room table. herself dinner using a verware. When 11 finished er chair back from the table recreation room. ASM #2 apkin, and silverware from dishes in the dishwasher. ndividual Program Plan) led, in part: follow my meal plan as ian and recommended by in contained no evidence of ependence before, during, was not available for m., ASM #1, the QIDP disability professional) was iked to define active it is different for everyone,	W	227			

Facility ID: VAVINCPLA

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 09/07/2023 1 APPROVED 2: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY
		49G056	B. WING			07/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 Pl SUFFOLK, VA 23439	RUDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 227	attempted despite the an individual might or stated those types of should be attempted. are saying. We at least is independent in mar capable of accomplish tasks like setting the t around mealtime. A review of the facility revealed, in part: "Eac Person-Centered Plan shall be measurable i progression from dep functioning and should to be accomplished a of functioning. No further information 2. For Individual #2 (I2 identify and implement independent function A review of I2's IPP de part: "GoalPersonal dailyI will receive su receive support with g for my bath/shower. I DSP (direct support p bath/shower. I will acc handed to me by DSF On 7/12/23 at 2:27 p.1 frequently with I2, was she tells I2 when it's t	d independence should be e staff's expectation of what might not want to do, she interventions probably She stated: "I see what you st need to try." She stated 11 by functions, and is likely hing more independent table and clearing the table r policy, "Active Treatment," ch individual will have a in (PCP)/IPPThe goals in terms of the individual's endent to independent d reflect both specific skills ind a general, desired level in was provided prior to exit. 2), the facility staff failed to at objectives to promote for personal hygiene. ated 12/21/22 revealed, in HygieneI like to bathe upport with bathingI will gathering necessary supplies will receive support from	W 22	7			

Facility ID: VAVINCPLA

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM): 09/07/2023 APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	
		49G056	B. WING		_	07/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 PF SUFFOLK, VA 23439	RUDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 227	She stated she (DSP She stated she was n expectations or interve daily bath. On 7/13/23 at 9:45 a.r (qualified intellectual of interviewed. When as treatment, she stated and the goals should b personalized for each facility staff is "consta treatment by engaging other than what might asked if interventions should be attempted v ADLs (activities of dai types of interventions attempted. She stated "capable" of much mo IPP. She stated: "I set at least need to try." No further information 3. For Individual #3 (IX identify and implement independent function On 7/11/23 at 4:50 p.r in her wheelchair in th behind the wheelchair "Let's go check you." back into her bedroon care.	 #1) "does all the washing." to aware of any other entions for I2 regarding the m., ASM #1, the QIDP disability professional) was sked to define active it is different for everyone, be specific and individual. She stated the intly implementing" active g the individuals in ways to be stated in a plan. When toward independence whenever possible during ily living), she stated those probably should be d she was not sure I2 was one than was listed in the e what you are saying. We n was provided prior to exit. 3), the facility staff failed to not objectives to promote for toileting. m., I3 was observed reclined the day room. DSP #2 walked r, unlocked it, and said: DSP pushed the individual in and provided incontinence 	W 227				

Facility ID: VAVINCPLA

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 49G056 B. WING 07/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 976, 4373/4395 PRUDEN BOULEVARD VINCES PLACE/CHASES WAY SUFFOLK, VA 23439 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 227 Continued From page 13 W 227 supported with my toileting schedule every two hours daily...DSP will monitor for bowel movement each shift...DSP will support [13] by checking her briefs to prevent skin breakdown." On 7/12/23 at 2:35 p.m., DSP #2 was interviewed. When asked about what she does to promote I3's independence in toileting, she stated she was not sure. She stated: "I usually just check her every couple of hours and change her when it's needed." On 7/13/23 at 9:45 a.m., ASM #1, the QIDP (qualified intellectual disability professional) was interviewed. When asked to define active treatment, she stated it is different for everyone, and the goals should be specific and personalized for each individual. She stated the facility staff is "constantly implementing" active treatment by engaging the individuals in ways other than what might be stated in a plan. When told about the observations regarding toileting I3 on 7/11/23, she reviewed I3's IPP for toileting. She stated: "[13] is probably not capable of being independent with toileting." When asked if interventions toward independence should be attempted despite the staff's expectation of what an individual might or might not want to do, she stated those types of interventions probably should be attempted. No further information was provided prior to exit. W 234 INDIVIDUAL PROGRAM PLAN W 234 CFR(s): 483.440(c)(5)(i) Each written training program designed to implement the objectives in the individual program plan must specify the methods to be

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 09/07/2023

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 09/07/2023 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY
		49G056	B. WING		_	07/	13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VINCES P	LACE/CHASES WAY		1	PO BOX 976, 4373/4395 PR	RUDEN BOULEVARD		
				SUFFOLK, VA 23439			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 234	used. This STANDARD is m Based on observation document review, and facility staff failed to c be used for promoting active treatment for tw survey sample, Individ The findings include: 1. For Individual #2 (I2 clearly state the steps individual about side e during medication adm On 7/11/23 at 3:22 p.r in her wheelchair in th facility. DSP (direct su administered eye drop the physician's order. saying: "Are you read you. All done." DSP # else to the individual a administration. A review of I2's IPP (in dated 12/21/22 reveal "GoalMedication Su safe as agreed upon in [medications] as prese information about the my medicationsDSF engaging in conversal	 bot met as evidenced by: n, staff interview, facility clinical record review, the learly state the methods to n independence through vo of six individuals in the duals #2 and #5. 2), the facility staff failed to to be taken to educate the effects of the medication ninistration. m., I2 was observed sitting te common area of the upport personnel) #3 to to I2 in accordance with DSP #3 addressed I2 y? One, two, three. Thank 3 did not say anything to at the time of the eye drop ndividual program plan) ed, in part: pportI will be healthy and n my planDSP will apply cribed. I will learn side effects associated with will support me with tion through gestures and arding the side effects of 	W 234				

Facility ID: VAVINCPLA

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 09/07/2023 APPROVED 2: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY
		49G056	B. WING		_	07/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 PF SUFFOLK, VA 23439	RUDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 234	administers medication 12. She stated: "I will tis. I will ask her if it is When asked if she tail the side effects of the don't usually say anyt look for the side effect When asked to review support and to determ DSP are clear, DSP # stated: "I'm not really say. What is she support On 7/12/23 at 3:40 p.1 interviewed. She stated about the side effects stated she needed to exactly what is support administering her eye IPP, DSP #3 stated she exactly she was support was supposed to say On 7/13/23 at 9:45 a.1 staff member) #1, the disability professional asked who is ultimate sure the IPP is writtent the DSP, she stated: ' see how the IPP for m I2 was not clearly writt No further information 2. For Individual #5 (Red) clearly state the steps	 ans, including eye drops, to ell her what the medication okay for me to give it." ks with the individual about medications, she stated: "I hing to her about it, but I to see if she is having it." v I2's IPP for medication ine if the instructions for the 1 reviewed the IPP. She sure what I'm supposed to bosed to do? I'm not sure." m., DSP #3 was ed she does not talk to I2 of the medication. She review I2's IPP to know sed to be done while drops. After reviewing the ne was not clear about what osed to say, and when she it. m., ASM (administrative QIDP (qualified intellectual) was interviewed. When ly responsible for making with clear instructions for "I am." She stated she could hedication administration for ten. a was provided prior to exit. 5), the facility staff failed to to be taken to educate the effects of the medication 	W 234				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/07/2023 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		49G056	B. WING			07/	13/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VINCES P	PLACE/CHASES WAY				PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
W 234	On 7/11/23 at 6:04 p.1 in a chair in the medic support personnel) #3 be administered to 15. your name?" 15 told th handed the medicatio medications from the mouth, and drank wat down. DSP #3 did not with 15 about the med A review of 15's IPP d part: "GoalMedicati identify my pills and le side effects associate On 7/12/23 at 2:27 p.1 interviewed. She state administers medicatio her name. Then I give asked if she talks with side effects of the me don't usually say anyt look for the side effect When asked how she are in place to suppor toward independence she stated: "When we supposed to read it. V we just know." When medication support ar instructions for the DS reviewed the IPP. She it's clear at all."	m., I5 was observed sitting cation room. DSP (direct 3 prepared medications to . DSP #3 said to I5: "What's he DSP her name. DSP #3 ons to I5, and I5 poured the medication cup into her ter to wash the medications t have any further discussion dications. ated 3/20/23 revealed, in ionI will earn (sic) how to earn information about the ed with my medications." m., DSP #1 was ed she frequently ons to I5. She stated: "I'll ask e the medication." When n the individual about the edications, she stated: "I thing to her about it, but I et to see if she is having it." e knows what interventions rt an individual's progress e as documented on the IPP, e are hired, we are <i>Ne</i> are here with them, and asked to review I5's IPP for nd to determine if the SP are clear, DSP #1 e stated: "No. I don't think	W	234			

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	-	ID HUMAN SERVICES): 09/07/2023 I APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				<u>OMB NO</u>	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G056	B. WING		_	07/ [,]	13/2023
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 PF SUFFOLK, VA 23439	RUDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 234	She stated: [I5] is so s take all those pills." A #3 stated she was no	e 17 slow; it takes her forever to fter reviewing the IPP, DSP ot clear about what exactly say to I5 about the side	W 234				
	effects of the medicat supposed to say it.	tions, or how she was					
	staff member) #1, the disability professional asked who is ultimate sure the IPP is written the DSP, she stated:	m., ASM (administrative e QIDP (qualified intellectual I) was interviewed. When ely responsible for making n with clear instructions for "I am." She stated she could nedication administration for tten.					
W 249			W 249				
	each client must rece treatment program co interventions and serv and frequency to supp	ndividual program plan, ive a continuous active					
	Based on observation document review, and facility staff failed to ir	not met as evidenced by: n, staff interview, facility d clinical record review, the mplement the IPP (individual ee of six individuals in the duals #2. #3, and #5.					

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	-	D HUMAN SERVICES				FORM	0: 09/07/2023
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	
		49G056	B. WING		_	07/ [,]	13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 PR SUFFOLK, VA 23439	UDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	implement the IPP for on 7/11/23 at 3:22 p.r in her wheelchair in th facility. DSP (direct su administered eye drop the physician's order. saying: "Are you read you. All done." DSP # else to the individual a administration. A review of I2's IPP (in dated 12/21/22 revea "GoalMedication Su safe as agreed upon in [medications]as prese information about the my medicationsDSF engaging in conversa facial expressions reg my medications." On 7/12/23 at 2:27 p.r interviewed. She state administers medication I2. She stated: "I will t is. I will ask her if it is When asked if she tal the side effects of the don't usually say anyt	2), the facility staff failed to medication administration m., I2 was observed sitting the common area of the upport personnel) #3 ps to I2 in accordance with DSP #3 addressed I2 y? One, two, three. Thank to add not say anything to at the time of the eye drop ndividual program plan) led, in part: upportI will be healthy and in my planDSP will apply cribed. I will learn side effects associated with P will support me with tion through gestures and yarding the side effects of m., DSP #1 was	W 24		DEFICIENCY)		
	are in place to suppor	knows what interventions t an individual's progress as documented on the IPP,					

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	-					FORM	0: 09/07/2023
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		49G056	B. WING			07/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 PI SUFFOLK, VA 23439	RUDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	she stated: "When we supposed to read it. V we just know." On 7/12/23 at 3:40 p.r interviewed. She state about the side effects stated she needed to exactly what is suppo- administering her eye On 7/13/23 at 9:45 a.r staff member) #1, the disability professional stated the plan was no did not address the m A review of the facility revealed, in part: "Eac Person-Centered Plar setting forth measural integrated program of therapies, activities ar achieve such goals or [QIDC] is responsible treatment is provided. 2. For Individual #3 (IS implement the IPP for On 7/11/23 at 1:35 p.r in a wheelchair at the (direct support person I3, and was feeding I3 #2 was not assisting I feeding in any way. On 7/11/13 at 5:47 p.r	e are hired, we are We are here with them, and m., DSP #3 was ed she does not talk to I2 of the medication. She review I2's IPP to know sed to be done while edrops. m., ASM (administrative c QIDP (qualified intellectual) was interviewed. She ot implemented if the staff nedication's side effects. c policy, "Active Treatment," ch individual will have a n/IPP which is a written plan ble outcomes foran f individually designed and experiences necessary to r objectives. The designated for ensuring that active	W 249				

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	-	D HUMAN SERVICES				FORM	0: 09/07/2023
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	
		49G056	B. WING		_	07/ [.]	13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
VINCES P	LACE/CHASES WAY			PO BOX 976, 4373/4395 PR SUFFOLK, VA 23439	UDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	(direct support persor 13, and was feeding 13 #4 was not assisting I feeding in any way. A review of 13's IPP d part: "GoalDietary using hand over hand spoon independently. On 7/12/23 at 2:35 p. takes care of 13, was would have to check t hand over hand feedi she did not know the hold the spoon independently be messy." On 7/13/23 at 9:45 a. staff member) #1, the disability professional stated the plan was n did not provide hand of assistance or allow the spoon independently. No further information 3. For Individual #5 (I implement the IPP for on 7/11/23 at 6:04 p.1 in a chair in the medic support personnel) #3 be administered to 15. your name?" I5 told th handed the medication	anel) #4 was sitting beside 3 using a soft spoon. DSP 3 with hand over hand ated 6/27/23 revealed, in DSP will support me by 1 and allowing me to hold my " m., DSP #2, who frequently interviewed. She stated she to see if I2 was to receive ng assistance. She stated individual was allowed to endently. She stated: "It m., ASM (administrative QIDP (qualified intellectual) was interviewed. She ot implemented if the staff over hand feeding e individual to hold the	W 245				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/07/2023 APPROVED . 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	SURVEY
		49G056	B. WING		_	07/1	3/2023
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
VINCES P	PLACE/CHASES WAY) BOX 976, 4373/4395 PRU JFFOLK, VA 23439	UDEN BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC) CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	mouth, and drank wat down. DSP #3 did not with I5 about the med A review of I5's IPP d part: "GoalMedicati identify my pills and le side effects associate On 7/12/23 at 2:27 p.1 interviewed. She state administers medication her name. Then I give asked if she talks with side effects of the me don't usually say anyt look for the side effect When asked how she are in place to suppor toward independence she stated: "When we supposed to read it. V we just know." On 7/12/23 at 3:40 p.1 interviewed. She state about the side effects not ask the individual She stated: [I5] is so take all those pills." On 7/13/23 at 9:45 a.1 staff member) #1, the disability professional stated the plan was n	ter to wash the medications t have any further discussion dications. ated 3/20/23 revealed, in ionI will earn (sic) how to earn information about the ed with my medications." m., DSP #1 was ed she frequently ons to 15. She stated: "I'll ask e the medication." When in the individual about the edications, she stated: "I thing to her about it, but I et to see if she is having it." e knows what interventions rt an individual's progress e as documented on the IPP, e are hired, we are We are here with them, and m., DSP #3 was ed she did not talk to I5 of the medications and did to identify each medication. slow; it takes her forever to m., ASM (administrative e QIDP (qualified intellectual I) was interviewed. She ot implemented if the staff nedication's side effects or	W 249				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 09/07/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		49G056	B. WING			07	/13/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VINCES P	LACE/CHASES WAY				PO BOX 976, 4373/4395 PRUDEN BOULEVARD SUFFOLK, VA 23439		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG W 249	Continued From page			249	DEFICIENCY)	RATE	

Event ID: I4EV11

Facility ID: VAVINCPLA

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