Voice/TDD (540)373-3223 / Fax (540) 371-3733

NOTICE

To: Program Planning & Evaluation Committee: Nancy Beebe, Glenna Boerner, Claire Curcio, Ken Lapin, Susan Muerdler, Jacob Parcell, Sarah Ritchie, Carol Walker, Matt Zurasky

From: Joseph Wickens
Executive Director

Subject: Program Planning & Evaluation Committee Meeting
February 14, 2023, 10:30 AM
600 Jackson Street, Board Room 208, Fredericksburg, VA

Date: February 09, 2023

A Program Planning & Evaluation Committee meeting has been scheduled for Tuesday, February 14, 2023 at 10:30 AM. The meeting will be held at 600 Jackson Street, Board Room 208, Fredericksburg VA 22401.

Looking forward to seeing you on February 14th at 10:30 AM

Cc: Nancy Beebe, Chairperson

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Program Planning and Evaluation Committee Meeting

February 14, 2023 – 10:30 AM

600 Jackson Street, Room 208 Fredericksburg, VA 22401

Agenda

MEMORANDUM

TO: Joe Wickens, Executive Director

FROM: Patricia Newman – Mental Health Case Management Supervisor
Elizabeth Wells – Lead State Hospital Liaison & NGRI Coordinator
Chanda Bernal – Adult Mental Health Case Manager

PC: Brandie Williams – Deputy Executive Director
Jacqueline Kobuchi, LCSW – Clinical Services Director
Amy Jindra – Community Support Services Director
Nancy Price – MH Residential Coordinator
Tamra McCoy – ACT Coordinator
Jennifer Acors – Coordinator Developmental Services Support Coordination

SUBJECT: Extraordinary Barriers List (EBL)

DATE: February 14, 2023

RACSB currently has two individuals on the Extraordinary Barriers List (EBL), to include one individual at Southern Virginia Mental Health Institute (SVMHI) and one individual at Western State Hospital (WSH). Individuals ready for discharge from state psychiatric hospitals are placed on the EBL when placement in the community is not possible within 7 days of readiness, due to barriers caused by waiting lists, resource deficits, or pending court dates.

Southern Virginia Mental Health Institute

Individual #1: Was placed on the EBL 12/4/22. Barriers to discharge include identifying and being accepted to an assisted living facility (ALF) that can meet both their physical and psychiatric needs. The individual's treatment team is working to complete the Uniform Assessment Instrument (UAI), which will be used to refer this individual to ALFs that are willing to accept registered sex offenders. This individual is not always cooperative with staff with regard to completing their activities of daily living, causing it to be challenging to provide them with care. This individual also requires a legal guardian and have been referred to Jewish Family Services to continue this process. An additional challenge to identifying an accepting placement will be that this individual is a Tier III Registered Sex Offender. This individual will discharge once accepted to an ALF and once a guardian is in place.

Western State Hospital

Individual #2: Was placed on the EBL 12/27/22. Barriers to discharge include working through current legal charges as well as being accepted to an ALF that is able to support their needs. This individual has resided in the community as well as in RACSB Supervised Apartments, however it has been determined that they require a higher level of care with more support and supervision.

They will also benefit from an ALF that has a younger population. The treatment team is currently in communication with Heart2Heart ALF regarding possible placement for this individual. They will discharge to the community once they are able to work through their legal charges and are accepted to an ALF.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Donna Andrus, Child and Adolescent Support Services Supervisor
Date: January 6, 2023
Re: Independent Assessment Certification and Coordination Team (IACCT) Update
****

I am writing to provide an update to the Independent Assessment Certification and Coordination Team (IACCT) program. The Department of Medical Assistance Services (DMAS) with Magellan launched the IACCT program July 1, 2017. The Rappahannock Area Community Services Board is the IACCT provider for Planning District 16.

RACSB received twelve IACCT referrals and completed eleven assessments in the month of January. Seven referrals were initial IACCT assessments and five were re-authorizations. Four were from Spotsylvania, five from Stafford, two from Caroline, none from King George and one from the City of Fredericksburg. One initial IACCT was withdrawn by the parent. Of the eleven completed assessments in January, six recommended Level C Residential, four recommended Level Group Home, one recommended community-based services. No reauthorizations recommended discharge at this time.

Attached is the monthly IACCT tracking data for January 2023.

Report Month/Year	Jan-23
1. Total number of Referrals from Magellan for IACCT:	12
1.a. total number of auth referrals:	7
1.b. total num. of re-auth referrals:	5
2. Total number of Referrals per county:	
Fredericksburg:	1
Spotsylvania:	4
Stafford:	5
Caroline:	2
King George:	0
Other:	
3. Total number of extensions granted:	2
4. Total number of appointments that could not be offered within the prescribed time frames:	0
5. Total number of "no-shows":	0
6. Total number of cancellations:	1
7. Total number of assessments completed:	11
8a. Total number of ICA's recommending: **residential:**	6
8b. Total number of ICA's recommending: **therapeutic group home:**	4
8c. Total number of ICA's recommending: **community based services:**	1
8g.Total number of ICA's recommending: **Other:**	0
8h.Total number of ICA's recommending: **no MH Service:**	0
9. Total number of reauthorization ICA's recommending: **requested service not continue:**	0
10. Total number of notifications that a family had difficulty accessing **any** IACCT-recommended service/s:	0

To: Joe Wickens, Executive Director

From: Suzanne Poe, IT Coordinator

Re: Information Technology and Electronic Health Record Update

Date: February 7, 2023

This report provides an update on projects related to Information Technology and the Electronic Health Record. The IT department completed 983 tickets in the month of January. Information is provided on state reporting initiatives, facility technology needs, and on-going projects.

Information Technology and Electronic Health Record Update

IT Systems Engineering Projects
During January 2023, 983 tickets where closed by IT Staff.

The Average number of tickets closed in 2022 was 1,023 per month.

IT is working with staff from Permanent Supportive Housing to order and setup their networking and IT needs for their new space at the Bowman center. All of their equipment and services are on order and should be installed prior to the March 1, 2023 move in date.

Community Consumer Submission 3
The December 2022 CCS was submitted on January 26, 2023. Staff reviewed and provided input on the draft specifications for the upcoming fiscal year CCS changes.

Waiver Management System (WaMS)
DBHDS has released their new 2023 specifications for ISP version 3.4. Netsmart and the IT team have implemented the ISP changes into the Avatar test system and are waiting for DBHDS to open the WaMS testing period. IT staff are continuing to meet with DBHDS, WaMS, and Netsmart to discuss ISP 3.4 changes/testing period.

On January 30, 2023 DBHDS changed the transfer mechanism of how WaMS and Electronic Heath Records communicate. There was a brief testing period the week prior. Netsmart is still working through a communication issue, between systems. In the interim, IT is working with ID/DD Case Management to directly enter service plans.

Trac-IT Early Intervention Data System
In November, RACSB program and IT staff attended a demo on the upload functionality for Trac-It. This functionality will be key for our ability to meet expanded data requirements when the new date for that implementation is announced. After the demo, there are system-wide concerns around the functionality. We met as part of the DMC Trac-IT workgroup with DBHDS Part C Staff to express our concerns. There are no additional updates since that meeting.

Zoom
We continue to utilize Zoom for telehealth throughout the agency.

- January 2023 – 2,402 video meetings with a total of 6,668 participants
- Average from January to December 2022 was 2,800 video meetings and 8,154 Participants
- Average from January to December 2021 was 3,648 video meetings and 11,087 Participants

Avatar
The ACT and PEID teams are using Bells to create notes, however they both discovered a problem with how the notes are currently displaying in Avatar. IT met with the Bells team on February 3, 2023 to discuss upcoming features and the note display issue. The Bells team is reviewing the issue and will provide guidance on how to correct the issue.

Camera System and Maintenance Request for Proposals-
The IT department has decided due to the cost of camera maintenance and that we maintain the Axis camera systems in house and replace the Alibi systems as they breakdown.

Staffing

The IT department will have 1 vacant Data Analyst position. The current Data Analyst, Robert Rezendes, is staying within RACSB but moving back to Quality Assurance. The date of his transfer is TBD.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Tabitha Taylor, Emergency Services Law enforcement liaison
Date: February 8, 2023
Re: Crisis Assessment Center and CIT report January 2023

The CIT Assessment Center assessed 20 individuals in the month of January 2023. The number of persons served by locality were the following: Fredericksburg 6; Caroline 4; King George 2; Spotsylvania 6; Stafford 4.

The CIT program held it's first 40-hour training for law enforcement. Twenty two individuals were trained from the following jurisdictions: Rappahannock Regional Jail, Ft. Belvoir, District 21 probation, Stafford, King George, Spotsylvania, Fredericksburg City and Germanna.

Please see attached CIT data sheet

January 2023 RACSB CIT Assessment Center Data

Date	Number of ECOs Eligible To Utilize CAC Site	Number of Individuals Assessed at CAC Site	Locality who brought Individual	Locality working at the Assessment Site
1/1/2022	1	1	Caroline	Spotsylvania/Stafford
1/2/2022	0	0	n.a	Fredericksburg
1/3/2022	3	1	Spotsylvania	Spotsylvania
1/4/2022	3	2	Spotsylvania/Fredericksburg	Spotsylvania
1/5/2022	0	0	n/a	Spotsylvania
1/6/2022	2	1	Spotsylvania	Spotsylvania
1/7/2022	1	0	n.a	Spotsylvania
1/8/2022	2	0	n/a	Spotsylvania
1/9/2022	1	0	n.a	Spotsylvania/Fredericksburg
1/10/2022	1	0	n.a	Spotsylvania
1/11/2022	1	1	Stafford	Spotsylvania
1/12/2022	5	0	n.a	Spotsylvania/Stafford
1/13/2022	2	0	n.a	Spotsylvania
1/14/2022	0	0	n.a	Spotsylvania
1/15/2022	5	1	Fredericksburg	Spotsylvania/King george
1/16/2022	6	0	n/a	Spotsylvania
1/17/2022	6	0	n.a	Spotsylvania/Stafford
1/18/2022	3	2	Fredericksburg (2)	Spotsylvania
1/19/2022	4	1	Fredericksburg	Spotsylvania/Fredericksburg
1/20/2022	2	1	Stafford	Spotsylvania/Stafford
1/21/2022	2	2	Spostylvania; King George	Spotsylvania/Fredericksburg
1/22/2022	1	0	n.a	Spotsylvania/Stafford
1/23/2022	1	1	Spotsylvania	Spotsylvania
1/24/2022	3	0	n.a	Spotsylvania
1/25/2022	2	0	n/a	Spotsylvania
1/26/2022	1	1	Stafford	King George
1/27/2022	2	2	Fredericksburg; King George	Spotsylvania/Fredericksburg
1/28/2022	3	1	Stafford	Spotsylvania
1/29/2022	1	0	n.a	Spotsylvania/King george
1/30/2022	4	2	Spotsylvania/Caroline	Spotsylvania/Fredericksburg
1/31/2022	0	0	n/a	King George
Total	68	20		

Total Assessments at Center in January: 20

Brought by:		**Cumulative Total:**
Caroline	4	143
Fred City	6	1006
Spotsylvania	6	954
Stafford	4	993
King George	2	124
Other	0	3

Cumulative number of Assessment since September 2016: 3223

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Kari Norris, Emergency Services Coordinator
Date: February 8, 2023
Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – January, 2023

In January 2023, Emergency Services staff completed 389 emergency evaluations. Eighty-one emergency custody orders were assessed and eighty six total temporary detention orders served of the 389 evaluations. Staff facilitated four admissions to a state hospital. The two adult admissions went to NVMHI. Two admissions were adolescents and children and were admitted to CCCA.

A total of nineteen individuals were involuntarily hospitalized outside of our catchment area in January. Four individuals were able to utilize alternative transportation and four others were appropriate, but unable to utilize due to no available driver.

Please see attached data reports.

DATE: 2.8.2023

Emergency Services Activity Reports

Month	Contacts	Evaluations	ECOs	TDOs Issued	TDOs Executed
September 2020	[redacted]	422	94	91	91
October 2020		492	113	85	85
November 2020		413	88	88	88
December 2020		373	75	79	79
January 2021		374	88	89	89
February 2021		358	84	83	83
March 2021		465	82	100	100
April 2021		449	92	100	100
May 2021		507	93	93	93
June 2021		453	95	95	92
July 2021		379	76	74	74
August 2021		394	86	77	77
September 2021		517	98	86	86
October 2021		422	60	72	72
November 2021		425	59	60	60
December 2021		401	67	66	66
January 2022		355	74	63	63
February 2022		442	87	64	64
March 2022		375	74	81	81
April 2022		390	85	87	87
May 2022		417	92	73	73
June 2022		342	75	66	66
July 2022		343	77	83	83
August 2022		367	79	76	76
Setpember 2022		341	66	76	76
October 2022		351	70	75	75
November 2022		359	69	73	73
December 2022		296	55	51	51
January 2023		389	81	86	86

FY23 CSB/BHA Form (Revised: 06/28/2022)

CSB/BHA	Rappahannock Area Community Services Board	Month	January 2023

1) Number of Emergency Evaluations	2) Number of ECOs			3) Number of Civil TDOs Issued	4) Number of Civil TDOs Executed				5) Number of Criminal TDOs Executed
	Magistrate Issued	Law Enforcement Initiated	Total		Minor	Older Adult	Adult	Total	
389	32	49	81	84	10	3	71	84	2
			0					0	

FY '23 CSB/BHA Form (Revised: 06/28/2022)

CSB/BHA	Rappahannock Area Community Services B	Reporting month	January 2023		No Exceptions this month	

Date	Consumer Identifier	1) Special Population Designation (see definition)	1a) Describe "other" in your own words (see definition)	2) "Last Resort" admission (see definition)	3) No ECO, but "last resort" TDO to state hospital (see definition)	
1/6/23	41458	Adolescent		Yes	No	CCCA
1/15/23	16700			Yes	No	NVMI
1/12/23	71729	Child		Yes	No	CCCA
1/14/23	39376			No	Yes	NVMHI

ALTERNATIVE TRANSPORT DATA January 2023

Date	ID	LE DEPT	Location of Individual	Receiving Hospital	Travel time Round Trip (minutes)	ECO Y or N	Gender	Age	TDO criteria	Presented for AT: Y or N	Reason for Decline
1/4/23	100404	Caroline	MWH-ED	Clearview	644	No	F	23	Danger to self	Y	No available driver
1/4/23	108756	Spotsylvania	MWH-ED	Poplar Spring	160	Yes	F	17	Danger to self	Y	AT utilized
1/6/23	41458	Spotsylvania	MWH-ED	CCCA	240	Yes	M	16	Danger to others/Inability to care	Y	No available driver
1/8/23	86561	Spotsylvania	MWH-ED	Newport News	208	Yes	F	15	Danger to self	N	Client attempted to elope while in custody
1/12/23	72179	Spotsylvania	MWH-ED	CCCA	240	Yes	M	12	Danger to others	Y	No available driver
1/14/23	39376	Stafford	MWH Med Floor	NVMHI	100	No	F	41	Danger to self/Inability to care	Y	
1/15/23	88726	Spotsylvania	MWH-ED	Lewis Gale	344	No	F	59	Danger to self	Y	AT utilized
1/15/23	16700	Fredericksburg	MWH-ED	NVMHI	100	Yes	F	38	Danger to others/Inability to care	N	No due to aggression
1/19/23	21161	Fredericksburg	MWH-ED	Roanoke - Carillion	384	Yes	F	31	Inability to care	N	Too impulsive and erratic
1/20/23	67939	Stafford	MWH-ED	Richmond Comm Hospital	124	No	M	27	Danger to others/Inability to care	N	No due to elopement risk
1/21/23	52351	King George	MWH-ED	Poplar Spring	160	Yes	M	20	Danger to self/Other/Inability to care	N	Client too paranoid and impulsive
1/22/23	108955	Caroline	MWH-ED	Poplar Springs	160	No	F	21	Danger to self	N	Client was too aggressive in ED and assaultive
1/23/23	102153	Stafford	MWH-ED	Poplar Springs	160	No	M	31	Inability to care	N	No client is too impulsive and unpredictable
1/27/23	109029	King George	MWH-ED	Dominion	120	No	F	16	Danger to self	N	No due to agitation, impulsivity and aggression

1/28/23	84921	Fredericksburg	MWH-ED	Pavilion at Williamsburg	180	No	F	41	Danger to self	Y	Client then refused AT when they arrived
1/28/23	109032	Stafford	MWH-ED	Poplar Springs	160	No	F	30	Danger to self	Y	AT utilized
1/30/23	109057	Stafford	MWH-ED	Clearview	644	Yes	M	22	Inability to care	N	No due to aggression
1/30/23	43165	Spotsylvania	MWH-ED	Clearview	644	Yes	M	50	Danger to others/Inability to care	N	Risk for Elopement
1/30/23	104045	Caroline	MWH-ED	Newport News	208	Yes	M	11	Danger to self	Y	AT utilized

Total Out of Area			
19			
Total Utiliz	**% Utilized**	**Total Appropriate for AT**	
4	21%	8	42%

Memorandum

To: Joe Wickens, Executive Director

From: Steve Curtis, DD Residential Coordinator

Date: February 2, 2023

Re: Lucas Street, Ross Drive ICF Recertification Survey

On January 18th and 19th 2023, the Virginia Department of Health (VDH) conducted on-site visits (surveys) at Lucas Street and Ross Drive Intermediate Care Facilities (ICF's). Two medical facility inspectors (surveyors) conducted the surveys focusing on a sampling of the following from each program: Observation of 5 individuals, the supports provided to the individuals, and the individuals' charts. The surveys were conducted as an annual requirement for each program's recertification as ICF's.

The surveyors' findings were included in 2 separate program reports which we received by email on January 25th. Each report contained deficiencies listed by federal regulations (W-tags and E-tags) that did not meet standards. Out of the 401 total regulations that the programs are surveyed for, 6 deficiencies were noted for Lucas Street ICF and 2 deficiencies were noted for Ross Drive ICF.

Lucas Street ICF:

- W111: Facility staff did not ensure the clinical record was complete and accurate. Specifically:
    - The ISP did not include the need for the use of a cup with a base for an individual, whereas the home's "eating precaution plan", a meal time quick reference sheet for staff use, did mention the need for use of this particular item. The citation was incurred because the 2 documents did not match.
- W125: Facility staff did not provide a dignified dining experience for 1 individual. Specifically:
    - While supporting an individual with a meal, a staff member was standing beside the person assisting them rather than being seated beside them. The staff member responsible was brand new to working in the program and learning program protocols; this was an oversight on her part.
- W153: Facility staff failed to convey information to administration regarding an allegation of abuse in a timely manner.
    - A staff member did not make a timely report regarding an allegation of abuse to the program coordinator and Quality team in a timely fashion. (Incidentally, the RACSB Office of Consumer affairs investigated this incident upon discovery and corrective action was taken with staff.)

- W159: The Qualified Intellectual Disability Professional (QIDP) failed to accurately document the use of a cup with a base on the ISP (individual support plan).

    - This is a result of the above referenced issue with the ISP missing what the "eating precaution plan" reference sheet contained about use of the cup with a base for one individual.

- W440: The facility failed to conduct fire/evacuation drills for each shift quarterly, potentially affecting all individuals in the facility.

    - Specifically, 1 drill in March 2022 was not completed for the home. The person responsible for this issue has since resigned.

- W503: Facility staff failed to implement COVID-19 vaccination requirements for 2 of 7 employee vaccination records reviewed.

    - Out of the random sampling of all staff, 1 contractor failed to turn in a copy of her vaccination record. One staff member failed to turn in evidence of her 2nd dose of the vaccine series. Both issues went undetected in the records prior to the survey.

Ross Drive ICF:

- W159: The QIDP failed to ensure the individual's ISP (individualized service plan) for eating was implemented. The QIDP failed to ensure the individual's ISP (individualized service plan) for medication management was implemented.

    - The QIDP bears the responsibility of staff actions for this tag. During the survey, a staff member decided to feed an individual capable of feeding himself to help prevent the individual from throwing his food on the floor. For a second individual that receives his medications in applesauce, the ISP states that after staff feeds him the applesauce with the meds, he should be encouraged to take the spoon and finish the last bite of applesauce independently. The idea behind this is to slowly promote independence towards taking his own medications. Staff fed him the entire cup of applesauce without offering him the chance to participate as dictated in the plan.

- W249: Facility staff failed to implement active treatment for 2 of 3 individuals in the survey sample.

    - This tag was cited as a direct result of tag W159 in which support staff were not following the ISP support instructions for the 2 individuals.

Noted deficiencies are being corrected and plans of correction were submitted to VDH on February 2nd, 2023. The plans were approved on that same day by VDH.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET 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 01/17/2023 through 01/18/2023. 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 Fundamental Medicaid re-certification survey was conducted 01/17/2023 through 01/18/2023. 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 bed facility was four at the time of the survey. The survey sample consisted of three current individual reviews (Individuals #1, #2 and #3).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observation, staff interviews and clinical record reviews it was determined that the facility staff failed to ensure the clinical record was accurate for one of three individuals in the survey sample, Individual #2.	W 111		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 1 The findings include: For Individual #2, the facility staff failed to accurately document the use of a cup with a base on the ISP (individual support plan). Individual #2 was admitted to the facility with diagnoses that included but were not limited to: profound intellectual disability (1) and swallowing difficulties. An observation at dinner was conducted of Individual #2 on 01/17/2023 at approximately 5:00 p.m. Individual #2 was observed seated at the dinner table with other residents of the facility. Individual #2 was served his meal using the following adaptive equipment: a Dycem (2) mat, small plastic cup, flat maroon spoon and a divided plate with a guard. Further observation failed to evidence a cup with a base. Individual #2's ISP dated 04/13/2022 through 04/12/2023 documented in part, "Goal: 12. Important for: (protocol). (Individual #2) is supported to follow his prescribed nutrition and eating plan. Provide a small amount of liquid in a cup (4oz (four ounce) nosey cup can be used as well) at a time (1-2 (one to two) oz or less). Provide hand over hand or tactile prompts when drinking to help control size of sip." The facility's "Eating Precaution Plan" for Individual #2 documented in part, "Adaptive equipment required: Dycem mat, divided plate w (with)/plate guard, maroon spoon and plastic cup w/ a base and clothing protector. On 01/18/2023 at approximately 1:28 p.m., an interview was conducted with OSM (other staff	W 111	**W111** **How corrective action will be accomplished for individual #2:** Facility staff will ensure that that they document the use of a cup with a base in Individual #2's ISP (Individual Support Plan). **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will ensure that the adaptive equipment for each individual is accurately documented in their ISPs. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The Program Manager or designee will review the clinical record to ensure that the adaptive equipment for each individual is accurately documented in their ISPs. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QIDP will review, revise, and monitor the clinical records to ensure that the adaptive equipment for each individual is accurately documented in their ISPs. **Date of Completion:** 2/10/2023	2/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 2 member) #1, Qualified Intellectual Disabilities Professional (QIDP). After reviewing Individual #2's ISP, the eating precaution plan and informed of the above observation, OSM #1 stated that the ISP did not accurately document the correct cup that Individual #2 uses. OSM #1 further stated that they review the Individual's ISPs to make sure that they are accurate and that this inaccuracy was over looked. On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A non-slip, rubber-like plastic material used to stabilize surfaces. Reusable. Cut to most any size or shape with scissors. Cleans with soap and water. Blue (except where noted). Matting is 1/32" thick. Not made of natural rubber latex. Long lasting. Unlimited uses. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.ht	W 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 111	Continued From page 3 ml.	W 111	**W125** **How corrective action will be accomplished for individual #2:** Facility staff will support individual #2 to exercise his right to dignity during all meals and snacks by sitting beside him (rather than standing) when he is eating .	**2/10/2023**
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 an individual to exercise their right of dignity during a meal for one of three individuals in the survey sample, Individual #2. The findings include: For Individual #2, the facility staff stood next to the Individual as they ate their dinner. Individual #2 was admitted to the facility with diagnoses that included but were not limited to: profound intellectual disability (1) and swallowing difficulties. An observation at dinner was conducted of Individual #2 on 01/17/2023 at approximately 5:00 p.m. Individual #2 was observed seated at the dinner table with other individuals of the facility eating their dinner, feeding themselves independently, while staff provided verbal cues. Further observation revealed OSM (other staff member) #2, day support direct support professional, standing next to Individual #2 while they ate their dinner.	W 125	**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 all meals and snacks by sitting beside them (rather than standing) when they are eating. **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 meals and snacks by sitting beside them (rather than standing) when they are eating. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Dining protocols will be revised as needed and reviewed a minimum of annually with all staff and will include instructions for supporting all individuals to exercise their right to dignity during all meals and snacks by sitting beside them (rather than standing) when they are eating. ICF Management will monitor and document various shift checks to ensure that these protocols are being adhered to. **Date of Completion**: 2/10/2023	

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	49G064	A. BUILDING _____ B. WING _____	01/18/2023

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LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 125	Continued From page 4 On 01/18/2023 at approximately 1:15 p.m. an attempt was made to interview OSM #2 but was unsuccessful as they were not available. On 01/18/2023 at approximately 1:28 p.m., an interview was conducted with OSM (other staff member) #1, Qualified Intellectual Disabilities Professional (QIDP). After being informed of the above observation, OSM #1 stated that it was a dignity issue and that staff should be seated next the individuals during their meals. 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 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100	W 125		

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W 125	Continued From page 5 (2) A non-slip, rubber-like plastic material used to stabilize surfaces. Reusable. Cut to most any size or shape with scissors. Cleans with soap and water. Blue (except where noted). Matting is 1/32" thick. Not made of natural rubber latex. Long lasting. Unlimited uses. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.html.	W 125	**W153** **How corrective action will be accomplished for Individual #2:** Disciplinary action was taken with facility staff responsible for not following mandated reporting policies and protocols. Human Rights policies have been reviewed with facility staff to ensure that they will immediately report allegations of abuse for Individual #2.	**2/1/2023**
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interviews and clinical record review and facility document review it was determined that the facility staff failed to report an allegation of abuse in a timely manner for one of three individuals in the survey sample, Individual #2. The findings include: For Individual #2, the facility staff failed to convey information to administration regarding an allegation of verbal abuse in a timely manner. The facility's "Human Rights Investigation" dated 06/10/2022 documented in part, "On June 8, 2022, (OSM Other staff member) #3, compliance specialist, and OSM #4, utilization review specialist, interviewed (LPN (licensed practical nurse) #1) and (Name Staff Member). (Name of	W 153	**Assurance that other residents are protected from the possibility of the deficiency:** Human Rights policies have been reviewed with facility staff to ensure that they will immediately report allegations of abuse for all individuals. Any facility staff that fails to follow mandated reporting policies and protocols will receive disciplinary action. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** QIDP and ICF Management will monitor facility staff adherence to Human Rights policies to ensure compliance in the facility. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Human Rights policies will be reviewed at mandatory staff meetings at least annually. ICF Management will conduct ongoing 1:1 supervision meetings and team meetings to discuss/review policies, protocols, and expectations of staff to help further ensure that there are no unreported allegations or concerns. **Date of Completion:** 2/1/2023	

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W 153	Continued From page 6 LPN #1): During the interview, (LPN #1) stated that on Saturday (6/4/22) around noon, Individual #2 was eating lunch, and as typical for Individual #2, was up and down out of his chair. (LPN #1) stated that she observed DSP (direct support professional) #1 tell (Individual #2) to "Sit his ass down." (LPN #1) stated that the next day, Sunday (6/5/22) (Individual #3) slept in and between 1:00 - 2:00 pm (p.m.) she woke up and began grunting and vocalizing. (LPN #1) stated that she witnessed (DSP #1) telling (Individual #3) to "Shut up." (LPN #1) stated that she reported these incidents to her supervisor on Tuesday, because she had been off on Monday." On 01/18/2023 at approximately 1:43 p.m., an interview was conducted with ASM (administrative staff member) #1, residential coordinator. When asked about staff training regarding abuse and reporting ASM #1 stated that all staff members are mandated reporters and receive mandated reporter training when they are hired. ASM #1 further stated that if an allegation of abuse is witnessed it should be reported to the supervisor immediately. When asked how they defined "immediately" in terms of a time frame ASM #1 stated that it should be within an hour of the incident. When asked about the reporting from LPN #1 regarding the allegation of verbal abuse dated June 4th and 5th 2022, ASM#1 stated that it should have been reported immediately. On 01/18/2023 at approximately 2:07 p.m., an interview was conducted with LPN #1. When asked if they were a witness to the allegations of abuse on June 4th and 5th 2022 LPN #1 stated yes. When asked to describe the procedure for reporting allegations of abuse LPN #1 stated that they would report it to management. When	W 153		

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W 153	Continued From page 7 asked how long they would wait before reporting the allegation of abuse LPN #1 stated that they did not know. After review the facility's policy "Client Protection Section 2-3: Abuse and Neglect" LPN # 1 stated that they were not aware that an allegation of abuse should be reported immediately. The facility's policy "Client Protection Section 2-3: Abuse and Neglect" documented in part, "Any employee who witnesses any behavior prohibited by RACSB's Human Rights Plan is required to complete an incident report and immediately inform the supervisor and RACSB's Human Rights Advocate in accordance with RACSB's Code of Ethics and Corporate Compliance Plan. Failure to do so violates RACSB's Human Rights Plan and Corporate Responsibility Resolution." On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit.	W 153		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate the individuals' active treatment programs for one of three individuals in the survey sample, Individual #2.	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 159	Continued From page 8 The findings include: For Individual #2, the QIDP failed to accurately document the use of a cup with a base on the ISP (individual support plan). Individual #2 was admitted to the facility with diagnoses that included but were not limited to: profound intellectual disability (1) and swallowing difficulties. An observation at dinner was conducted of Individual #2 on 01/17/2023 at approximately 5:00 p.m. Individual #2 was observed seated at the dinner table with other residents of the facility. Individual #2 was served his meal using the following adaptive equipment: a Dycem (2) mat, small plastic cup, flat maroon spoon and a divided plate with a guard. Further observation failed to evidence a cup with a base. Individual #2's ISO dated 04/13/2022 through 04/12/2023 documented in part, "Goal: 12. Important for: (protocol). (Individual #2) is supported to follow his prescribed nutrition and eating plan. Provide a small amount of liquid in a cup (4oz (four ounce) nosey cup can be used as well) at a time (1-2 (one to two) oz or less). Provide hand over hand or tactile prompts when drinking to help control size of sip." The facility's "Eating Precaution Plan" for Individual #2 documented in part, "Adaptive equipment required: Dycem mat, divided plate w (with)/plate guard, maroon spoon and plastic cup w/ a base and clothing protector. On 01/18/2023 at 1:23 p.m., an interview was	W 159	**W159** **How corrective action will be accomplished for Individual #2:** The QIDP will revise individual #2's ISP to ensure it contains the use of a cup with a base. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will review each individual's current ISP to ensure each plan includes directives for use of the correct adaptive equipment. **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 and monitor each individual's ISP on an ongoing basis to ensure that each plan includes directives for the use of the corrective adaptive equipment. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program supervisor and assistant manager will provide ongoing monitoring and review of all ISPs to ensure that they include directives for the use of the corrective adaptive equipment. **Date of Completion:** 2/10/2023	**2/10/2023**

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W 159	Continued From page 9 conducted with OSM (other staff member) #1, QIDP. OSM #1 stated active treatment is collaborative and they are responsible for coordinating care. OSM #1 stated they write the ISPs and is able to update them. OSM #1 stated that since he is in the facility, he can make sure staff are implementing the ISPs and explain to staff why they are supposed to do something the way they do it. OSM #1 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. OSM #1 stated he also communicates ISPs through monthly staff meetings and staff must sign off on individuals' ISPs. After reviewing Individual #2's ISP, the eating precaution plan and informed of the above observation, OSM #1 stated that the ISP did not match the eating precaution guidelines for Individual #2. On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website:	W 159		

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W 159	Continued From page 10 https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A non-slip, rubber-like plastic material used to stabilize surfaces. Reusable. Cut to most any size or shape with scissors. Cleans with soap and water. Blue (except where noted). Matting is 1/32" thick. Not made of natural rubber latex. Long lasting. Unlimited uses. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.html.	W 159		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. 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, potentially affecting all individuals in the facility. The finding include: Review of the facility's fire drill forms dated 08/2021 through 012/2022 failed to evidence that a fire drill was conducted in March 2022. On 01/18/2023 at approximately 1:43 p.m., an interview was conducted with ASM (administrative staff member) #1, residential coordinator. When informed of the missing fire drill in March 2022 ASM #1 stated that they did not have documentation that a fire drill was conducted in March of 2022. On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential	W 440	**W440** **How corrective action will be accomplished:** Facility staff will conduct evacuation drills at least quarterly for each shift of personnel. **Assurance that other residents are protected from the possibility of the deficiency:** All ICF facilities will conduct evacuation drills at least quarterly for each shift of personnel. **Measures to be put in 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 evacuation drills at least quarterly for each shift of personnel. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Director of Compliance and Human Rights, or designee, will review to ensure that evacuation drills are conducted at least quarterly for each shift of personnel. **Date of Completion:** 2/1/2023	**2/1/2023**

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LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 440	Continued From page 11 coordinator, was made aware of the above findings. No further information was provided prior to exit.	W 440	**W503** **How corrective action will be accomplished for DSP #2 and OSM #5:** Facility staff will ensure that DSP (direct support professional) #2 meets their second dose of the COVID-19 vaccine requirements, and will ensure they obtain documentation evidencing that OSM (other staff member) #5, registered dietitian, meets the COVID-19 vaccine requirements. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will ensure that all DSPs and OSMs meet COVID-19 vaccination requirements and that documentation has been obtained as evidence of meeting these requirements for agency records. **Measures to be put in place or systemic changes to be made to ensure that the deficient practice will not recur:** The program supervisor or designee will monitor to ensure that all facility staff and contracted staff meet COVID-19 vaccination requirements upon recommendation of hire/ utilization in the program. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Human Resources department will monitor to ensure documentation is filed as evidence that all facility staff and contracted staff members meet COVID-19 vaccination requirements. **Date of Completion:** 2/15/2023	**2/15/2023**
W 503	COVID-19 Policies and Procedures: Vaccination CFR(s): 483.460(a)(4)(iv) § 483.460(a)(4)(iv) In situations where COVID-19 vaccination requires multiple doses, the client, client's representative, or staff member is provided with current information regarding each additional dose, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of each additional doses. This STANDARD is not met as evidenced by: Based on employee record review, facility document review and staff interview, it was determined that the facility staff failed to implement COVID-19 vaccination requirements for two of seven employee vaccination records reviewed; DSP #2 and OSM #5. The findings include: Facility staff failed to ensure DSP (direct support professional) #2 received their second dose of the COVID-19 vaccine, and failed to obtain documentation evidencing OSM (other staff member) #5, registered dietician, received the COVID-19 vaccine. On 01/17/2023 at approximately 12:30 p.m., a request was made to the facility's human resource department for documentation evidencing DSP#2 and OSM #5 received the COVID-19 vaccine.	W 503		

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

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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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ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

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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**

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

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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		

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 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		

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

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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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ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 503	Continued From page 12 On 1/18/23 at approximately 1:50 p.m., an interview was conducted with ASM (administrative staff member) #1, residential coordinator. ASM #1 stated all potential new hires are asked if they are vaccinated for COVID-19 and are told that the company is federally mandated to ensure staff vaccination. ASM #1 stated exemption paperwork must be completed prior to hire and new hires must provide evidence of vaccination to the human resources department on their first day of employment. On 1/18/23 at approximately 3:30 p.m., ASM #1 stated that they did not have evidence of DSP #2's second COVID-19 vaccine nor did they have evidence of OSM #5 receiving the COVID-19 vaccine. The facility's policy "Rappahannock Area Community Service Board COVID-19 Employee & Volunteer Vaccination Policy" documented in part, "RACSB (Rappahannock Area Community Service Board) now requires all employees to be vaccinated against COVID-19 unless a reasonable accommodation is approved. Employees not in compliance with this policy will be placed on unpaid leave until the Human Resource Director, in consultation with the Executive Director, determines their employment status. This policy will be administered in compliance with all applicable laws and is based on guidance from the Centers of Disease Control and Prevention; the Virginia Department of Health; the Equal Employment Opportunity Commission; the Occupational Safety Health Administration, and, local and state health authorities.	W 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 503	Continued From page 13 On 01/18/2023 at approximately 3:30 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit.	W 503		

MEMORANDUM

To: Joe Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: February 8, 2023
Re: January 2023 Waiting Lists

Identified below you will find the number of individuals who were on a waiting list as of January 31, 2023.

OUTPATIENT SERVICES

- Clinical services: As of January 31, 2023, there are 269 individuals on the wait list for outpatient therapy services.
  - Individuals are placed on the wait list if they cannot be seen at a regularly scheduled appointment within 30 days of request. Individuals who fall in a priority category are seen during open access.
    - Due to an increase in request for outpatient services, the Fredericksburg Clinic implemented a waitlist for new clients seeking outpatient services beginning October 5, 2021, the Spotsylvania Clinic implemented a waitlist beginning May 2022, and the Caroline Clinic implemented a waitlist beginning November 2022.
      - The waitlist in Fredericksburg is currently at 160 clients.
      - The waitlist in Spotsylvania is currently at 67 clients.
      - The waitlist in Caroline is currently at 42 clients.
      - This is an decrease of 73 from the December 2022 waitlist.

    - If an individual is not in a priority category the following may occur: 1) he or she may be placed on a waiting list and called weekly by a therapist to review presenting situation, individuals are then offered an appointment as one becomes available; 2) if an individual has private insurance staff will assist in locating a private provider if the individual does not wish to wait for an appointment. Staff are working to avoid scheduling an individual too far into the future as this increases the likelihood of no-shows.

  - Clinical services are initiated through Same Day Access. Due to COVID-19 concerns, Same Day Access appointments are scheduled versus having multiple individuals come to the clinic and having to wait for their appointment time. Same Day Access schedules are as follows:

    - Fredericksburg Clinic: Monday, Wednesday, and Thursday 8:30a.m. to 2:30 pm
      Tuesday 9:30am – 2:30PM
    - King George Clinic: Tuesday-1:00 pm-5:00 pm and Wednesday- 8:00 am- 12:00 pm
    - Stafford Clinic: Tuesday and Thursday 9:00 am – 12:00 pm
    - Spotsylvania Clinic: Tuesday, Wednesday, and Thursday 9:00 am – 2:00 pm
    - Caroline Clinic: Tuesday and Thursday 8:30am – 11:30 am

- Psychiatry intake: As of February 8, 2023, there are 11 older adolescents and adults waiting longer than 30 days for their intake appointment. This is an increase of eight from the December 2022 waitlist. The furthest out appointment is 4/26/2023. There are zero children age 13 and below waiting longer than 30 days for their intake appointment.

PSYCHIATRY INTAKE – As of January 3, 2023 the number of individuals waiting longer than 30 days for a regularly scheduled psychiatric intake appointment include:

	Adults	Children: Age 13 and below
o Fredericksburg –	7 (3)	0 (0)
o Caroline –	1 (0)	0 (0)
o King George –	0 (0)	0 (0)
o Spotsylvania –	0 (0)	0 (0)
o Stafford –	3 (0)	0 (0)
Total	**11 (3)**	**0 (0)**

	Appointment Dates
Fredericksburg Clinic	
	3/13/23 3/20/23 3/24/23 3/27/23 3/29/23 4/3/23 4/26/23
Caroline Clinic	
	3/22/23
King George	
	N/A
Spotsylvania Clinic	
	N/A
Stafford Clinic	
	3/14/23 3/20/23 3/21/23

Community Support services:

Waitlist Definitions

Needs List - A person is placed on the Needs List when an individual, family member, RACSB staff, or external agency notifies that particular program service that the individual needs services provided by that program.

Referral - Persons are placed on this Referral List when services have been requested and all necessary documentation for the referral process is submitted to the program Coordinator. At this time, the person is placed on the Referral List and removed from the Needs List.

All referrals are sent to the Coordinator for initial review. The Coordinator determines that all information is in the packet and makes a disposition for acceptance, rejection, or assessment. The Coordinator will forward the referral packet to the appropriate staff for assessment. Time frame for completion of assessment is also be indicated.

If the assessment leads to acceptance, the client will be placed on the acceptance list. If the assessment leads to a decision which does not involve acceptance, the program Coordinator will reach a decision about disposition of the referral.

Acceptance List - This list includes all persons who have been assessed for services and accepted to the program. These individuals are waiting for appropriate supports.

MH RESIDENTIAL SERVICES - 2

Needs List: 0
Referral List: 1
Acceptance List: 1

Count by County:

Caroline	1
King George	0
Fredericksburg	0
Spotsylvania	0
Stafford	1

- The one individual on the acceptance list is a referral from the community and has completed two successful trial passes at Home Road. He has been accepted for the next community bed that is available at Home Road, which is expected to be in February 2023.

Intellectual Disability Residential Services – 96

Needs List: 91
Referral List: 5
Acceptance List: 0

Count by County:

Caroline	10
King George	8
Fredericksburg	7
Spotsylvania	34
Stafford	37
Richmond	1

Assertive Community Treatment (ACT)– 17

Caroline: 1
Fredericksburg: 7
King George: 0
Spotsylvania: 4
Stafford: 5

Total Needs: 8
Total Referrals: 9
Total Acceptances: 0

Total program enrollments = 50

Admissions: 0
Discharges: 1

- During the month of January, an ACT South client asked to be discharged after his 90-day Mandatory Outpatient Treatment Order (MOT) expired in December. This client was compliant while receiving services again. However, when the MOT expired, they requested to return to the Jackson Street Clinic for medication management supports only. This client is aware they can resume ACT services in the future.

ID/DD Support Coordination

There are 792 individuals on the waiting list for a DD waiver.

P-1 326
P-2 183
P-3 287

MEMORANDUM

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: February 2023

Re: Quality Assurance Report

The Quality Assurance (QA) staff completed chart reviews for the following Rappahannock Area Community Services Board (RACSB) programs:

- Galveston Intellectual Disability Group Home
- Mental Health Outpatient King George

Galveston Intellectual Disability Group Home

There was one staff member responsible for the selected charts.

Findings for the six open charts reviewed for Galveston Intellectual Disability Group Home was as follows:

- Six charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - Six charts were missing the program agreement.
    - Three charts were missing releases.

- Six charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - Three charts were missing signature pages.

- Six charts were reviewed for Quarterly Review compliance:
  - There were no noted discrepancies found.

- Six charts were reviewed for Progress Note compliance:
  - There were no noted discrepancies found.

- Six charts were reviewed for Medical compliance:
  - **Discrepancies noted with Medical:**
    - Six charts were missing multiple prescriptions.

Comparative Information:

In comparing the audit reviews of Galveston Intellectual Disability Group Home charts from the previous audits to the current audits, the average score decreased from 90 to 66 on a 100-point scale.

Corrective Action Plan

1. Corrective supervision and coaching have been completed with the program manager as of 12/29/2022 to ensure charting is complete and timely moving forward. Focusing on ensuring all active prescriptions were filed in the chart was a point of emphasis in the corrective action.
2. Charting standards and expectations have been and will continue to be discussed through weekly DD Residential Supervisor meetings, supervision, offered training opportunities, and through periodic program audits of charting.
3. Charting and documentation expectations will continue to be reinforced through documented supervision and through the peer auditing and supervision processes to help ensure compliance.
4. Should there be further issue with meeting these expectations, progressive corrective action will be issued.
5. Oversight and corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.

Mental Health Outpatient King George

There was three staff members responsible for the randomly selected charts.

Findings for the ten open and two closed charts reviewed for Mental Health Outpatient- King George was as follows:

- Ten charts were reviewed for Assessment compliance:
    - **Discrepancies noted with Assessments:**
        - One chart was missing the Daily Living Activities 20 (DLA 20).
        - Two charts were missing current Comprehensive Needs Assessments (CNA).

- Ten charts were reviewed for Individual Service Plan (ISP) compliance:
    - **Discrepancies noted with Service Plan:**
        - Three charts were missing current ISPs.

- Ten charts were reviewed for Progress Note compliance:
    - **Discrepancies noted with Progress Notes:**
        - One chart contained notes which were completed more than 24hrs late.

- Ten charts were reviewed for Quarterly Review compliance:
    - **Discrepancies noted with Quarterly Reviews:**
        - Six charts were missing current quarterly reviews.

- Ten charts were reviewed for Documentation compliance:
    - **Discrepancies noted with Documentation:**
        - Three charts were missing Consumer Orientations.

- Two charts were reviewed for Discharge compliance:
    - **No discrepancies noted with Documentation:**

Comparative Information:

In comparing the audit reviews of Mental Health Outpatient King George charts from the previous audits to the current audits, the average score increased from 70 to 73 on a 100-point scale.

Corrective Action Plan

1. Staff will block 4 hours documentation time to audit full caseload and update needed documentation by February 28th
2. Moving forward starting week of 1/30/23, staff will block 1 hour documentation time weekly for charting, and not book over this time with client sessions-ongoing
3. At least 15 minutes of administrative supervision time will be devoted to chart audits-ongoing and starting the week of 1/30/23
4. Clinic Coordinator, Sarah Davis, will be responsible party for ensuring that corrective action plan is followed.