

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BRAMBLETOWN GROUP HOME B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2018
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NAME OF PROVIDER OR SUPPLIER BRAMBLETON GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS Surveyor: 35700 The Facility is a two story on a basement single family type residence. The Facility is Type V construction and is fully sprinkled. An unannounced recertification Life Safety Code survey was conducted on 1/9/18 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Persons with mental Retardation. The Facility was surveyed for compliance using the LSC 2012 Existing Regulations.	K 000		
K0211	The Facility was not in compliance with the Requirements for Participation for Medicare and Medicaid. Means of Egress - General CFR(s): NFPA 101 Means of Escape – General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This Standard is not met as evidenced by: Surveyor: 35700 Based on observation the facility failed to properly install and maintain correct operation of its emergency egress lighting. On 1/9/2018 at approximately 4:00 PM it was observed that the Emergency lighting was mounted and properly wired and failed to operate.	K0211	Spoke with the Program Manager (PM) and explained the importance of emergency lighting and what is acceptable. A call was made to the county to make the necessary arrangements to replace these with properly wired lights. The PM will review this with her team at the next staff meeting. Regular status checks will be made to make sure the lighting is operational.	2/22/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeff Scannell</i>	TITLE Facility Manager	(X6) DATE 2/1/2018
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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.