PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>0MB NO. 0938-0391</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G052	B. WING			01/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME	=		2275	ET ADDRESS, CITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE IBURN, VA 20148	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT DF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION
W 000	INITIAL COMMENT	rs	W	000		
	Intermediate Care I Intellectual Disabilit 1/24/17 through 1/2 compliance with 42 for Intermediate Ca Intellectually Disabl survey report will fo	ed. The Life Safety Code llow. seven bed facility was six at				
W 111	consisted of four cu (Individuals # 1, # 2		W	111		
	recordkeeping syste	velop and maintain a em that documents the client's treatment, social information, e client's rights.				
	Based on staff inte review it was detern failed to ensure the and accurate for the	s not met as evidenced by: rview and clinical record mined that the facility staff clinical record was complete ree of four individuals in the viduals # 1, #2 and # 3.				
	evacuation drill prog (Name of Group Ho	ndividual # 1's emergency gram was accurate in the ome) clinical record.			RECE MAY 1 VDH/	6 2017
,		ailed to ensure the ndividual # 2's emergency gram was accurate in the			الله الم الله الله الله الله الله الله ا	

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(Name of Group Home) clinical record.

TITLE

(X6) DATE

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 (hese 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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CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES	est consumitation	A	######	OMB	NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	1×3	) DATE SURVEY COMPLETED	
		49G052	B. WING	i			01/26/2017	
NAME OF	PROVIDER OR SUPPLIER			इग्र	ET ADDRESS, CITY, STATE, ZIP COI	DE	0.020.2011	
BRAMBI	LETON GROUP HOME	<b>;</b>		1	5 SWEET ANDREA DRIVE IBURN, VA 20148			
(X4) ID PREFIX TAĞ	(EACH DEFICIENCY	SC IDENTIFAING INFORWATIONI WIRST BE BUSCEDED BA ENIT TEITENT OF DELICIENCIES	IO PREF TAG		PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE AF DEFICIENCY)	HOULD BE	CONFLETION E TATE	
W 111	Continued From pa	ge 1	W	111			7	
	3a. The facility staff		W111					
	documentation of Individual # 3's emergency evacuation drill program was accurate in the (Name of Group Home) clinical record.			The Program Manager/ QMRP will review #1,2, and 3; current fire drill 3/8/17 schedules for accurate documentation.  The Program Manager/ QMRP will also review all other individuals current fire drill schedule for accurate documentation.				
	<ul> <li>b. The facility staff failed to ensure Individual # 3's current consent for the behavior treatment plan was in the (Name of Day Program) clinical record.</li> <li>The findings include:</li> <li>1. The facility staff failed to ensure the</li> </ul>		The P	The Program Manager will update a the fire drill schedule for 2017. The schedule will ensure that a drill is completed on the day, evening, and night shift each quarter				
			The Cland a	The Clinical Director will also review fire drill documentation quarterly and also complete unannounced fire drills.				
	documentation of In	dividual # 1's emergency gram was accurate in the	The Clinical Director will review within supervision with the Program Manager to ensure fire drills are completed as required and to ensure its documented accurately.					
	admitted to (Name of Diagnoses in the clinot limited to: mode gastroesophageal re	35 year old male, who was of Group Home) on 7/19/11, nical record included but were rale intellectual disability (1), affux disease (2), dysphagia e disorder (4), impulse control dety (6).						
	through 07/01/2017 Outcome: (Individual Support Activities: (I emergency evacuat Instructions: 1. (Indistime to perform an 2. (Individual # 1) d (Individual # 1) exits time(y manner, 4, (I	exit ISP dated 07/01/2016 documented, "Desired al # 1) maintains his safety, ndividual # 1) practices ion drills. Support ividual # 1) is notifies when it in emergency evacuation drill, resses appropriately. 3, the building in a safe and individual # 1) waits in the one. 5. (Individual # 1)						

re-enters the building after it has been determined to be safe. 6. Staff provides supports and assistance as needed. Frequency:

PRINTED: 02/07/2017

		TANU NUMAN SERVICES				ORM APPROVED
		E & MEDICAID SERVICES	1		OME	<u>B NO. 0938-0391</u>
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED
		49G052	8 WING_	4		01/26/2017
NAME OF I	PROVIDER OR SUPPLIER	£	1	STREET ADORESS, CITY, STATE, Z	IP CODE	S U S VI S S S S S S S S S S S S S S S S S
DO ANDO	· ተቸላቀ! ለማለበሽ ሀለቴክ			22755 SWEET ANDREA DRIVE		
РКИМОГ	LETON GROUP HOME	<u> </u>		ASHBURN, VA 20148		
(X4)ID PREFIX TAC	(EACH DEFICIENCY	ATE MENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FIJLL SC IDENTIFYING INFORMATION}	ID PREFIX TAG		TION SHOULD BE THE APPROPRIA	
W 111	Continued From pa	ade 2	W 1°	111	**************************************	
	Monthly. Amount: (	-				
	The "Drograss Note	es" for Individual # 1 dated				
		es for individual # 1 dated n 01/07/2017 for the				
		tion drill program were				
	reviewed. The "Pro	ogress Notes" dated 01/01/17,				
		01/05/17, 01/06/17 and				ĺ
		ted Individual # 1 had				
	participated in an ev	vacuation drill on each date.				
	# 1's "Progress Note 01/01/2017 through with ASM (administre (Name of Group Ho During the review of notes and data college evacuation drill programmary 2017 evacuation drill state progress notes for legariticipation in drills					
	Management" docur occurs on a regular program requirement assessment, individuates, quarterly report monthly nursing not individual's written of legible, current, date	"1.3.2 Written Record imented, "A. Documentation basis in accordance with the ints [i.e. progress notes, dual service planning, IDT ports, monthly QIDP notes, and tes]. The entries into an or electronic record must be ed, authenlicated by the staff / notating with full name and				

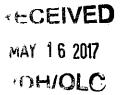
FORM CLIS-2507(02-99) Previous Versions Obsolete

On 1/25/17 at 4:40 p.m. ASM (administrative staff member) # 1, program manager of (Name of Group Home) and RN (registered nurse) # 1were

Event ID:30J411

Facility IO: VAICEMR60

If continuation sheet Page 3 of 103



STATEMEN	T OF DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA	79725 B.H	LIPLE CONS	t ten (/Tune	<del></del>	(VI) (ALLE CONTRACA
	OF CORRECTION	IDENTIFICATION NUMBER:			a managamanananananananananananananananana		(X3) DATE SURVEY COMPLETED
		49G052	B. Wilk	3			01/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOM!			22755 SV	ADDRESS, CITY, STATE, ZIP WEET ANDREA DRIVE RN, VA. 20148	COOF	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	KTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREI TAC	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO ROSS REFERENCED TO TH DEFICIENCY)	IN SHOULD E APPROP	DE CONFERION
W 111	Continued From pa		W	111			
	No further informat	ion was provided prior to exit.	W1	11	V	. <del></del>	***************************************
	by a limited mental adaptive behaviors schedules and rout Intellectual disabiliting the limit of	op of disorders characterized capacity and difficulty with such as managing money, lines, or social Interactions. If yoriginates before the age of rom physical causes, such as palsy, or from nonphysical cheef of stimulation and adult its information was obtained whithfactsheets/ViewFactSheef to leak back, or reflux, into irritate it. This information	that if and : The if to en signe The if and if and if preventions	individual #3 of signed in a firm OMRP will consume that the led in a timely a Program Manaquarterly record of ensure comprogram Managht further definition and	Intplote a day program reco- consents "Behavioral Suppo- nely manner or as needed, implete a day program revie "Behavioral Support Plan" i manner annually or as need asger/QMRF will conduct mander annually or as need interview to ensure all considerations of care, interview to ensure all considerations of care, interview to ensure all considerations of care, unaction of the consideration of the consideration of care, and the consideration of the	ori Plan" is  w of all off is current a  dod  onthly day sents is cur  s to ensure eness/ Cir	current  ner individuals  and  program observations  rent, up-to-date,  compliance and to  ice! Director
	(3) A swallowing disobtained from the working from the working in the sorders. It was a large of the brain. This infort website:  https://www.nlm.nih.ml.  (5) Impulse control an inability to resist	.gov/medlineplus/gerd.html. .order: This information was					

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO					
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		STRUCTION		DATE SURVEY COMPLETED	
		49G052	B WING		***************************************	1	01/26/2017	
	PROVIDER OR SUPPLIER LETON GROUP HOME			22755 5	FADORESS, CITY, STATE, ZIP COOE BWEET ANDREA DRIVE URN, VA 20148	*		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	≀D PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPI DEFICIENCY)	OULD BE	OMPLETION DATE	
W 111	and the most commexplosive disorder, compulsive gamblin trichotillomania. The from the website: http://medical-dictio pulse+Control+Disorder.  (6) Fear. This inforwebsite: https://www.nim.nih.#summary.  2. The facility staff of documentation of frevacuation drill prog (Name of Group Hottndividual # 2 was a admitted to (Name Diagnoses in the clinot limited to: mild ispastic diplegia (2), disease (3), selzure (right) side (5).  Individual # 2's currithrough 07/01/2017 Outcome: I will maparticipating in mondrills. Support Activup and gets ready idrill; wearing approg 2. (Individual # 2) game, 3. Once at the (Individual # 2) wait	lass of personality disorders, non of these are intermittent kleptomania, pyromania, ng disorder, and is information was obtained nary thefreedictionary.com/Imporders.  mation was obtained from the gov/medlineplus/anxiety.html  ailed to ensure the edividual # 2's emergency gram was accurate in the some) clinical record.  29 year old male, who was of Group Home) on 5/5/14, nical record included but were ntellectual disability (1), gastroesophageal reflux disorder (4), renal calculicant ISP dated 07/01/2016 documented, "Desired	W:	<del>1</del> 11				

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

(Individual # 2) enters his home when the

Event (D:30J411

Facility (D; VAICEMREO

If continuation sheet Page 5 of 103

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MAY 16 2017

VDH/OLC

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OM8	VO. 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MU A. BUILO		ONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		49G052	B. WING	;			01/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME		•	2275	EET ADDRESS, CITY, STATE, ZIP CC 5 SWEET ANDREA DRIVE IBURN, VA 20148		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	JENENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR. (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X3) GONIPLETION DATE
W 111	safe to re-enter. 5.	ion drill is completed and it is Staff provides supports and ed. Frequency: Monthly.	W	111			
	01/01/2017 through emergency evacuat reviewed. The "Pro and 01/05/17 docum	es" for Individual # 2 dated 01/07/2017 for the ion drill program were gress Notes" dated 01/02/17 nented Individual # 2 had vacuation drill on each date.					
	# 2's "Progress Note 01/01/2017 through with ASM (administr (Name of Group Ho During the review of collection for the em program ASM # 1 st evacuation drill had was scheduled for J stated the document	eximately 12:00 p.m. Individual es" and data collection dated 01/07/2017 were reviewed rative staff member) # 1, me) program manager. If the progress notes and data rergency evacuation drill rated that the January 2017 not yet been conducted and anuary 26, 2017. ASM #1 tation in the progress notes licating participation in drills					
	member) # 1, progra	o.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1were above findings					
	No further information	on was provided prior to exit.					
	References:						

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	No.		OMB NO. 0	)938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION	(X3) DATE : COMPL	SURVEY
		49G052	B. WING		01/2	6/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TÉMENT OF DEFICIENCIES / MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	IÓ PREFI TAG		ULD BE	(XS) COMPLETION DATE
W 111	adaptive behaviors schedules and rout Intellectual disabiliti 18 and may result frautism or cerebral reauses, such as lac responsiveness. The from the website: https://report.nih.go.t.aspx?csid=100.  (2) A form of cerebration of cerebration of the condition that usual childhood and permand coordination. A muscle tone which muscles and exagg. The arm muscles and affected at all. Comay include delaye milestones (i.e. rolli walking on toes; an walking). It occurs that controls mover abnormally. This in the website: https://rarediseases.pastic-diplegia-cere (3) Stomach content the esophagus and was obtained from https://www.nlm.nih	such as managing money, ines, or social interactions. y originates before the age of rom physical causes, such as palsy, or from nonphysical ck of stimulation and adult has information was obtained by/nihfactsheets/ViewFactSheetal palsy, a neurological ly appears in infancy or early anently affects muscle control affected people have increased leads to spasticity (stiff or tight for the regenerally less affected or other signs and symptoms directed motor or movement and over, sitting, standing); die "scissored" gait (style of when the portion of the brain ment is damaged or develops formation was obtained from sinfo-nih gov/diseases/9637/sebral-palsy.  Into the leak back, or reflux, into irritate it. This information the website: "gov/medlineplus/gerd.html."	W	111		
	because of sudden	brain problem. They happen abnormal electrical activity in mation was obtained from the				

FORMOMS-2567(02-99) Previous Versions Obsoleje

https://www.nlm.nih.gov/medlineplus/seizures.ht

Event ID:30J411

Facility ID: VAICENIRSD

If continuation sheet Page 7 of 103

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VDH/QLC

CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES		2017 2017 2017	OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	V BARC (XS) WAT	LTIPLE CONSTRUCTION DING		E SURVEY PLETED
		49G052	B, WING	28.10 HW 1991-1-11111111	01//	26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOMI			STREET ADDRESS, CITY, STATE, ZIP C 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148		
X4  ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI IX (EACH CORRECTIVE ACTION	SHOULD BE	(XS) COMPLETION DATE
W 111	Continued From parml.	ge 7	W	111		
	crystals. One or mo or ureter at the san obtained from the v	s a solid mass made up of tiny ore stones can be in the kidney be time. This information was vebsite: gov/ency/article/000458.htm.				
	documentation of Ir	failed to ensure the ndividual # 3's emergency gram was accurate in the time) clinical record.				
	admitted to (Name Diagnoses in the cl not limited to: sever	28 year old female, who was of Group Home) on 9/22/11. inical record included but were re intellectual disability (1), eflux disease (2), seizure ixiety (4).				
	through 09/30/2017 Activities: (Individual emergency evacual Instructions: 1. (Individual emergency evacual makes sure she is of (Individual # 3) walk zone. 4. (Individual until she is notified building. 5. Staff p	tividual # 3) acknowledges the tion drill. 2. (Individual # 3) dressed appropriately. 3, as to the designated safe al # 3) remains in the safe zone it is safe to return inside the rovides support and ed. Frequency: Monthly.				
	01/01/2017 through emergency evacual	s" for Individual # 3 dated 01/07/2017 for the tion drill program were gress Notes" dated 01/01/17,				

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO. 0938-0391
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER.			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G052	B. WING			01/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME			2275	ET ADDRESS, CITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE BURN, VA 20148	The state of the s
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
V∜ 111	01/02/17, 01/03/17 and 01/07/17 document	age 8 , 01/04/17, 01/05/17, 01/06/17 mented Individual # 3 had evacuation drilt on each date.	<b>W</b> 1	111		
	# 3's "Progress Not 01/01/2017 through with ASM (administ (Name of Group Ho During the review of collection for the er program, ASM # 1 evacuation drill had was scheduled for stated the document.	oximately 12:00 p.m. Individual tes" and data collection dated to 01/07/2017 were reviewed trative staff member) # 1, ome) program manager. of the progress noles and data mergency evacuation drill stated that the January 2017 I not yet been conducted and January 26, 2017. ASM #1 intation in the progress notes dicating participation in drilts				
•	member) # 1, progr Group Home) and i made aware of the	p.m. ASM (administrative staff ram manager of (Name of RN (registered nurse) # 1were above findings. ion was provided prior to exit.				
	References:					
	by a limited mental adaptive behaviors schedules and rout Inteltectual disabilit 18 and may result f autism or cerebral causes, such as lace	up of disorders characterized capacity and difficulty with such as managing money, ines, or social interactions, y originates before the age of from physical causes, such as palsy, or from nonphysical ck of stimulation and adult his information was obtained				

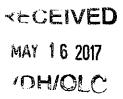
FORM CLIS-2567(02-99) Previous Versions Obsolute

https://report.nih.gov/nihfactsheets/ViewFactShee

Event ID:30J411

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If continuation sheet Page 9 of 103



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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G052	B. WING	- Halliana	01/26/2017		
	PROVIDER OR SUPPLIER LETON GROUP HOME		22	REET ADDRESS, CITY, STATE. ZIP CODE 1755 SWEET ANDREA DRIVE SHBURN, VA. 20148			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	io Prefix Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION		
W 111	Continued From pa	ge 9	W 111				
	the esophagus and was obtained from t	its to leak back, or reflux, into irritate it. This information the website: .gov/mediineplus/gerd.html.					
	because of sudden, the brain. This infor website:	orain problem. They happen abnormal electrical activity in mation was obtained from the gov/medlineplus/selzures.ht					
	website:	mation was obtained from the .gov/medlineplus/anxiety.html					
	current consent for	ailed to ensure Individual # 3's the behavior treatment plan f Day Program) clinical record.					
	Program) clinical re- reviewed. The (Nam- record revealed a "E Individual # 3 dated 09/30/2017. Furthe	a.m. the (Name of Day cord for Individual # 3 was ne of Day Program) clinical Behavior Support Plan" for 10/01/2015 through r review of the clinical record onsent for the "Behavior					
	conducted with OSN (Name of Day Progr When asked about Individual # 3's "Bet	a.m. an interview was  if (other staff member) # 4,  ram) program manager,  the missing consent for  navior Support Plan" dated  09/30/2017, OSM # 4 stated,					

	OF DEFICIENCIES OF CORRECTION	IX11 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		ATE SURVEY OMPLETED
		49G052	B. WING		and the second s	0	1/26/2017
,	PROVIDER OR SUPPLIER ETON GROUP HOME	-		2275	ET ADDRESS, CITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE (BURN, VA 20148		
(X4) ID PREPIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(XS) COMPLETION DATE
W 111	to this surveyor a c signed by the guard # 3's behavior supp in the clinical record needed to be filed." On 1/25/17 at 4:40 member) # 1, progr	1:20 a.m. OSM # 4 presented appy of the consent dated and dian on 09/01/16 for Individual out plan and stated, "It wasn't d, it was in a pile of papers that p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1were	W	<b>111</b>			
W 113	No further informat 483.410(c)(3) CLIE	on was provided prior to exit. NT RECORDS	W	113			
	and procedures go- client information, in	velop and implement policies verning the release of any ncluding consents necessary varents (if the client is a minor)					
	Based on staff inte review it was deter- failed to ensure a n	s not met as evidenced by: rview and clinical record mined that the facility staff nedia and video release form ne of four individuals in the vidual #3.					
		ip Home) staff failed to obtain d video release form for					
	The findings includ	é:					
	admitted to (Name	28 year old female, who was of Group Home) on 9/22/11. inical record included but were					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OM	IB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 .	TEPLE CONSTRUCTION		X3) OATE SURVEY COMPLETED
		49G052	B. WING	***************************************		01/26/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET AODRESS, CITY, \$TATE, ZII	P CODE	
BRAMBI	ETON GROUP HOME			22755 SWEET ANDREA DRIVE		
	*·	· · · · · · · · · · · · · · · · · · ·		ASHBURN, VA 20148		
(X4) IĐ PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OFFICIENCIES  MUST BE PRECEOED BY FULL  SC IOENTIFYING INFORMATION	IO PREFI TAG	PROVIDER'S PLAN OF ( KEACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD E HE APPROPRI	
W 113	Continued From pa	- ·	<b>₩</b> 1	13		
!	disorder (3), and anxiety (4).		W113		***************************************	
	#3's clinical record Group). Further reprogram record revand a "Video Relea #3's guardian on 9' (Name of Group) clacurrent "Media Ru"Video Release" for On 1/26/17 at approinterview was condistaff member) #1, program manager. #3's missing current Release" forms, AS and locate it. ASM is staff member) #1, Intellectual Disabilit stated, "He (OSM # the clinical record." that she was unable current consents for	eximately 10:45 a.m., an ucted with ASM (administrative (Name of Group Home) When asked about the video to "Video M#1 stated she would try then called OSM (other	The Qivithat the The Proquenter ensure: The Proto to praye it also o	IRP will complete a record review to els "Media Release" is current end sign "RP will complete a record review el al "Media Release" is current and signer gram Manager/QMRP will conduct moy record review to ensore all consents continuity of care.  gram Manager will review this process in further deficiencies. Mission Effect onduct quartedy record review to ensure	ed in a fimely if other individ d in a timely in onthly observa is current, up s to ensure co fiveness/ Citni	manner, iuals to ensure halliner annually stions and -lo-date, and to mpliance and date of the color

References:

No further information was provided prior to exit.

(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.

thtellectual disability originates before the age of 18 and may result from physical causes, such as

CENTER	(2 LOK MEDICAKE	S MEDICHID SEVAICES	-		CIVIL 140, 0300-0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION SING	(X3) DATE SURVEY COMPLETED
		49G052	B. WING		01/26/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP CO	ODE
BRAMBL	ETON GROUP HOM			22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	
(X4) ii) PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLETION
W 113	causes, such as lar responsiveness. The from the website: https://report.nih.got.aspx?csld=100.  (2) Stomach content the esophagus and was obtained from https://www.nlm.nih.(3) Symptoms of a because of sudder the brain. This inforwebsite: https://www.nlm.nih.ml.  (4) Fear. This inforwebsite:	palsy, or from nonphysical ck of stimulation and adult his information was obtained by/nlhfactsheets/ViewFactShee his to leak back, or reflux, into dirritate it. This information	W	113	
W 154		FF TREATMENT OF CLIENTS ave evidence that all alleged bughly investigated.	W	154	
	Based on staff intereview it was deter failed to conduct a injuries of unknown individuals in the staff failed two incidents of Individual # 4 on 2/2				
	The findings include	ie:			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .	TIPLE CONSTRUCTION INC	(X3) DATE SURVEY COMPLETED			
		49G052	B. WING		01/26/2017			
NAME OF	PROVIDER OR SUPPLIER		L-,,_,	STREET ADDRESS, CITY, STATE, ZIP CODE	1 011201#011			
DOMMOI	ETON GROUP HOME	•		22755 SWEET ANDREA DRIVE				
DIVAMOL	ETON GROOT HOISE			ASHBURN, VA 20148				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FILL SC IDENTIFYING INFORMATION)	ID PREFI TAG		UDBE COMPLETION			
W 154	Continued From pa	ge 13	W 1	54				
		49 year old female, who was	W15	<u> </u>				
	admitted to (Name of Group Home) on 6/4/13. Diagnoses in the clinical record included but were not limited to: profound intellectual disability (1), encephalopathy (2), history of Graves disease (3), vitamin D deficiency (4), autism (5) and self-injurious behavior (6).							
Review of the facility's "Incident Reports" revealed two injuries of unknown origin dated 2/17/16 and 4/7/16 for individual # 4.			The Program Mänager, Clinical Director and/or Mission Effectiveness will conduct a fact finding and document the findings on the incident report to initiate an investigation.					
	# 4 documented, "S Incidents: Bruising Under "Incident /Be noticed a large blac Under the heading" documented, "Revide Director) [ASM (admicilized director of art The "Incident Report 4 documented, "Sig Bruising or injury of	t" dated 4/7/16 for Individual # nificant and Serious Incidents: unknown origin." Under it documented, "(Individual #	action The P all oth The C	Elinical Director will schedule an IDT and develor plan and recommendations if needed regions Manager and Clinical Director will review or individuals to ensure that they are investigated included Director will review this process to ensure the further deficiencies.	w incidents layolying ad throughly.			
	semi-circular in sha Further review of the 4/7/16 failed to docu On 1/24/17 at 1:45 p conducted with ASM program manager, process staff follows unknown origin, ASI the staff, Individual	ne size of a fingertip ipe on her right bicep." be "Incident Report" dated iment clinical director's notes. b.m. an interview was if #1 (Name of Group Home) When asked about the for incidents of injuries of if #1 stated, "We interview and day program staff if its distinction it's						

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CHILL	VOLOW MEDICAVE	A MICUIUMID SERVICES				ONDI	VO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIEROLIA IDENTIFICATION NUMBER	A. BURT	TIPLE CONSTRU	ICTION		DATE SURVEY COMPLETED
		49G052	B. WING				01/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME	· · · · · · · · · · · · · · · · · · ·			RESS. CITY, STATE, ZIP COI ET ANDREA DRIVE VA. 20148	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (DAK	ROVIDER'S PLAN OF CORR CIT CORRECTIVE ACTION S S-REPERENCED TO THE AL DEFICIENCY)	HOULD BE	1X5) COMPLETION DATE
W 154	the corporate office determines if further When asked for the 4's incidents of injut 2/17/16 and 4/7/16, was another clinical covering (Name of stated she would coinvestigations.  On 1/25/17 at approprovided this survey from ASM # 4 in reg 2/17/16 and 4/7/16.  The email dated 1/24 documented, "t did	rectiveness. It's a team from who reviews all incidents and r investigations are required." Investigations for Individual # rections for Individual	W	154			
W 159	oversight because thave been changed necessitating further on 1/25/17 at 4:40 member) # 1, programade aware of the No further informati 483.430(a) QIDP  Each client's active integrated, coordinated qualified intettectual This STANDARD is Based on residenti day program record	p.m. ASM (administrative staff am manager of (Name of RN (registered nurse)# 1were	W	159			

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

Event ID: 30J/(1)

Facility ID: VAICEMRG0

If continuation sheet Page 15 of 103

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<b>4</b>		10	VB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	!	ETIPLE CONSTRUCTION DIAG		(X3) DATE SURVEY COMPLETED	
		49G052	B. WING	i		01/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	IP CODE		
BRAMBL	ETON GROUP HOME	<u>:</u>		22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	·		
(X4) ID PREFIX IAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD THE APPROPE	BE COMPTEDICM	
W 159	Continued From page 15 Intellectual Disabilities Professional) falled to			159	TO A STREET WATER COMMISSION OF THE STREET	. ALS.	
	treatment programs	and monitor the individuats' active programs for three of five individuals in sample, individuals # 1, # 2 and # 3.		IRP y/ill revise individuals (/1, 2, and 3 Icomesigoals into measurable lerris.	3's Person Ce	nleir <u>3/8/1</u> 7	
		d to ensure objectives on the rice Plan) for Individual #1	reflect II	ክRP will update their goals to ensure I ho needs of individuals #1,2,& 3.			
were developed in measurat  b. The QIDP falled to ensure			The Program Manager/QMRP will review all other individual's outcomes objectives to ensure that it accurately reflects their needs and it is incorporated within the Person Center Plan.				
of the ISP outco		s/goals for Individual # 1 were					
Ī	for social skills, ADI	to ensure Individual # 1's ISP Ls (Activities for Daily Living) ninistration were implemented.	[service	igram Manager/QMRP will continue to needs of the individuals are accurated by operation meetings.	o monilor to éa ly refiected thr	naure that att rough the ose	
-		d to ensure objectives on the 2 were developed in	The Program Manager/QMRP will conduct morthly assessments to ensuthal all services and needs are meet and are accurately reflected on the OMRP ricky.				
	b. The QIDP failed	to ensure the data collection s/goals for Individual # 2 were s.					
	for ADLs (Activities	to ensure Individual # 2's ISP of Daily Living); fine motor and medication management	/				
		d to ensure objectives on the 3 were developed in	And the second of the second o				
D. H. H. MARINES		to ensure the data collection s/goals for Individual #3 were s.					

c. The QIDP failed to ensure Individual # 3's ISP

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	OLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
		49G052	B. WINC	3		01/26/2017		
	ROVIDER OR SUPPLIER ETON GROUP HOME		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148		J 1120,20 ; (		
(X4) ID PRFFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	ID PRSF TAC	FIX FEACH CORRECTIVE ACTIO	ON SHOULD BE BE APPROPRIATE	COMPLETION DATE		
W 159	Communication; Ac Participate in House	of Daily Living); Leisure Time; tivity; Money Management, Meetings; medication	ieπns Tha ₽	9 IMRP will revise the outcome/objectives i to colloct appropriate data for individuals regrem Manager\QMRP will update the f orporate these changes for those individu	s #1,2, & 3. Person Cepter F	·		
	Management; Evacuation Drills were implemented.			rogram Manager/OMRP will complete th trals to prevent further deficionolos.	is process for all	lother		
T)ne findings include:			The Program Manager\QMRP will continue to monitor to ensure that all service needs of the individuals are accurately reflected through the use of weekly operation meetings.					
1a. The QIDP failed to ensure objectives on the ISP (Individual Service Plan) for Individual # 1 were developed in measurable terms.		The Clinical Director will review within stipervision with the Program Manager for documentation to support the coordination of services for each individual.						
	Individual # 1 use s	35 year old mate, who was	W15	9				
	admitted to (Name of Diagnoses in the cli	of Group Hame) on 7/19/11. nical record included but were	The QMRP will revise the individuals outcomes/objectives to ensure that it accurately reflect their needs:					
	gastroesophageal r (3), history of seizur	ot limited to: moderate intellectual disability (1), astroesophageal reflux disease (2), dysphagia 3), history of seizure disorder (4), impulse control isorder (5) and anxiety (6).		3: ADL's, Leisure Time, Communication, Activity, Money Management				
	Individual # 1's current ISP dated 07/01/2016 through 07/01/2017 documented, "Desired Outcome: (Individual # 1) increases his social skills. "Support Activities: (Individual # 1)			and Evacuation Drills.  The Program Manager\QMRP will review all individual's outcomes/ objectives to ensure that it accurately reflects their needs and it is incorporated within the Person Center Plan.				
	practices appropriating increase his social: (Individual # 1) uses conversation; active	le social interactions to skills. Support Instructions 1. sproper etiquette for listening, body language, mal boundaries, appropriate	individ Prega Perso	rogram Monagor/OMRP will provide train dual's Person Center Plans within the rise am Manager will provide supervision to c an Center Plan accurately raflects the nas priotety.	xt staff meeting. all staff to ensure	The that the		
	subject matter, etc. and assistance as r Amount: Continually	Staff provides support needed. Frequency: Daily.     Support Activities:	lhala	rogram ManageAQMRP will conduct mo Il services and needs are nyel and are ac Pinòle.	onthly assessmen couralsty reflects	nis to ensure at on the		
	Support Instructions an activity, i.e.: draw	ages in activities with others.  5: 1. (Individual # 1) chooses ving painting, exercising, games, etc. 2. (Individual #	the do	Dinical Director will review within supervisionmentation to support the coordination dual needs	sion with the Pro vol services for a	ogram Manager each		

FORMOMS-2567 (02-99) Previous Versions Obsolete

1) invites his housemates and/or staff members

Event ID: 30J411

Facility ID: VAICELIR60

It continuation sheet Page 17 of 103

MAY 16 2017 VDH/OLC

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	OF DEFICIENCIES IF CORRECTION	(XT) PROVIDER/SUPPLIER/CLIA IDÉNTIFICATION NULIBER:		TIPLE CONSTRUCTION	-	(X3) DATE SURVIY COMPLETED
		49G052	8 WING			01/26/2017
MAKE OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
BRAMBL	ETON GROUP HOME			22755 SWEET ANDREA DE ASHBURN, VA 20148	RIVE	
(XI) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRÉCEDED BY FULL  SC (DEMTIFYING INFORMATION)	ID PREFI TAG	X (ÉACH CORRECTIV CROSS-REFERENCEI		BE COMPLETION
₩ 159	provides support ar Frequency: Weekly "Desired Outcome: ADLs to increase h Activities: (Individual appearance. Supp # 1) recognizes who (Individual # 1) kee (Individual # 1) kee (Individual # 1) com Support and assista Daily. Amount: 15 (Individual # 1) com Support Instruction his toothbrush from 1) put water and too (Individual # 1) brus 1) flosses and rinse (Individual # 1) to ethoroughly cleaned 15 minutes. Support Individual # 1) cho clean shave, goate (Individual # 1) gets (	selected activity. 3. Staff and assistance as needed.  (Individual # 1) practices his is independence. "Support al # 1) maintains his room's out instructions: 1. (Individual en his room is out of order. 2. ps his floor clean of clutter. 3. ps his belongings organized; atile Disc), CDs (compact ires, etc. 4. Staff provides ance as needed. Frequency: minutes. Support Activities: apletes his oral hygiene. s: 1. (Individual # 1) retrieves in the cabinet. 2. (Individual # othpaste on his toothbrush. 3. shes his teeth, 4. (Individual # es. Staff follows up with insure his teeth have been. Frequency: Daily. Amount: ort Activities: (Individual # 1) air. Support Instructions: 1. oses a style of facial hair, e, beard, mustache, etc. 2. is his grooming supplies. 3. oms his facial hair. 4. Staff and assistance as needed. Amount: 15 minutes. Support at # 1) his laundry. Support dividual # 1) chooses when he aundry. 2. (Individual # 1) the site the laundry room and water. 3. (Individual # 1)	W :	AND CONTROL OF THE CO		
	4. (Individual #1) a	riate cycle and soap amount. adds the soap and starts the dual # 1) puts his washed				

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	OF DEFICIENCIES F CORRECTION	(XT) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	1		ONSTRUCTION		E SURVEY IPLETED	
		49G052	B. WING	***************************************		01/	26/2017	
	PROVIDER OR SUPPLIER ETON GROUP HOMI	1		22755	ET AOORESS, CITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE BURN, VA 20148			
(XA) ID PREFIX TAG	{EACH DEFICIENCS	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY PULL SCIDENTIFYING INFÓRMATION)	ID PREFI TAG	-	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D SE	(XS) CONFEERON DAIE	
W t59	the dryer cycle and # 1) takes his clear them away. 8. Sta assistance as need Amount: 30 minute. "Desired Outcome: community resource (Individual # 1) particularly and activities of his support and assista Monthly. Amount: (Individual # 1) tries Instructions: 1. (Individual # 1) dev Instructions: (Individual # 3). (Indivi	starts the dryer. 7. (Individual and clothes to his room and puts of provides support and ded. Frequency: Daily. s."  (Individual # 1) Intilizes his ses. Support Activities: ticipates in volunteer and es. Support Instructions: 1. Inmunicates his preference for nd activities. 2. (Individual # outings and activities. 3. ticipates in volunteer outings choice. 4. Staff provides ance as needed. Frequency: 30 minutes. Support Activities is new activities. Support dividual # 1) chooses a new activity. 3. (Individual # 1) est to try. 2. (Individual # 1) est to try. 4. Staff provides ance as needed. Frequency: 15 minutes. Support Activities: elops new abilities. Support dual # 1) choose a new ability velop. 2. (Individual # 1) or practice developing his real # 1) practices developing provides support and led. Frequency: Monthly. s."	W	159				
	decision making to over things in his til (Individual # 1) part	(Individual # 1) practices increase his personal control e. Support Activities: licipates in the scheduled Support Instructions: 1.						

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	y	The second secon	OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER	1 ''	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49G052	e. Wing	18	01/26/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRAMBI	ETON GROUP HOME	<u> </u>		22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	GEÁRINT OF DEFICIENCIES MAUST BE PRÉCEDED BY FULL SC IDENTIFYING INFÖRMATION)	ID PREFA 1AG		ULO BE COMPTETION
W 159	(Individual #1) cho house meeting. 2. communicate his poutings, meal choice would like to be avaprovides support an Frequency: Weekly Support Activities: (contact with his moinstructions; 1. (Incontact his family, phone to contact his chooses to schedumon, dad or brother schedules visits or brother. Staff provinceded. Frequence minutes:"	oses to attend the scheduled (Individual # 1) will verbally references for community es, and other activities he allable/participate in. 3. Staff and assistance as needed.  Amount: 30 minutes. Individual # 1) has regular im, dad and brother. Support dividual # 1) chooses to 2. (Individual # 1) uses the sfamily. 3. (Individual # 1) le visits or outlings with his er. 4. (Individual # 1) outlings with his mom, dad or des support and assistance as y: Weekly. Amount: 15	Wa	169	
	live a healthy lifesty well-being. Support completes his med Support Instruction communicates whe medication adminish his medication box out the correct med (Individual # 1) expreason and dosage medication as preshis medication box supports and assis Daily. Amount: Co "Desired Outcomes safety. Support Ac practices emergen.	(Individual # 1) chooses to ble and increase his overall that Activities: (Individual # 1) ication administration. s: 1. (Individual # 1) en he is ready to complete his stration. 2. (Individual # 1) get out. 3. (Individual # 1) takes dication for administration. 4. lains his medication times, s. 6. (Individual # 1) takes his cribed. (Individual # 1) puls away. 6. Staff provides tance as needed. Frequency: ntinually."  (Individual # 1) maintains his dividual # 1) ey evacuation drills. Support dividual # 1) is notifies when it			

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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVIC					OMB NO. 0938-0391		
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	COLLARS WANTED CO. A	49G052	8 WING			1/26/2017		
	PROVIDER OR SUPPLIER ETON GROUP HOMI	=		STREET ATIDRESS, CITY, STATE, ZIF 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	, CODE			
(XÅ) 3D PREFIX TAG	£ΛCH DEFICIENC	TEMENT OF DEFICIENCIES Y LINUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	iksi Completion Date		
W 159	2. (Individual # 1) exit timely manner. 4. I designated safety a re-enters the building determined to be supports and assis Monthly. Amount:  On 1/24/17 at 2:30 was conducted in the conducted in the conducted in the conducted in the line of (Name of Intellectual Disability). The OIDP. OSM for an individual, the the individual, the the individual, the the purpose of the ASM #1 and OSM skills to develop a lindividual's potential outcomes being with measureable terms of (Name of Group clinical director of that all the outcomes were reviewed and in measurable terms they were aware of was the responsibility.	in emergency evacuation drill. dresses appropriately. 3. s the building in a safe and (Individual # 1) waits in the cone. 5. (Individual # 1) ing after it has been afe. 6. Staff provides tance as needed. Frequency: Continually."  p.m. a meeting and interview he presence of and with ASM I member) # 1, program of Group Home), ASM # 2, Name of Group Home), OSM in # 1, the QIDP (Qualified ties Professional) and OSM # #1 was asked how outcomes SP are developed. OSM # 1 ple sources, input from family, eam (interdisciplinary team) its strengths, wants, needs and the individual." When asked ISP (Individual Service Plan), # 1 stated, "To teach various level of independence to the al." When asked about the		159				

"Yes."

measurable terms, OSM # 1 and ASM # 1 stated,

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-,		(		0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 , -		CONSTRUCTION	(X3) DAY CO	TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER	Pro- and the state of the state	<del></del>	STR	EET ADDRESS, CITY, STATE, ZIP CODE		5 m (5 m (5 b )
BRAMBI	ETON GROUP HOME	<b></b>		2275	55 SWEET ANDREA DRIVE		
U111 1111 -	The Same of Control of Control	·		ASH	HBURN, VA 20148		
(x4) ID PROFIX TAG	(EACH DEFICIENCY	NTENERT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	JD PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	HOITS PRACO #JACO
W 159	Continued From pa	ige 21	W	159			
	The facility's policy	"8.1 Qualified hitellectual					
	Disabilities Professi	ional" documented, "The					
		ple for the integration,					
	- coorgination, monta Individual Service F	oring and development of the Plan, and to ensure quality					
	active treatment in t	the program." Under "8.1.2					
		al Disabilities Professional					
		ices" it documented, "A. ecords to include clinical,					
		al to ensure prescribed					
		ices are being implemented					
		ted appropriately and that any ve been incorporated into					
	program services."	Ae pean illeoibhiatea illio					
	On 1/25/17 at 4:40	p.m. ASM (administrative staff					
		am manager of (Name of RN (registered nurse) # 1were					
	made aware of the						
		ion was provided prior to exit.					1
	References:						
		ip of disorders characterized					
	by a limited mental	capacity and difficulty with					
		such as managing money,					
		ines, or social interactions. y originates before the age of					
	18 and may result fr	rom physical causes, such as					
		palsy, or from nonphysical					
		ck of stimulation and adult his information was obtained					
	from the website;	no impuliation was cotalied					
	https://report.nih.go	v/nihfactsheets/ViewFactShee					
	t.aspx?csid=100.						

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information

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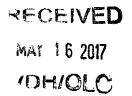
	ON DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G052	B WING		01/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME	-		STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST DE PRÉCÉDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULT CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
W 159	was obtained from https://www.nlm.nih (3) A swallowing disobtained from the vibit ps://www.nlm.nih sorders.html. (4) Symploms of a because of sudden the brain. This inforwebsite: https://www.nlm.nihml. (5) Impulse control an inability to resist action that is harmlis a retatively new cand the most commexplosive disorder, compulsive gamblistichotillomania. The from the website: http://medical-dictiopulse+Control+Disobsite: (6) Fear. This inforwebsite:	the website: h.gov/medlineplus/gerd.html. sorder. This information was vebsite: h.gov/medlineplus/swallowingdi brain problem. They happen abnormal electrical activity in mation was obtained from the h.gov/medlineplus/seizures.ht disorders are characterized by the impulse to perform an ful to one's self or others. This class of personality disorders, non of these are intermittent kleptomania, pyromania, ng disorder, and his information was obtained onary thefreedictionary.com/lm	W 159	CANA CHARLES	
	mark 1 1100 months 1 14-10-20-2	I to ensure the data collection as/goals for Individual # 1 were as.			
		e" for Individual # 1 dated h 01/07/2017 were reviewed.			

FORM CMS 2567(112-99) Previous Versions Obsolete

Event ID:30.1411

Facility ID, VAICEMR60

If continuation sheet Page 23 of 103



PRINTED: 02/07/2017 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PRÓVIOÉR/SÚPPÉLIER/CÉ/A IDENTIFICATION NUI/BER:	1 "		ONSTRUCTION		TE SURVEY WPLETED
		49Ğ052	B. WING	à		01	/26/2017
NAME OF F	PROVIDER OR SUPPLIER	despectace (1990)		STRE	ET ADDRESS, CITY, STATE, ZIP COOE	MVICT F	
BRAMBL	ETON GROUP HOM	<b>.</b>		1	5 SWEET ANDREA DRIVE IBURN, VA 20148		
(X4) IO PREFIX TAIS	(EACH DEFICIENC)	VIEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIGER'S PLAN OF CORRECT (FACH CORRECTIVE ACTION SHOU CROSS-REFERENCE O TO THE APPRO OSFICIENCY)	)L() (ԵĘ	JAKI TYÖHT-LIGUD TAGU
W 159	The progress notes documentation of the progress notes documentation of the 1's ISP outcome/ On 1/24/17 at 2:30 was conducted in the (administrative staff manager of (Name clinical director of (other staff member intellectual Disability). The QIDP. When notes or data collection measureable termanager of (Name 2, the clinical directs latted that all the principle in measureable termanager of the were written in measureable that they we asked if it was the review the outcome written in measural 1 stated, "Yes."  On 1/25/17 at 4:40 member) #1, progroup Home) and made aware of the No further information. The QIDP failed	s failed to evidence he data collection of Individual goals in measurable terms.  p.m. a meeting and interview he presence of and with ASM f member) # 1, program of Group Home), ASM # 2. Name of Group Home), OSM r) # 1, the QIDP (Qualified the saked about the progress of the progress of the progress of Group Home) and ASM # tor of (Name of Group Home) and ASM # tor of (Name of Group Home) rogress notes for all the viewed and that none of them asurable terms. They further the aware of the issue. When responsibility of the QIDP to be and ensure they were oble terms, QSM # 1 and ASM # p.m. ASM (administrative staff ram manager of (Name of RN (registered nurse) # 1were above findings.  In was provided prior to exit.		159			
		Plan) for social skills, ADLs Living) and medication implemented.					

Individual # 1's current ISP dated 07/01/2016

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		141.400	OMB NO	0.0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l .	TIPLE CONSTRUCTION HING		TE SURVEY MPLETED
		49G052	P. WING	Account of the second of the s	01	1/26/2017
	ROVIDER OR SUPPLIER ETON GROUP HOME		L COMMON	STREET ADDRESS, CITY, ST 22755 SWEET ANDREA DR ASHBURN, VA 20148	VIE. ZIP CODE	
(X4) ID PRÉFIX TAG	(PACH DEFICIENCY	(TEMENT OF DEFICIÉNCIES Y LIUST BE PRECEDED BY FULL SC IDENTIFYING INPORTATIONI)	ID PREI YAG	X (EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
W 159	social skills. "Suppractices appropria increase his social (Individual # 1) use conversation; activitone of voice, persesubject matter, etc and assistance as Amount: Continual (Individual # 1) eng Support Instruction an activity, i.e.: dra board games, vide 1) invites his house to participate in the provides support a Frequency: Weekly "Desired Oulcome ADLs to increase hactivities: (Individual # 1) kee (Individual # 1) kee (Individual # 1) kee (Individual # 1) cor Support and assist Daily. Amount: 15 (Individual # 1) cor Support Instruction his toothbrush from 1) put water and to (Individual # 1) bru 1) flosses and rins (Individual # 1) to (Individual # 1) t			159		

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STATEMENT OF DEFICIENCES AND PLANTIFE CONSTRUCTION  ADJUNCT AND PLANTIFE CONSTRUCTION  ADJUNCT	CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB NO	D. 0938-0391
NAME OF PROVIDER OR SUPPLIER  BRAMBLETON GROUP HOME  (MAI)  (MAI)  PREFIX  ASHBURN, M. 20148  ASHBURN, M. 20148  ASHBURN, M. 20148  PREFIX  PROMICES SHAPE  PREFIX  ASHBURN, M. 20148							(X3) DA	ITE SURVEY
STREET ADDRESS, DITY, STATE, ZIP CODE  27755 SWEET ANDREAD RIVE ASHBURN, VA 20148  W 159  CONTINUED FROM PLANT OF DEFICIENCES TAG  W 159  CONTINUED FROM PAGE  W 159  CONTINUED FROM PAGE  TO CONTINUED FROM PAGE TO CONTINUED FROM P			49G052	B. WING	3 <u></u>	annonnonnonnon ara ( / c ) - E (TERRORERO E V Nobbellando de la	01	1/26/2017
SIMMARY STATEMENT OF DEFICIENCIES  HACK DEFICIENCY AUST BE PRECISION BY FULL REGULATORY OR LSC IGENTIFYING INFORMATION)  W 159  Continued From page 25  15 minutes. Support Activities: (Individual # 1) grooms his facial hair, Support Instructions: 1. (Individual # 1) chooses a styte of facial hair, clean shave, goatee, beard, mustache, etc. 2. (Individual # 1) gets his grooming supplies. 3. (Individual # 1) gets his laundry. Support Activities: (Individual # 1) takes his dirty clothes to the laundry room and places them in the water. 3. (Individual # 1) takes his dirty clothes to the laundry room and places them in the water. 3. (Individual # 1) selects lhe appropriate cycle and soap amount. 4. (Individual # 1) sale to his room and puts lhe washer. 5. (Individual # 1) selects lhe dryer cycle and staffs the washer. 5. (Individual # 1) selects lhe dryer cycle and staffs the dryer. 7. (Individual # 1) takes his clean clothes to his room and puts lhem away. 8. Staff provides support and ussistance as needed. Frequency: Daily. Amount: 30 minutes.*  "Desired Outcome: (Individual # 1) chooses to live a healthy lifestyle and increase his overall well-being. Support Activities: (Individual # 1) completes his medication administration. 2. (Individual # 1) completes his medication administration. 2. (Individual # 1) takes in clinidiate when he is ready to complete his medication administration. 2. (Individual # 1) takes out the correct medication if medication limes, reason and dosage. 5. (Individual # 1) takes his cases on and dosage. 5. (Individual # 1) takes his					227	755 SWEET ANDREA DRIVE		
### HACH DEFICEMENT MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC DENTIFYING INFORMATION)  W 159  Continued From page 25  15 minules. Support Activities: (Individual # 1) grooms his facial hair. Support Instructions: 1. (Individual # 1) chooses a style of facial hair, clean shave, goatee, beard, mustache, etc. 2. (Individual # 1) grooms his facial hair. A Staff provides support and assistance as needed. Frequency: Daily. Amount: 15 minutes. Support Activities: (Individual # 1) the laundry. Support Instructions: 1. (Individual # 1) the same sheen he is ready to do his laundry. 2. (Individual # 1) selects the appropriate cycle and soap amount. 4. (Individual # 1) adds the soap and starts the washer. 5. (Individual # 1) selects the dryer cycle and starts the dryer. 7. (Individual # 1) selects the basher. 5. (Individual # 1) selects the dryer cycle and starts the dryer. 7. (Individual # 1) selects line dryer. 8. (Individual # 1) selects line dryer. 9. (Individual # 1) selects line dryer. 1. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 3. (Individual # 1) selects line dryer. 4. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 3. (Individual # 1) selects line dryer. 4. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 3. (Individual # 1) selects line dryer. 4. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 2. (Individual # 1) selects line dryer. 3. (Individual # 1) selects line dryer. 4. (Individual # 1) selects line dryer. 3. (Individual # 1) selects line dryer. 4. (Individual # 1) selects line dryer. 3. (Individual # 1) selects line dryer. 4. (Individual # 1) selects line dryer. 4. (Individual # 1) selects line dryer. 4. (I			**************************************		AS			***
15 minutes. Support Activities: (Individual # 1) grooms his facial hair. Support Instructions: 1. (Individual # 1) chooses a style of facial hair, clean shave, gostee, beard, mustache, etc. 2. (Individual # 1) grooms his facial hair, 4. Staff provides support and assistance as needed. Frequency: Daily. Amount: 15 minutes. Support Activities: (Individual # 1) his laundry. Support Instructions: 1. (Individual # 1) hooses when he is ready to do his faundry. 2. (Individual # 1) takes his dirty clothes to the laundry room and places them in the water. 3. (Individual # 1) selects the appropriate eycle and soap amount. 4. (Individual # 1) adds the soap and starts the washer. 5. (Individual # 1) puts his washed clothes in the dryer. 8. (Individual # 1) selects the dryer cycle and soap amount. 4. (Individual # 1) takes his clean clothes to his room and puts them away. 8. Staff provides support and assistance as needed. Frequency: Daily. Amount: 30 minutes."  "Desired Oulcome: (Individual # 1) chooses to live a healthy lifestyle and increase his overall well-being. Support Activities: (Individual # 1) completes his medication administration. 2. (Individual # 1) communicales when he is ready to complete his medication box out. 3. (Individual # 1) takes out the correct medication for administration. 4. (Individual # 1) explains his medication for edministration. 4. (Individual # 1) explains his medication for edministration. 5. (Individual # 1) takes out the correct medication for administration. 4. (Individual # 1) explains his medication firmes, reason and dosage. 5. (Individual # 1) takes his	PREFIX	HEACH DEFICIENCY	MUST BE PRECEOED BY FULL	PREF	ŦΙΧ	(EACH CORRECTIVE ACTION SHOU CROSS-REPERENCED TO THE APPRI	LD BE	COVILIFICAN
his medication box away. 6. Staff provides	W 159	15 minules. Suppor grooms his facial had (Individual # 1) choclean shave, goated (Individual # 1) grooms his facial had (Individual # 1) grooms had been a frequency. Daily. Activities: (Individual Instructions: 1. (Individual # 1) at takes his dirty cloth places them in the selects line appropriate directions. (Individual # 1) awasher. 5. (Individual # 1) takes his clean linem away. 8. State assistance as need Amount: 30 minutes. The sired Outcome: live a healthy lifesty well-being. Suppor completes his medication adminishis medication adminishis medication adminishis medication as presentation as presentation as presentation as presentation box medication box medication box medication box medication box	art Activities: (Individual # 1) air. Support Instructions: 1. oses a style of facial hair, a, beard, mustache, etc. 2. bis grooming supplies. 3. oms his facial hair. 4. Staff and assistance as needed. Amount: 15 minutes. Support al # 1) his laundry. Support dividual # 1) chooses when he undry. 2. (Individual # 1) es to the laundry room and water. 3. (Individual # 1) aids the soap and starts the lual # 1) puts his washed a (Individual # 1) selects starts the dryer. 7. (Individual a clothes to his room and puts a clothes to his room a clothes to his a clothes t	1	159			

Daily. Amount: Continually."

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		C		0938-0391
	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY JPŁETED
		49G052	B. WING	)		01	/26/2017
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		Į.	ET ADDRESS, CITY, STATE, ZIP CONS	1	**************************************
BRAMBL	ETON GROUP HOME			l .	5 SWEET ANDREA DRIVE BURN, VA 20148		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DALE
W 159	# 1's "Progress Not 01/01/2017 through with ASM (administ (Name of Group He Further review of the collection revealed program was imple opportunities; the A on only three out of medication administinglemented on on opportunities.  On 1/25/17 at 2:45 conducted with OS Intellectual Disability asked about the do Individual # 1's part treatment programs reflect the outcome If the documentation to cannot say that the was implemented."  On 1/25/17 at 4:40 member) # 1, programs reflect the outcome If the documentation to cannot say that the was implemented."  On 1/25/17 at 4:40 member) # 1, programs and aware of the No further information.	oximately t2:00 p.m. Individual tes" and data cottection dated to 01/07/2017 were reviewed rative staff member) # 1, ome) program manager. The progress notes and data individual # t's social skills mented only five out of seven DL program was implemented frequency from the program was implemented frequency from the program was sky three out of seven opportunities; the stration program was ly three out of seven p.m. an interview was M # 1, the QIDP (Qualified ties Professional). When cumentation regarding ticipation in their active statement and all parts of it, on does not reflect the outcome e active treatment program.  p.m. ASM (administrative staff ram manager of (Name of RN (registered nurse) # 1 were	W	159			
	ISP for Individual # measurable terms.	•					

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Individual # 2 was a 29 year old mate, who was admitted to (Name of Group Home) on 5/5/14.

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Facility IO: VAICENIR60

If continuation sheet Page 27 of 103



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	OF DEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETEO
		49G052	B. WING	and the Art	01/26/2017
NAME OF F	PROVIDER OR SUPPLIER	**************************************		STREET ADDRESS, CITY, STATE, ZIP CODE	
BRAMBL	ETON GROUP HOME			22755 SWEET ANOREA DRIVE ASHBURN, VA 20148	
(X4) ID PREFIX TAQ	(BAÇH DEFICIENCY	TEMENT OF BEFORENCIES  * MUST BE PRECEDED BY FULL  SCIDENTIFYING IMPORIMATION;	lo PREFI TAG		JUD HE COMPLETION
W 159	Continued From pa	ge 27	W:	<b>1</b> 59	
	Diagnoses in the cl not limited to: mild i spastic diplegia (2)	inical record included but were ntellectual disability (1), gastroesophageal reflux adisorder (4), renal calculi	,		
	Individual # 2's curr through 07/01/2017	ent İSP dated 07/01/2016 documented,			
	schedule to practice Support Activities: (and makes it. Sup#2) chooses what 2. (Individual #2) cincluded in his lunchis lunch. 4. (Individual #2) cho his tunch box. 5. Sassistance as need Amount: Continuall (Individual #2) cho wants to participate (Individual #2) attemeetings to learn thannouncements rejoutings/activities for (Individual #2) comand ideas for outing in. 3. (Individual #community outing reaction to the outing reaction to the outing than in the surface of the same action to the outing same action to the outing than the same action to the outing that is a same action to the action to the outing that is a same action to the action that is a same action to the action to	garding community If the upcoming week. 2. If the upcoming weekly are upcommunity weekly. If the upcoming weekly are upcoming weekly are upcoming weekly. If the upcoming weekly are upcoming weekly are upcoming weekly are upcoming weekly. If the upcoming weekly are upcoming we upcoming we upcoming weekly are upcoming we upcoming weekly are upcoming we upcoming we upcom			
	(activities of daily lit (Individual # 2) brus	I will practice my ADLs ving) daily. Support Activities: shes his teeth. Support dividual # 2) retrieves his			

toothbrush from his room.. 2. (Individual #2)

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	IX3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING	COMPLETED
49G052 B WING	01/26/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BRAMBLETON GROUP HOME 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	
(X4) 10 SUMIMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLANOF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IN TAG CROSS-REFERENCED TO THE APPROPRIATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY;	Notizijiko 38
w 159 Continued From page 28 applies toothpaste to his toothbrush. 3. (Individual # 2) brushes his teeth for 2 (two) minutes. 4. Staff provides support and assistance as needed. Frequency: Dally. Amount: 15 minutes. Support Activities: (Individual # 2) participates in his showering. Support Instructions: 1. (Individual # 2) soaps both arms and chest. 2. (Individual # 2) rinses both arms and chest. 3. Staff provides support and assistance as needed. Frequency: Daily. Amount: 30 minutes. Support Activities: Laundry. Support Instructions: 1. (Individual # 2) folds his clothes that he would put into his dresser. 2. (Individual # 2) puts his clothes away in his dresser. 3. Staff provides support and assistance as needed. Frequency: Daily. Amount: 30 minutes. Support Activities: PTs (Physical Therapies) [sic]. Support Instructions: 1. (Individual # 2) utilizes his adaptive equipment needed for PT (physical therapy). 2. (Individual # 2) completes a minimum of 3 (three) laps. 3. Staff provides support and assistance as needed. Frequency: Weekly. Amount: 45 minutes."  "Desired Outcome: I will increase my fine motor skills. Support Activities: (Individual # 2) chooses fine motor activities. Support Instructions: 1. (Individual # 2) chooses which activity he would like to participate for his fine motor skills, such as shredding paper/cutting paper, chopping/sliring/preparing meals, coloring, drawing, writing, or picking up playing cerds. 2. (Individual # 2) completes an activity of his choosing. 3. Staff provides support and assistance as needed. Frequency: Weekly. Amount: 30 minutes."  "Desired Outcome: I vill plan when I would like to	

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make contact with my mom, dad and sister.

Event ID: 30J411

Facility ID: VAICEMR80

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CENTER	RSFORMEDICARE	& MEDICAID SERVICES			<u> </u>	AB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	TIPLE CUNS IRUCTION DING	4	(X3) DATE SURVEY COMPLETED
		49G052	B. WING	 		01/26/2017
	ROVIDER OR SUPPLIER ETON GROUP HOME		<del>10</del>	STREET ADDRESS, CITY, STATE, Z 22755 SWEET ANDREA DRIVE ASHBURN, VA. 20148	IP COOE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAC		TIIÒN SHOULD I THE APPROPR	BE COMPLESSON
W 159	with his family ment (Individual # 2) coo make plans to visit to schedule a visit. phone numbers. 3 family visit schedule (Individual # 2) disc and what he did. 5 assistance as need Amount; 30 minute (Individual # 2) cho his choice. Suppor 2) plans and sched (Individual # 2) atte that he chose. 3. assistance as need Amount; 30 minute "Desired Outcome: management. Suppractices money minstructions: 1. (Inwhich store he woutype of item he is to the outing, (Individual to ensure he has e 3. Before purchasicounts his personal amount needed and the outing, (Individual money he has speinas left. 5. Staff passistance as need Amount; 30 minute	Individual # 2) schedules visits obers. Support Instructions: 1. rdinates when he wants to his family via (by) phone calls 2. (Individual # 2) dials the . (Individual # 2) reviews his e. 4. After the event busses how the outing went. Staff provides support and led. Frequency: Weekly. s. Support Activities: oses one-on-one outings of t Instructions: 1. (Individual # ules his one on one outings Staff provides support and led. Frequency: Weekly. s."  I will practice money weekly. s."  I spending money to the dopays the cashier. 4. After well # 2) counts how much money he rovides support and ded. Frequency: Weekly. s."	W	159		
	control in my life. 3	: I will increase my personal Support Activities: (Individual # personal control by using the				

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	w posterior and a second		MB NO. 0938-0391
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLISR/CLIA IDENTIFICATION HUMBER:	1''	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G052	B, WING		01/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME		221	REET AODRESS, CITY, STATE ZIP CODE 155 SWEET ANDREA DRIVE HBURN, VA 20148	1 4172011
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W 159	(Individual # 2) receive restroom. 2. (Inthe restroom. 3. (Inallings for support Inimself accordingly and assistance as Amount: 15 minute. "Desired Outcome: safety by participation administration proceive (Individual # 2) participation administration proceive (Individual # 2) statinis medications. 2 private area he was (Individual # 2) choose medications, dosagthose medications, takes his medications to support and assistations. Continuity. Amount: Continuity.	ently. Support Instructions: 1. ognizes when he needs to use ndividual # 2) takes himself to ndividual # 2) uses the hand 4. (Individual # 2) positions 6. 5. Staff provides support needed. Frequency: Daily, s."  I will improve my health and ing in my medication ess. Support Activities: ticipates in his medication ess. Support Instructions: 1. es when he is ready to take (Individual # 2) chooses a his to lake his medications. 3. oses the correct medications. 3. oses the correct medications. eviews the names of ge and the reason for taking 5. (Individual # 2) returns the box. 7. Staff provides ance as needed, Frequency: ntinually."	W 159		
	participating in mor drills. Support Active up and gets ready to drill; wearing appro 2. (Individual # 2) years zone. 3. Once at to (Individual # 2) waite evacuation drill is of (Individual # 2) entergency evacual	I will manage my safety by athly emergency evacuation vities: 1. (Individual # 2) gets for the emergency evacuation priate clothing for the weather. goes to the designated safety zone, the designated safety zone, the until the emergency over to ensure safety. 4. ers his home when the attention drill is completed and it is			

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assistance as needed. Frequency: Monthly.

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Facility ID. VAICEMR60

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(XI) () PRETIX TAG	(£ACH DEFICIENC)	NEXENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORTIECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPIRON DEFICIENCY)	38 C	(X5) COLPLETION NATE
W 159	Continued From pa	y."	W	59			
	was conducted in tale (administrative staff manager of (Name clinical director of (other staff member Intellectual Disability). The QIDP. OSM for an individual's I stated, "From multithe individual, the tale using the individual what is important to about the purpose Plan), ASM #1 and various skills to detect to the individual's particular and the outcomes bein measureable terms of (Name of Group clinical director of (that all the outcom were reviewed and in measurable terms they were aware of was the responsible outcomes and ens	p.m. a meeting and interview he presence of and with ASM if member) # 1, program of Group Home), ASM # 2, Name of Group Home), OSM or) # 1, the QIDP (Qualified ties Professional) and OSM # # 1 was asked how outcomes SPs are developed. OSM # 1 iple sources input from family, eam (interdisciplinary team) Its strengths, wants, needs and of the ISP (Individual Service) OSM # 1 stated, "To teach velop a level of independence obtential." When asked about g written/developed in s, ASM # 1, program manager Home) and ASM # 2, the Name of Group Home) stated es for all the individual's ISPs I that none of them were written ins. They further slated that I the issue. When asked if it lility of the QIDP to review the ure they were written in, OSM # 1 and ASM # 1 stated,					
	member) # 1, prog	p.m, ASM (administrative staff pram manager of (Name of RN (registered nurse) # Twere a above findings.					

No further information was provided prior to exit.

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	VOT ON MERIONINE	A MEDIOMID OF LANDER	,			<u>vo. 0930-0381</u>
STATEMĚNE AMD PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING	(X3) L C	DATE SURVEY COMPLETED
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NAXE OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Œ	
BRAMBL	ETON GROUP HOME	5		22755 SWEET ANDREADRIVE ASHBURN, VA 20148		
(74) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION S)	IOULD BE	DONPLETION DONPLETION HATE
W 159	by a limited mental adaptive behaviors schedules and rout Intellectual disability 18 and may result fautism or cerebral grauses, such as lac responsiveness. The from the website: <a href="https://report.nih.get.aspx?csid=100">https://report.nih.get.aspx?csid=100</a> (2) A form of cerebrate condition that usual childhood and permand coordination. A muscles and exagg The arm muscles and exagg The arm muscles a not affected at all. Contained the major include delayer milestones (i.e. rollimation). It occurs that controls mover abnormally. This in the website:	op of disorders characterized capacity and difficulty with such as managing money, ines, or social interactions. The originales before the age of rom physical causes, such as palsy, or from nonphysical sk of stimulation and adult his information was obtained ov/nihfactsheets/ViewFactShe al palsy, a neurological ly appears in infancy or early panently affects muscle control fected people have increased leads to spasticity (stiff or tight erated reflexes) in the legs, re generally less affected or other signs and symptoms dimotor or movementing over, sitting, standing) dia "scissored" gail (style of when the portion of the brain nent is damaged or develops formation was obtained from	W	159		
	pastic-diplegia-cere (3) Stomach conter the esophagus and was obtained from	nts to leak back, or reflux, into irritate it. This information				

(4) Symptoms of a brain problem. They happen

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ONSTRUCTION		TE SURVEY MPLETED
		49G052	# WING		Marie A Marie (mary 12) - 1 control decorate (marie 12) - 1 co	01	/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME	<b>Ξ</b>		2275	ET ADDRESS, CITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE IBURN, VA. 20148		
(X4)10 PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(Xă) COMPLETURI DATE
W 159	the brain. This inforwebsite:	age 33 , abnormal electrical activity in mation was obtained from the r.gov/medlineplus/seizures.ht	W	159			
	or ureter at the san obtained from the v	is a solid mass made up of tiny ore stones can be in the kidney ne time. This information was website: s.gov/ency/article/000458.htm					
		I to ensure the data collection as/goals for Individual # 2 were as.					
	01/01/2017 through The progress note: documentation of t	e" for Individual # 2 dated n 01/070/2017 were reviewed, s failed to evidence he data collection of Individuat goals in measurable terms.	,				
	was conducted in to (administrative statementager of (Name clinical director of (other staff member Intellectual Disabilia), the QIDP. When notes or data cotler in measureable termanager of (Name 2, the clinical direct stated that the programmental director direct	p.m. a meeting and interview he presence of and with ASM if member) #1, program of Group Home), ASM #2, Name of Group Home), OSM er) #1, the QIDP (Qualified ties Professional) and OSM #1 asked about the progress ction being written/documented ms, ASM #1, program of Group Home) and ASM # tor of (Name of Group Home) gress notes for all the viewed and that none of them					

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

Event ID: 30J411

Facility for VAICEMR60

If continuation sheet Page, 34 of 103

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CENIE	42 LOW MEDICAKE	& MEDICAID SEKVICES			OMP INC	<u>Y D839-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		49G052	B. WING	And the state of t	01	/26/2017
	ROVIDER OR SUPPLIER ETON GROUP HOME			STREET ADORESS, CITY, STATE, ZIP CODI 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	Ē	
(XJ(10) PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FUEL SCIDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRE IX (EACH CORRECTIVE ACTION SH	OULD BE	iX5) ROHLIJANON BYAU
W 159	on 1/25/17 at 4:40 member) # 1, programmer of the No further information. The OIDP failed (Individual Support	psurable terms. They further re aware of the issue.  p.m. ASM (administrative staff ram manager of (Name of RN (registered nurse) # 1were above findings.  ion was provided prior to exit.  to ensure Individual # 2's ISP Plan) for ADLs (Activities of	W	159		
	Daily Living), fine medication manage Individual # 2's currethrough 07/01/2017 "Desired Outcome: Support Activities: (teeth. Support Instructives his toothb (Individual # 2) app toothbrush. 3. (the for 2 (two) minutes and assistance as a Amount: 15 minute (Individual # 2) part Support Instruction both arms and ches both arms and ches and assistance as a Amount: 30 minute Support Instruction clothes that he would instruction clothes that he would instruction clothes that he would instruction manager in the manager instruction clothes that he would instruction manager in the manager instruction clothes that he would instruction in the manager instruction clothes that he would instruction in the manager instruction i	notor skills; restroom use and ement were implemented.				
	dresser, 3. Slaft p	rovides support and led. Frequency: Daily.				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS SOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				Ot	MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	TIPLE CONSTRUC	•		(X3) DATE SURVEY COMPLETED
		49G052	B. WING				01/26/2017
	ROVIOER OR SUPPLIER ETON GROUP HOME				ESS, CITY, STATE, ZIP ( T andrea drive Va. 20148	CODE	
(X-I) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EAC	ROVIDER'S PLAN OF CO CH CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY)	NSHOULD	BE DOMPLETION
W 159	(Physical Therapies 1. (Individual # 2) uneeded for PT (phy 2) completes a min Staff provides supp Frequency: Weekly "Desired Outcome: control in my life. S 2) will increase his prestroom independe (Individual # 2) received the restroom. 2. (I the restroom. 3. (I railings for support. himself accordingly and assistance as a Amount: 15 minutes "Desired Outcome: safety by participati administration proce (Individual # 2) participati administration proce (Individual # 2) stall-his medications. 2. private area he ware (Individual # 2) chowledge (Individual #	s. Support Activities: PTs s) [sic]. Support Instructions: utilizes his adaptive equipment sical therapy). 2. (Individual # imum of 3 (three) laps. 3. port and assistance as needed. Amount: 45 minutes."  I will increase my personal support Activities: (Individual # personal control by using the ently. Support Instructions: 1. agnizes when he needs to use individual # 2) takes himself to individual # 2) uses the hand 4. (Individual # 2) positions 5. Staff provides support needed. Frequency: Daily. s."  I will improve my health and ing in my medication ess. Support Instructions: 1. es when he is ready to take (Individual # 2) chooses a nits to take his medications. ess the correct medications. eviews the names of the and the reason for taking 5. (Individual # 2) returns the box. 7. Staff provides the box. 7. Staff provides the cas needed. Frequency:	₩.	59			

FORM CNS-2567(02-99) Provious Versions Obsolete

# 2's "Progress Notes" and data collection dated

Event ID.30J41f

Facility ID: VAICEMR60

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PRINTED: 02/07/2017 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
	CIF OEFICIENCIES I' DORRECTION	(X1) PROVIDER/SUPPLICR/CLIA IDENTIFICATION NUMBER:	· ·		ONSTRUCTION	(X3) OATE SURVEY COMPLETED
	Ĭ	49G052	B. WING			01/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME			2275	ET ADDRESS, CITY, STATE. ZIP CODE 5 SWEET ANDREA DRIVE BURN, VA. 29148	
(X4) ID PREFIX TAG	(EACH OFFICIENCY	TEMENT OF OEFICIENCIES * MUST HE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC LEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DUFICIENCY)	DBB VOMECTION
W 159	with ASM (administ (Name of Group Horollection revealed was implemented in the use of a restroction three of seven opadministration programmanager. documentation regardicipation in their OSM # 1 statement and atlip does not reflect the active freatment programmanager. On 1/25/17 at 4:40 member) # 1, programmanager.	in 01/07/2017 were reviewed rative staff member) # 1, ome) program manager, he progress notes and data Individual # 2's ADL program in zero of seven opportunities; om program was implemented opportunities; the medication ram was implemented in two lies.  p.m. an interview was M # 1, (Name of Group Home) When asked about the arding Individual # 2's in active treatment programs, should reflect the outcome arts of it. If the documentation is outcome I cannot say that the opprain was implemented."  p.m. ASM (administrative staff ram manager of (Name of RN (registered nurse) # 1 were	W.	159		
THE THE PARTY OF THE	tndividual # 3 was a admitted to (Name Diagnoses in the cl	a 28 year old female, who was of Group Home) on 9/22/11. inical record included but were re intellectual disability (1),				

gastroesophageal reflux disease (2), seizure

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			A 2 4 4 4 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	OMB NO	<u>), 0938-0391</u>
STATEM NY OF DEFICIENCIES AND FLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(x2) MULTIPLE CONSTRUCTION A. BUILDING				re survey
		49G052	B. WINE	i	our en la la la SM accombanación de la companya del companya de la companya de la companya del companya de la c	0.	1/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME		i.vii.XC#P	2275	EET ADDRESS, GITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE BURN, VA 20148		The state of the s
(XI)10 PREFIX TAG	(EAGH DEFICIENC)	OTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDEN REYING INFORMATION;	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND SHOUND FOR THE APPROPRIES OF THE APPROPRIES	ULD BE	ixa) Completrin Oate
W 159	"Desired Outcome: her preferences to (Individual # 3) effect others. Support Incommunicates her 2. Staff provides a needed. Frequence Support Activities: variety of activities: variety of activities: Support Instruction an activity she wan (Individual # 3) schit. 3. At the end of shares her thought supports and assist Monthly. Amount: (Individual # 3) corduring the house in support and assist Weekly. Amount: (Individual # 3) par Support Instruction communicates while to have for the support and assist Monthly. Amount: "Desired Outcome	ent ISP dated 10/01/2016 7 documented, (Individual #3) communicates others. Support Activities: ectively communicates with structions: 1. (Individual #3) wants her wants and needs. upport and assistance as ry: Daily. Amount: Continually. (Individual #3) chooses a and outings to participate in. is: 1. (Individual #3) chooses its to participate in. 2. redules her activity and attends if the activity, (Individual #3) is about it. 4. Staff provides tance as needed. Frequency: 30 minutes. Support Activities: arributes her ideas during Support Instructions: 1. rends the house meetings. 2. Inmunicates her preferences inceting. 3. Staff provides ance as needed. Frequency: 30 minutes. Support Activities: ticipates in menu planning. is: 1. (Individual #3) at meals and snacks she would week. 2. Staff provides ance as needed. Frequency:	W	159			
	Activities: (Individu	al #3) picks out her clothes for					

the day. Support Instructions: 1. (Individual #3)

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STATEMENT AND PLAN O	OF DEFICIENCIES CORRECTION	(XT) PROVIDER SUPPLICATION AUGUST	(X2) MUL A. BUILO	TIPLE CONSTRUCTION ING		(X3) OATE SURVEY COMPLETED
		49G052	B. WING	MININ MANAGAMAN, J.W. (* / PT. VITE/PTTT/ANDITAN/MININFERMINI		01/26/2017
	RIDVIDER OR SUPPLIER	And the state of t	L <sub>iston</sub>	STREET ALLIRESS, CITY, STATE, ZIP ( 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	CODE	
(X-I) IO PREFIX TAG	(EADIS DEFICIENC)	TEMENT OF DEFICIENCIES Y MIDST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULO E APPROPE	BE COMPLETION
W 159	and bedtime). 2. (I Staff provides supp frequency: Daily. Activities: (Individua Support Instruction her toothbrush with brushes her teeth. 3's) teeth to ensurcleaned. 4. Staff passistance as need Amount: 15 minute (Individual # 3) should be soap off her board assistance as Amount: 30 minute (Individual # 3) con Support Instruction what household che (Individual # 3) followed the chare of her chesupport and assist Daily. Amount: 30 (Individual # 3) par Support Instruction a meal to cook. 2. grocery list and should individual # 3) followed. 4. Staff proas needed. Frequeninutes."	age 38  would like to wear (for the day ndividual # 3) gets dressed. 3. port and assistance as needed. Amount: 30 minutes. Support al # 3) brushes her teeth. s: 1. (Individual # 3) prepares a toothpaste. 2. (Individual # 3) 3. Staff check (Individual # 4) they have been thoroughly provides support and ded. Frequency: Daily. ss. Support Activities: swer/bathes herself, Support dividual # 3) uses the hand and exiting the shower. 2. pares her wash cloth with soap and exiting the shower. 2. pares her wash cloth with soap and exiting the shower. 2. pares her wash cloth with soap and exiting the shower. 3 (Individual # 3's) rinses dy. 4. Staff provides support needed. Frequency: Daily. ss. Support Activities: npletes household chores. ss. 1. (Individual # 3) chooses ore(s) she wants to do. 2. bus through with completing noice. 3. Staff provides ance as needed. Frequency: minutes. Support Activities; ticipates in meat preparation. ss. 1. (Individual # 3) makes a pops for the needed items. 3. ows a recipe and prepares the vides support and assistance ency: Monthly. Amount: 30 st. (Individual # 3) enjoys a	W	159		
THE SECOND SECON	healthy lifestyle. S	upport Activities: (Individual # physical activity and/or				

Facility ID: VAICEMIR®C

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	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE. ZIP CO 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	DOE	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG	PROVIDER'S PLAN OF COR X JEACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULO BE	(X5) COMPLETION DATE
	Sales of the Control					**************************************

#### W 159 Continued From page 39

exercise for 15-30 minutes. Support Instructions: 1. (Individual # 3) decides what physical activity or exercise she would like to participate in. 2. (Individual # 3) actively participates in her exercises or physical activity. 3. Staff provides support and assistance as needed. Frequency: Daily. Amount: 30 minutes."

"Desired Outcome: (Individual #3) încreases her social and living skills. Support Activities: (Individual #3) participates in her medicalion administration. Support Instructions: 1. (Individual #3) notifies staff when it is time for her to take her medication. 2. (Individual #3) gets a cup of water. 3. (Individual #3) gels her medication box out and chooses the correct medication for lhat time. 4. (Individual #3) reviews her medication. 5. (Individual #3) takes her medication. 6. (Individual # 3) returns her medication box to the closet. 7. Staff provides support and assistance as needed. Frequency: Daily, Amount: 30 minutes. Support Activities: (individual #3) manages her money. Support Instructions: 1. (Individual # 3) reviews her balance and counts her money weekly. 2. (Individual #3) chooses which items/services she would like to buy. 3. (Individual #3) pays for her purchase and collects her receipt. 4. (Individual #3) balances her money. 5. Staff provides support and assistance as needed. Frequency: Weekly. Amount: 60 minutes. Support Activities: (Individual #3) participates in emergency evacuation drills. Support Instructions: 1. (Individual #3) acknowledges the emergency evacuation drill. 2. (Individual #3) makes sure sine is dressed appropriately. 3. (Individual #3) walks to the designated safe zone. 4. (Individual #3) remains in the safe zone until she is notified it is safe to return inside the building. 5. Staff

W 159

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STATEJEAN OF DEFICIONES  AND PLANGE CORRECTION  APROVIDER OR SUPPLIER  PRANBLETON GROUP HOME  PREPRIX TAG  SULMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUMBER)  PREPRIX TAG  SULMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUMBER)  TAG  PROVIDER OR SUPPLIER  PREPRIX TAG  SULMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUMBER) TAG  PROVIDER SPLAN OF CORRECTION (CACH DEFICIENCY NUMBER)  W 159 Continued From page 40 provides support and assistance as needed. Frequency: Monthly. Amount: 15 minutes."  On 1/24/17 at 2:30 p.m. a meeting and interview was conducted in the presence of and with ASM (administrative staff member) # 1, program manager of (Name of Group Home). ASM # 2, elinical director of (Name of Group Home). DSM (by the staff member) # 1, the QIDP (Qualified Intelloclual Disabilities Professional) and OSM # 3, the QIDP. OSM # 1 was asked how outcomes for an individual's Strengths, wants, needs and what is important to the Individual." When asked about the purpose of the ISP (Individual Service Plan), ASM #1 and OSM # 1 stated. "To teach various skills to develop a level of independence to the individual's potential." When asked disturbed the outcomes for all the individual's When asked disturbed the outcomes for gill the individual's When asked disturbed the outcomes for gill the individual's Strongths, wants, needs and what is important to the Individual's Vinen asked about the purpose of the ISP (Individual's Strongths) were reviewed and that none of them were written in measureable terms. They further stated that they were aware of the issue. When asked if it was the responsibility of the OIDP to review the outcomes before were written in	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
NAME OF PROVIDER OR SUPPLIER  BRAMBLETON GROUP HOME    2775 SWEET ANDREA DRIVE ASHBURN, VA 20148	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIERECLIA	1				
MANE OF PROVIDER OR SUPPLIER  BRAMBLETON GROUP HOME  CATION  CHAIN  CHAI			49G052	5. WING		. W t. Pironoch	0,	1/26/2017
ASHBURN, VA 20148	NAME OF F	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
### PREPRY TAG ** CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREPRY TAG ** CROSS-REFERENCED 10 THE APPROPRIATE DEFICIENCY)**  W 159 ** Continued From page 40	BRAMBL	ETON GROUP HOMI	<b>5</b>					Libert
provides support and assistance as needed. Frequency: Monthly. Amount: 15 minutes."  On 1/24/17 at 2:30 p.m. a meeting and interview was conducted in the presence of and with ASM (administrative staff member) #1, program manager of (Name of Group Home). ASM # 2, clinical director of (Name of Group Home). OSM (other staff member) #1, the QIDP (Qualified Intellectual Disabilities Professional) and OSM # 3, the QIDP. OSM #1 was asked how outcomes for an individual's ISPs are developed. OSM #1 stated, "From multiple sources, input from family, the individual's the team (interdisciplinary team) using the individual's strengths, wants, needs and what is important to the individual." When asked about the purpose of the ISP (Individual Service Plan), ASM #1 and OSM #1 stated, "To teach various skills to develop a level of independence to the individuals potential." When asked about the outcomes being written/developed in measureable terms, ASM #1, program manager of (Name of Group Home) and ASM #2, the clinical director of (Name of Group Home) stated the outcomes for all the individual's ISPs were reviewed and that none of them were written in measurable terms. They further stated that they were aware of the issue. When asked if it was the responsibility of the QIDP to review the outcomes and ensure they were written in	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPS.ETION
measurable terms, OSM # 1 and ASM # 1 stated, "Yes."  On 1/25/17 at 4:40 p.m. ASM (administrative staff member) # 1, program manager of (Name of Group Home) and RN (registered nurse) # 1were made aware of the above findings.	W 159	provides support a Frequency: Month! On 1/24/17 at 2:30 was conducted in the (administrative statemanager of (Name clinical director of (other staff member Intellectuat Disability), the QIDP. OSM for an individual's 1 stated, "From muttous the individual, the fusing the individual what is important the about the purpose Plan), ASM #1 and various skills to detent to the individual's 1 the outcomes being measureable terms of (Name of Group clinical director of the outcomes for a reviewed and that measurable terms were aware of the line responsibility outcomes and ensing the individual terms were aware of the line responsibility outcomes and ensing the individual terms "Yes."  On 1/25/17 at 4:40 member) #1, prog Group Home) and	nd assistance as needed. y. Amount: 15 minutes."  p.m. a meeting and interview the presence of and with ASM ff member) # 1, program of Group Home). ASM # 2, (Name of Group Home). OSM et ) # 1, the QIDP (Qualified ites Professional) and OSM # 1 was asked how outcomes ISPs are developed. OSM # 1 iple sources, input from family, team (interdisciplinary team) of the ISP (Individual Service of OSM # 1 stated, "To teach evelop a level of independence potential." When asked about ing written/developed in s, ASM # 1, program manager of Home) and ASM # 2, the (Name of Group Home) stated all the individual's ISPs were none of them were written in they further stated that they issue. When asked if it was of the QIDP to review the sure they were written in OSM # 1 and ASM # 1 stated of p.m. ASM (administrative stated arm manager of (Name of IRN (registered nurse) # 1were	i T	159			

No further information was provided prior to exit.

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

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CENTER	RS F OR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>אין מועונ</u>	<u>. บยอด-บอย เ</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i '		ONSTRUCTION		TE SURVEY MPLETED
		49G052	B. WING			01	/26/2017
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
BRAMBL	ETON GROUP HOME	<u> </u>			5 SWEET ANDREA DRIVE BURN, VA 20148	·	······································
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTING ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY;	D BE	1X51 COMPLETION SATE
W 159	Continued From pa	nge 41	W	159			
	References:						
	by a limited mental adaptive behaviors schedules and rout Intellectual disabilit 18 and may result tautism or cerebral causes, such as lar responsiveness. The from the website:	up of disorders characterized capacity and difficulty with such as managing money, tines, or social interactions. y originates before the age of from physical causes, such as palsy, or from nonphysical ck of stimulation and adult his information was obtained ov/nihfactsheets/ViewFaclShee					
	the esophagus and was obtained from	nts to leak back, or reflux, into f Irritate it. This information the website: n.gov/medlineplus/gerd.html.					
	because of sudder the brain. This info website:	brain problem. They happen in abnormal electrical activity in rmation was obtained from the higov/medfineplus/seizures.ht					
	website:	rmation was obtained from the h.gov/medlineptus/anxiety.html					
		d to ensure the data collection es/goals for Individual # 3 were as.					
	The "Progress Not	e" for Individual # 3 dated					

0 t/01/2017 through 0 t/070/2017 were reviewed.

		AND HOMAN OCH VICE					O. 0938-0391
222/14/20 50-1-10		& MEDICAID SERVICES			LE AAMO TELOTION		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		NTE SURVEY MPLETED
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NAME OF F	ROVIDER OR SUPPLIER			*	STREET ADDRESS, CITY, STATE, ZIP COOE	~ ~ .	
	PRAN ABANDUM NAME	<del>-</del>		1	22755 SWEET ANDREA DRIVE		
BRAMBL	ETON GROUP HOME			1	ASHBURN, VA 20148		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / NIUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT LEACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ULD BE	(XS) COMPRESSON EATE
<b>W</b> 150	Continued From pa	ine 42	W 1	159	)		
11 100	The progress notes						
	documentation of the	ne data collection of Individual					
	# 3's ISP oulcome/	goals in measurable terms.					
		p,m. a meeting and interview					
	was conducted in t	he presence of and with ASM					
	(administrative staf	f member) # 1, program					
	manager of (Name	of Group Home), ASM # 2, Name of Group Home), OSM					
	Cilinical director of (	r) # 1, the QIDP (Qualified					
	ilidaeil Italianaland Tiidaeil Italiaaland	ties Professional) and OSM#					
	3. the QIDP. When	asked about the progress					
i	notes or data collec-	ction being written/documented					
	in measureable ter	ms, ASM # 1, program					
	manager of (Name	of Group Home) and ASM#					
	2, the clinical direc	tor of (Name of Group Home)					
	stated that the prog	gress notes for all the viewed and that none of them					
	were written in mea	asurable terms. They further					
	slated that they we	re aware of the issue.					
	On 1/25/17 at 4:40	p.m. ASM (administrative staff					
	member) #1, prog	ram manager of (Name of					
	Group Home) and	RN (registered nurse) # 1were					
	made aware of the	above findings.					
	No further informat	tion was provided prior to exit.					
		to ensure Individual # 3's ISP					
	(Individual Support	Plan) for ADLs (Activities of					
		re Time; Communication; nagement; Participate in					
	ACTIVITY, MOREY MA	nagement, ranscipate in nedication Management;					
	Evacuation Drills w	vere implemented.					

Individual #3's current ISP dated 10/01/2016 through 09/30/2017 documented,

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** **		8 MEDICAID SERVICES			(		, 0938-0391
STAILMENT	OF DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(XII) DAT	E SURVEY IPLETED
		49G052	B. WING	i		01	/26/2017
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
BRAMBL	ETON GROUP HOME	-			65 SWEET ANDREA DRIVE BURN, VA 20148		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  LIUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERCY)	.D BE	(X4) COMPLE  IDN DATE
W 159	her preferences to (Individual # 3) effe others. Support Inscommunicales her 2. Staff provides someeded. Frequency Support Activities: (variety of activities: Support Instructions an activity she wand (Individual # 3) school it. 3. At the end of shares her thoughts supports and assist Monthly. Amount: (Individual # 3) conhouse meetings. Support and assists (Individual # 3) conduring the house mesupport and assists Weekly. Amount: 3 (Individual # 3) part Support Instruction communicales what like to have for the support and assists Monthly. Amount: "Desired Oulcome: schedule to comple Activities: (Individual the day. Support Indecides what she wand bedtime). 2. (I	(Individual # 3) communicates others. Support Activilies: ctively communicates with structions; 1. (Individual # 3) wants her wants and needs. upport and assistance as y. Daily. Amount: Continually. Individual # 3) chooses a and outlings to participate in. s: 1. (Individual # 3) chooses to participate in. 2. edules her activity and attends the activity, (Individual # 3) is about it. 4. Staff provides tance as needed. Frequency: 30 minutes. Support Activities: tributes her ideas during support Instructions: 1. Individual # 3. Staff provides ance as needed. Frequency: 30 minutes. Support Activities: tricipates in menu planning. s: 1. (Individual # 3) al meals and snacks she would week. 2. Staff provides ance as needed. Frequency:	W	159			

FORM CMS-2567 (1)2-99) Previous Voisions Obsolele

Frequency: Daily. Amount: 30 minutes. Support Activities: (Individual #3) brushes her teeth.

Event ID: 30J411

Facility ID: VAICEMR60

If continuation sheet Page, 44 of 103

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FORM APPROVED
OMB NO 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES		OMB NO, 0938-03					
STATEMENT	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED	
		49G052	e wine	i	***************************************	01/	/26/2017	
NAME OF F	PROVIDER OR SUPPLIER				EFT ADDRESS, CITY, STATE, ZIP CODE		***************************************	
BRAMBL	ETON GROUP HOME		***	ŀ	55 SWEET ANDRÉA DRIVE HBURN, VA. 20148			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION;	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	DBE	(X5) COMPLETION DATE	
W 159	her toothbrush with brushos her teeth.  3's) teeth to ensure cleaned. 4. Staff passistance as need Amount: 15 minute (Individual # 3) sho instructions: 1. (Incrails when entering (Individual # 3) prejand washes her bothe soap off her boand assistance as Amount: 30 minute (Individual # 3) com Support Instruction what household chrolindividual # 3) foliothe chore of her chsupport and assista Daily. Amount: 30 (Individual # 3) participates in a exercise for 15-30 1. (Individual # 3)	inge 44 s: 1. (Individual # 3) prepares toothpaste. 2. (Individual # 3) 3. Staff check (Individual # 4) they have been thoroughly provides support and led. Frequency: Daily. s. Support Activities: wer/battnes herself. Support dividual # 3) uses the hand and exiting the shower. 2. pares her wash cloth with soap dy. 3. (Individual # 3's) rinses dy. 4. Staff provides support needed. Frequency: Daily. s. Support Activities: apletes household chores. s: 1. (Individual # 3) chooses ore(s) she wants to do. 2. ows through with completing oice. 3. Staff provides ance as needed. Frequency: minutes. Support Activities: ticipates in meal preparation. s: 1. (Individual # 3) chooses (Individual # 3) makes a pps for the needed items. 3. ows a recipe and prepares the vides support and assistance ency: Monthly. Amount: 30  (Individual # 3) enjoys a upport Activities: (Individual # physical activity and/or minutes. Support Instructions decides what physical activity uld like to participate in. 2.	W	159				

(Individual #3) actively participates in her exercises or physical activity. 3. Staff provides

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·	OMB NO	<u> </u>
STATEMENT	OF DEFICIENCIES I' CORRECTION	(XI) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY IMPLETED
		49G052	B. WING	·	**************************************	0-	1/26/2017
	ROVIDER OR SUPPLIER	_	•	t	REET AODRESS, CITY, STATE, ZIP CODE 155 SWEET ANDREA DRIVE		
BRAMBL	ETON GROUP HOME			AS	HBURN, VA 20148		
(X4)HI PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MILIST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(MATE COMPLETION (X5)
W 159	Daity. Amount: 30 "Desired Outcome: social and living sk (Individual # 3) part administration. Su) (Individual # 3) noti to take her medication for that reviews her medication for that reviews her medication box to the support and assisted Daily. Amount: 30 (Individual # 3) main tructions: 1. (Individual # 3) chowould like to buy. Support and assisted Weekly. Amount: (Individual # 3) parevacuation drills. Support and assisted Weekly. Amount: (Individual # 3) ackey accuration drills. Support and assisted weekly. Amount: (Individual # 3) ackey accuration drills. Support and assisted weekly. Amount: (Individual # 3) ackey accuration drills. Support and assisted weekly. Amount: (Individual # 3) ackey accuration drills. Support and assisted weekly. Amount: (Individual # 3) ackey accuration drills. Support and assisted weekly. Amount: (Individual # 3) ackey accuration drills. Support and assisted weekly. Amount: (Individual # 3) ackey accuration drills. Support and assisted weekly. Amount: (Individual # 3) ackey accuration drills. Support and assisted weekly. Amount: (Individual # 3) ackey accuration drills. Support accuration drills.	ance as needed. Frequency:		159			

FORM CMB-2567[1)2-99) Provided Versions Obsolete

On 1/25/17 at approximately 1:35 p.m. Individual #3's "Progress Notes" and data collection dated

Event IO: 30J/b1

Facility (D: VA)CFMR66

If continuation sheet Page 46 of 103

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PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	11AID 140' 0920-038 !
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED
		49G052	B. WING		. a disamin	01/26/2017
	ROVIDER OR SLIPPLIER ETON GROUP HOMI	-		STREET AODRESS, C 22755 SWEET AND ASHBURN, VA 20	REA DRIVE	
(X4) IO PREFIX JAG	PACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREE TAG	X (EACH COR	R'S PLAN OF CORRECTIC RECTIVE ACTION SHOUL RENCED TO THE APPROF DEFICIENCY!	DSE CONFIGURA
W 159	with ASM (administration) (Name of Group Heurther review of the collection revealed communication, management implemented on zetthe ADL program was implemented opportunities.  On 1/25/17 at 2:45	n 01/07/2017 were reviewed lirative staff member) # 1, ome) program manager. ne progress notes and data Individual # 3's edication administration and int programs were ero out of seven opportunities; vas implemented on one out of s; the healthy lifestyle program on two out of seven		59		
	conducted with OS program manager, documentation reg participation in the OSM # 1 stated, "I statement and all p does not reflect the active treatment programmer) # 1, prosecutive from the programmer) # 1, prosecutive treatment programmer progr	SM # 1, (Name of Group Home) When asked about the parding Individual # 3's in active treatment programs, I should reflect the outcome parts of it. If the documentation e outcome I cannot say that the rogram was implemented."  I p.m. ASM (administrative stafter manager of (Name of RN (registered nurse) # 1were	1 ?			
W 231	No further informa 483.440(c)(4)(iii) h The objectives of must be expresse	lion was provided prior to exit. NDIVIDUAL PROGRAM PLAN the individual program plan d in behavioral terms that ble indices of performance.	W	231		
	This STANDARD	is not met as evidenced by:				

Facility IO: VAICEMR66

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391				
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,, .	TIPLE CONSTRUCTION NING		(X3) DATE SURVEY COMPLETED	
		49G052	B. WING			01/26/2017	
NAME OF F	ROVIDER OR SUPPLIER			STREET ALXDRESS, CITY, STATE, ZIP I	CODE		
BRAMBL	ETON GROUP HOME		···	22755 SWEET ANDREA DRIVE ASHBURN, VA 20148			
(X4)1 <u>0</u> PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD APPROPI	BE CONFIGURAL	
W 231	Continued From pa	age 47 ent review It was determined	W	231			
	that the facility staf	failed to develop objectives in	<b>9</b> 0231				
:: LOO ON	measurable terms	for three of four individuals in Individual # 1, # 2 and # 3.		RP will revise the Individuals outcomes/ re that it accurately reflect their needs.	objestives	3/8/17	
	ISP (individual serv measurable terms Skills; ADLs (Activi Community Resou	failed to define the following rice plan) outcomes/goals in for Individual # 1: "Social ties of Daily Living); rces; Personal Control; stration; and Evacuation Drills."	Pers 2: ADL Plan 3: ADL' Medi	al Skills, ADLs, Medication Administration unal Control, and Evacuation Drills 's, Fine Motor Skills, Restroom use, Med Visits with Family, Money Management, s, Edisura Time, Communication, Activity cation Administration, Participate in Hous Evacuation Drills.	ication ma , and Evac /, Money M	anagement oxiation Drills Vlanagement,	
	ISP (individual services measurable terms (Activities of Daily Visits with Family; Restroom Use; Me Evacuation Drills."  3. The facility staff ISP (individual services of Daily Communication; Activities of Daily Communication; A	failed to define the following vice plan) outcomes/goals in for Individual # 2: "ADLs Living); Fine Motor Skills, Plan Money Management; edication Management: and failed to define the following vice plan) outcomes/goals in for thdividual # 3: "ADLs Living); Leisure Time; activity; Money Management; se Meetings; medication Evacuation Drills."	objectly incorporate Program Person appropriate Program (that all QMRP)  The Clitical Control of the C	norm Manage/iOMRP will conduct mont services and needs are niet and are acc	ek needs a ng to all st staff mael staff to en s and is in thy assess urately refl	and it is  aff to review all  ling. The sure that the apionicated  smeals to ensure lected on the  Program Manager	
	ISP (individual ser measurable terms Skills; ADLs (Activ Community Resou	de:  If failed to define the following vice plan) outcomes/goals in for Individual # 1: "Social vities of Daily Living); arces; Personal Control; istration; and Evacuation Drills."					

FORM CMS-2567(O2-99) Previous Versions Obsolete

Individual # 1 was a 35 year old male, who was admitted to (Name of Group Home) on 7/19/11.

Event (0:30,41)

Facility ID VAICEMR60

If continuation sheet Page 48 of 103

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MAY 1 6 2017
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PRÍNTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION SING	(X3)	) DATE SURVEY COMPLETED
		49G052	B, WING	·		01/26/2017
-	PROVIDER OR SUPPLIER LETON GROUP HOME	Ŀ		STREET ADDRESS, CITY, STATE, ZIP CO 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148		
(X4) ID PREFIX TAG	TEACH DEFICIENCY	TEMENT OF DEFIGIENCIES  / MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	E DATE COMPLETION (XP)
W 231	not limited to: mode gastroesophageal (3), history of seizu disorder (5) and an Individual # 1's curr through 07/01/2017 "Desired Outcome: social skills. "Suppractices appropriatincrease his social (Individual # 1) use conversation; activitone of voice, perse subject matter, etc. and assistance as Amount: Continual (Individual # 1) eng Support Instruction an activity, i.e.: dra board games, vide 1) invites his house to participate in the provides support a Frequency: Weekly "Desired Outcome ADLs to increase hactivities: (Individual # 1) keekly individual # 1) keekly (Individual # 1) keekly (Individu	inical record included but were erate intellectual disability (1), reflux disease (2), dysphagla re disorder (4), impulse control xiety (6).	W 2	231		

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0.0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDEN (FICATION NUMBER	(* ,	TIPLE CONSTRUCTION		ITE SURVEY MPLETED
		49G052	B. WING		01	1/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOMI			STREET ADDRESS, CITY, STATE, ZIP ( 22755 SWEET ANDREA DRIVE ASHBURN, VA. 20148	CODE	
(X4HII PRL)TX TAG	(EACH DEFICIENC)	ATEMENT OF DEHICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 231	Support Instruction his toothorush from 1) put water and to (Individual # 1) hru 1) flosses and rins (Individual # 1) to 6 thoroughly cleaned 15 minutes. Support of the factor of the f	npletes his oral hygiene.  Is: 1. (Individual # 1) retrieves In the cabinet. 2. (Individual # Inothpaste on his toothbrush. 3. Ishes his teeth. 4. (Individual # Ies. Staff follows up with Ies. Staff follows up with Ies. Staff follows up with Ies. Tequency: Daily. Amount: Ior. Support Instructions: 1. Ior.		231		

1) plans volunteer outings and activities. 3. (Individual # 1) participates in volunteer outings

		& MEDICAID SERVICES				1APPROVED 0.0938-0391
STATEMENT	RS FOR MEDICARE FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
:	Lippology a pr	49G052	B. WING		**************************************	/26/2017
NAME OF	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP COO	E	
BRAMBI	ETON GROUP HOME	**		55 SWEET ANDREA DRIVE HBURN, VA 20148	X Andrews	
(X4) ID PREFIX IAG	(EACH DEFICIENCY	TEMENT OF CERCIENCIES  MUST BE PRECEDED BY (FULL SCIDENTIFYING INFORMATION)	IO PRESIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	IOULO BE	COMPLETION DATE
W 231	support and assistate Monthly. Amount: (Individual # 1) tries Instructions: 1. (Individual # 1) tries Instructions: 1. (Individual # 1) developer and assistate Monthly. Amount: (Individual # 1) developer and assistate Monthly. Amount: (Individual # 1) developer ability. 3. (Individual his ability. 4. Staff assistance as need Amount: 15 minute. "Desired Outcome: decision making to over things in his tif (Individual # 1) part house meetings. 3 (Individual # 1) cho house meeting. 2. communicate his poutings, meal choice would like to be avaprovides support as Frequency: Weekly Support Activities: (contact with his mount instructions: 1. (Incontact his family, phone to contact his chooses to schedu	choice. 4. Staff provides ance as needed. Frequency: 30 minutes. Support Activities: sinew activities. Support Activities: sinew activities. Support dividual # 1) chooses a new eto try. 2. (Individual # 1) as activity. 4. Staff provides ance as needed. Frequency: 15 minutes. Support Activities: elops new abilities. Support dual # 1) choose a new ability velop. 2. (Individual # 1) operatice developing his al # 1) practices developing provides support and led. Frequency: Monthly. s."  (Individual # 1) practices increase his personal control fe. Support Activities: ticipates in the scheduled Support Instructions: 1. oses to attend the scheduled (Individual # 1) witl verbally references for community references for	W 231			
	schedules visits or	er. 4. (Individual # 1) outings with his mom, dad or			1303300330	

Facility IO: VAIGEMR6[1]

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	INEMEDIA DE MEMBRIO.	& MEDICAID SERVICES			c	MB NO	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		49G052	B. WING			01/	26/2017
NAMEOFP	ROVIDER OR SUPPLIER				EET ADORESS, CITY, STATE, ZIP CODE		
BRAMBL	ETON GROUP HOME		A.1083H30NH-VV-V		IS SWEET ANDREA DRIVE IBURN, VA 20148	<b></b>	
(X4) ID PREFIX TAG	ZEACH DEFICIENCY	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	OBE	(X5) COMPLETION DATE
W 231	needed. Frequence minutes."  "Desired Outcome: live a healthy lifesty well-being. Support completes his med Support Instruction communicates whe medication adminish is medication box out the correct med (Individual # 1) expreason and dosage medication as presentation as presentation as presentation."	ides support and assistance as y: Weekly. Amount: 15  (Individual # 1) chooses to yie and increase his overall it Activities: (Individual # 1) ication administration. s: 1. (Individual # 1) en he is ready to complete his stration. 2. (Individual # 1) get out. 3. (Individual # 1) takes dication for administration. 4. plains his medication times, 5. (Individual # 1) takes his scribed. (Individual # 1) puts away. 6. Staff provides	W:	231			
	supports and assist Daily, Amount: Co "Desired Outcome safety. Support Ac practices emergen Instructions: 1, (In	tance as needed. Frequency: intinually."  (Individual # 1) maintains his stivities: (Individual # 1) icy evacuation drills. Support dividual # 1) is notifies when it					
	is time to perform a 2. (Individual #1) (Individual #1) exitimely manner. 4. designated safety re-enters the build determined to be \$	an emergency evacuation drill. dresses appropriately. 3. Its the building in a safe and (Individual # 1) waits in the zone. 5. (Individual # 1) ing after it has been safe. 6. Staff provides stance as needed. Frequency:					
	was conducted in	p.m. a meeting and interview the presence of and with ASM off member) #1, program					

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

manager of (Name of Group Home), ASM # 2, clinical director of (Name of Group Home), OSM

Event ID: 30J411

Facility ID: VAICEMR50

If continuation sheet Page 52 of 103

RECEIVED MAY 16 2017 **ADH/OFC** 

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		***************************************	<u>OMB NO</u>	), 0938-0391 <sub>.</sub>
	OF IDEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		49G052	8. WING	. yo. 1000 d. —	01	/26/2017
	ROVIDER OR SUPPLIER ETON GROUP HOME			STREET ADORESS, CITY, STATE, ZIP CO 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	), DE	
(X4; ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(IXS) (IDMPLETION DATE
W 231	Intellectual Disabilition 3, the QIDP. OSM for the individual's I stated, "From multiple individual, the trusing the individual what is important to about the purpose Plan), ASM #1 and various skills to detect the individual's purpose the outcomes being measureable terms of (Name of Group clinical director of (I the outcomes for a reviewed and none measurable terms, were aware of the individual's policy (ISP)" documented (Name of Corporat contain at a minimum measurable objection addressing each id Service Plan (ISP) Outcomes and Objectives / de expressed in terms	r) # 1, the QIDP (Qualified ies Professional) and OSM # # 1 was asked how outcomes SPs are developed. OSM # 1 ple sources, input from family, eam (Interdisciplinary team) is strengths, wants, needs and the individual." When asked of the ISP (Individual Service OSM # 1 stated, "To teach relop a level of independence otential." When asked about g written/developed in 5, ASM # 1, program manager Home) and ASM # 2, the Name of Group Home) stated If the individual's ISPs were of them were written in They further stated that they	W 2	:31		
	member) #1, prog	p.m. ASM (administrative staff ram manager of (Name of RN (registered nurse) # 1 were above findings				

Facility IO: VAICEMR60

No further information was provided prior to exit.

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

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OM	<u>B NO. C</u>	938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:	(X2) MÜL A. BUILO	TIPLE CONST	TRUCTION	C	(3) DATE ( COMPL	
		49G052	B. WING				01/2	6/2017
NAME OF F	PROVIDER OR SUPPLIER				OORESS, CITY, STATE, ZIP COI NEET ANDREA DRIVE	DE		
BRAMBL	ETON GROUP HOME	<u> </u>			RN, VA 20148			
(X4) ID PREFIX TAG	(EACH OFFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S ROSS-REFERENCEO TO THE AF DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
W 231	Continued From pa	age 53	W 2	231				
	References:							
	by a limited mental adaptive behaviors schedules and rout Intellectual disabilit 18 and may result autism or cerebral causes, such as la responsiveness. The from the website: https://ireport.nih.got.aspx?csid=100.  (2) Stomach contente esophagus and was obtained from https://www.nlm.nil	n.gov/medlineplus/gerd.html. sorder. This information was						
	https://www.nlm.nil sorders.html.	n.gov/medlineplus/swallowingdi						
	because of sudder the brain. This info website:	brain problem. They happen a abnormal electrical activity in rmation was obtained from the h.gov/medlineplus/seizures.ht						
	an inability to resis action that is harm is a relatively new	t disorders are characterized by t the impulse to perform an ful to one's self or others. This class of personality disorders, non of these are intermittent						

explosive disorder, kleptomania, pyromania,

PRINTED: 02/07/2017 FORMAPPROVED OMB NO. 0938-0301

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER	(X2) MUL A. BUILO	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G052	B. WING		01/26/2017
NAMI OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	3
BRAMBI	ETON GROUP HOME			22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	
(XI) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG		LD BE COMPLETION
W 231	compulsive gamblir trichotillomania. The from the website: http://medical-dictlopulse+Control+Disco.  (6) Fear. This infortwebsite: https://www.nlm.nih.#summary.  2. The facility staff ISP (individual servimeasurable terms for the facility staff).	ng disorder, and his information was obtained nary.thefreedictionary.com/lm	W 2	231	
	Fine Motor Skills; Pl Management, Restr Management: and E Individual # 2 was a admitted to (Name of Diagnoses in the cli- not limited to: mild in spastic diplogia (2).	lan Visits with Family, Money oom Use; Medication			
	Individual # 2's curre through 07/01/2017 "Desired Outcome: schedule to practice Support Activities: (I and makes it. Supp # 2) chooses what h 2. (Individual # 2) cl included in his lunch his lunch. 4. (Indivi	ent ISP dated 07/01/2016 documented, I have opportunities in my decision making skills, ndividual # 2) plans his lunch ort Instructions: 1. (Individual le wants for tomorrow's lunch, hooses whal he wants to be 1. 3. (Individual # 2) makes dual # 2) packs his lunch in taff provides support and			

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0038-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	VICES OMB NO. 0938-039				
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION ING		X3) DATE SURVEY COMPLETED	
		49G052	B. WING	THE TRANSPORT OF THE PARTY OF T		01/26/2017	
	PROVIDER OR SUPPLIER LETON GROUP HOME	4		STREET ADDRESS, CIT 22755 SWEET ANDRE ASHBURN, VA 201	EA DRIVE	V // NO. 12 0 11	
(X4) (I) PRECIX TAG	JEACH DEFICIENCY	FEMENT OF DEFICIENCIES OF DEPRECEDED BY FULL SO IDENTIFYING INFORMATION	ID PREF TAG	X (EACH CORR)	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRI DEFICIENCY)		
W 231	Amount: Continually (Individual # 2) choose wants to participate (Individual # 2) attermeetings to learn the announcements regoutings/activities for (Individual # 2) command ideas for outing in. 3. (Individual # community outing, reaction to the outing and assistance as in Amount: 45 minutes. "Desired Outcome: Support Activities: (Iteeth. Support Instrictieves his toothbrought (Individual # 2) applitoothbrush. 3. (Individual # 2) participate for 2 (two) minutes, and assistance as in Amount: 15 minutes (Individual # 2) participate both arms and ches and assistance as in Amount: 30 minutes Support Instructions clothes that he would (Individual # 2) puts dresser. 3. Staff prassistance as needed Amount: 30 minutes (Physical Therapies	ed. Frequency: Daily.  y. Support Activities: bese community outings he in. Support Instructions: 1. Indis the weekly house he updates and garding community the upcoming week. 2. Individual # 2) discusses g. 5. Staff provides support heeded. Frequency: Weekly.  i."  I will practice my ADLs daily. Individual # 2) brushes his huctions: 1. (Individual # 2) hush from his room. 2. his toothpaste to his his vidual # 2) brushes lils teeth 4. Staff provides support heeded. Frequency: Daily.  is. Support Activities: cipates in his showering.  it. 2. (Individual # 2) rinses t. 3. Staff provides support heeded. Frequency: Daily.  is. Support Activities: cipates in his showering.  it. 2. (Individual # 2) rinses t. 3. Staff provides support heeded. Frequency: Daily.  is. Support Activities: Laundry.  it. (Individual # 2) folds his d put into his dresser. 2. his clothes away in his	W 2	?31			

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039 t
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SHPPLIER/CLM IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49G052	B. WING	Attitude 1 > 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 /	01/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA. 20148	
(X4) IO PREFIX TAG	TEACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  BC (DENTIFYING IMFORMATION)	jia Prijeri Tag		OULD BE COMPLETION
W 231	2) completes a min. Staff provides supp Frequency: Weekly "Desired Outcome: skills. Support Actifine motor activities (Individual # 2) choolike to participate fo shredding paper/cu chopping/stirring/prdrawing, writing, or (Individual # 2) comehoosing. 3. Staff	sical therapy). 2. (Individual # imum of 3 (three) laps. 3. ort and assistance as needed Amount: 45 minutes."  I will increase my fine motor vities: (Individual # 2) chooses . Support Instructions: 1. oses which activity he would r his fine motor skills, such as tting paper, aparing meals, coloring, picking up playing cards. 2. pletes an activity of his provides support and ed. Frequency: Weekly.	W 2	?31	
	make contact with in Support Activities: (I with his family mem (Individual # 2) coor make plans to visit to schedule a visit, phorie numbers. 3. family visit schedule (Individual # 2) discuand hat he did. 5. Sassistance as needed Amounl: 30 minutes (Individual # 2) choo his choice. Support 2) plans and schedu (Individual # 2) atterthat he chose. 3. S	I will plan when I would like to my mom, dad and sister. Individual # 2) schedules visits bers. Support Instructions: 1. dinates when he wants to his family via (by) phone calls 2. (Individual # 2) dials the (Individual # 2) reviews his at 4. After the event usses how the outing went Staff provides support and ed. Frequency: Weekly.  Support Aclivities: uses one-on-one outings of Instructions: 1. (Individual # ales his one on one outings aleft provides support and ed. Frequency: Weekly.			

Amount: 30 minutes."

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CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB	NO. 0938-0391	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	{ <b>X3</b> }	(X3) DATE SURVEY COMPLETED	
		49G052	B. WING	)		01/26/2017	
	PROVIDER OR SUPPLIER LETON GROUP HOMI		•	STREET ADDRESS, CITY, STATE, ZIP 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	CODE	A 11 mm/, 200 11	
(X-I) ID PREFIX TAG	(EACH DEFICIENC)	งารัฟธุทร of Deficiencies Y Must be preceded by Full SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION E DATE	
W 231	"Desired Outcome: management. Suppractices money management. Suppractices money management. Suppractices money management. Suppractices money management. In the outing, (Individuate ensure he has eras. Before purchasicounts his personal amount needed and the outing, (Individuate outing)) assistance as needed and outing outling for support. In the restroom. 2. (Individuate outling) and assistance as needed outcome: safety by participating administration proceeding of the outlines of the outing outlines	I will practice money port Activities: (Individual # 2) anagement. Support dividual # 2) communicates ald like to go to and/or what woking to purchase. 2. Before usil # 2) goes over his finances mough to cover the purchase. In spending money to the dipays the cashier. 4. After usil # 2) counts how much and how much money he covides support and ed. Frequency: Weekly. S. "  I will increase my personal support Activities: (Individual # personal control by using the ently. Support Instructions: 1. ognizes when he needs to use individual # 2) takes himself to individual # 2) uses the hand 4. (Individual # 2) positions 5. Staff provides support needed. Frequency: Daily.	W	231			

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4. (Individual # 2) reviews the names of

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Facility ID, VAICEMR60

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FORM APPROVED
OMB NO 0038-0304

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(		0. 0938-0391
	TOF DEFICIENCIES OF CORRECTION	(XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) OATE SHRVEY COMPLETED	
		49G052	B. WING		· · · · · · · · · · · · · · · · · · ·	01	/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME	A.		227	EET AOORESS, CITY, STATE, ZIP COOE 55 SWEET ANDREA DRIVE HBURN, VA 20148	*	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPIRODEFICIENCY)	O Bā	(XS) COMPLETION DATE
W 231	medications, dosage those medications. takes his medications to takes his medication is medication to take this medication to take the medication to take the medication to take the medication the medication the medication the medication the medication to the medication that the medication that the medication the medication the medication that the medication the medication the medication the medication that the medication the medication that the medication the medication that the me	se and the reason for taking S. (Individual # 2) safely ns. 6. (Individual # 2) returns the box. 7. Staff provides ance as needed. Frequency: ntinually."  I will manage my safety by othly emergency evacuation wities: 1. (Individual # 2) gets or the emergency evacuation or the emergency evacuation or the designated safety needesignated safety and the emergency were to ensure safety. 4. From the work when the staff provides supports and ed. Frequency: Monthly.	W	231			

various skills to develop a level of independence to the individual's potential." When asked about

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347 tra   3   1 km	TO I OIT INCOID/ IIT	O BITTOLIA CATILATOR	<b>Т</b> от соно от	encentral section and the section of	Oliver 14	<u>U. 0936-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X3) PROVICER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
**************************************	***************************************	49G052	8 WING	© · · · · · · · · · · · · · · · · · · ·	o	1/26/2017
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP COI 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	Œ	
(XI) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID FREFI TAG	PROVIDER'S PLAN OF CORR X {EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AR DEFICIENCY)	HOULD BE	IXSI COMPLETION UALE
W 231	measureable terms of (Name of Group clinical director of (I) the outcomes for al reviewed and none measurable terms. Were aware of the is On 1/25/17 at 4:40 member) # 1, programed aware of the is No further information. References:  (1) Refers to a group by a limited mental of adaptive behaviors is schedules and roution and may result from the website: <a href="https://report.nih.get.aspx?csid=100">https://report.nih.get.aspx?csid=100</a> .  (2) A form of cerebrate condition that usually childhood and permand coordination. Af muscle tone which limuscles and exagget.	written/developed in , ASM # 1, program manager Home) and ASM # 2, the Name of Group Home) stated I the individual's ISPs were of them were written in They further stated that they sue.  p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1were	W 2	31		

not affected at all. Other signs and symptoms

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CENTE	KS FOR MEDICARE	E & MEDICAID SERVICES	······································	TO THE THE CONTRACTOR OF THE C	OMB NO	). <b>09</b> 38-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION ING	(X3) DAT	TE SURVEY VIPLETED
		49G052	8. WING	experience ( ) { } . If { }	01	/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME	Solution in the second		STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	T -5	Every C.
(84) ID PRECIX DAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEU TO THE APPH DEFICIENCY)	ULD BE	PAR PACITISON PARA
W 231	milestones (i.e. rolli walking on toes; an walking). It occurs that controls moved abnormally. This in the website: https://rarediseases.pastic-diplegla-cere (3) Stomach content the esophagus and was obtained from the https://www.nlm.nih (4) Symptoms of a because of sudden, the brain. This inforwebsite:	and motor or movement ing over, sitting, standing); and a "scissored" gait (style of when the portion of the brain ment is damaged or develops aformation was obtained from scinfo.nih.gov/diseases/9637/sebral-palsy.	W 23	31		
	crystals. One or mo or ureter at the sam obtained from the w <a href="https://medlineplus">https://medlineplus"&gt;.</a> 3. The facility staff to	s.gov/ency/article/000458.htm failed to deline the following				
	measurable terms for (Activities of Daily Li Communication, Activities)	tivity; Money Management; e Meetings; Medication				, regularis

Individual # 3 was a 28 year old female, who was admitted to (Name of Group Home) on 9/22/11.

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CENTER	RS FOR MEDICARE	: 8 MEDICAID SERVICES	Market to test subseque	MANAGEMENT I I - 1	O	MB NO. 0938-0391
STATEMENT	FOLDITICIENCIES OF CORRECTION	(x.t) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V. BOILD		STRUCTION	(X3) DATE SURVEY COMPLETEO
		49G052	6. WING			01/26/2017
	FROVIDER OR SUPPLIER LETON GROUP HOME			22755 S	ADDRESS, CITY, STATE, ZIP CODE WEET ANDREA DRIVE JRN, VA. 20148	T F F F T T - LOON TO T - LOON
(X4) ID FREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI: TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD PROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE COMPLETION
W 231	Diagnoses in the clinot limited to: sever gastroesophageal ridisorder (3), and ar Individual #3's curre through 09/30/2017  *Desired Outcome: her preferences to continuously (Individual #3) effect others. Support Inscommunicates her 2. Staff provides staneeded. Frequency Support Activities: (variety of activities: Support Instructions an activity she want (Individual #3) scheit. 3. At the end of shares her thoughts supports and assist Monthly. Amount: 3 (Individual #3) continuously meetings. Support and assista Weekly. Amount: 3 (Individual #3) part Support Instructions communicates what like to have for the	linical record included but were re intellectual disability (1), reflux disease (2), seizure nxiety (4).  ent ISP dated 10/01/2016 7 documented,  (Individual # 3) communicates others. Support Activities: ectively communicates with structions: 1. (Individual # 3) wants her wants and needs. upport and assistance as y: Daily. Amount: Continually. (Individual # 3) chooses a and outings to participate in. s: t. (Individual # 3) chooses ts to participate in. 2. edules her activity and attends the activity, (Individual # 3) s about it. 4. Staff provides tance as needed. Frequency: 30 minutes. Support Activities: dributes her ideas during support Instructions: 1. Individual # 3) and the house meetings. 2. Inmunicates her preferences neeting. 3. Staff provides ance as needed. Frequency: 30 minutes. Support Activities: ticipates in menu planning. s: 1. (Individual # 3) at meals and snacks she would week. 2. Staff provides ance as needed. Frequency:	W 2	31		

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"Desired Outcome: (Individual #3) has a flexible

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Facility ID: VAICENIRGO

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION	(X3) OA	NE SURVEY MPLETED
		49G052	B. WING		- dia = A.A. redokatana ana ana ana ana ana ana ana ana an	0.	1/26/2017
NAVE OF	PROVIDER OR SUPPLIER	#			EET ADDRESS, CITY, STATE, ZIP CODE		1120120 11
BRAMB	LETON GROUP HOME	2			55 SWEET ANDREA DRIVE HBURN, VA. 20148		
(XII) ID PREFIX TAG	(EAGH DEFICIENCY	JEMENT OF DEFICIENCIES MIUST BE PRECÉDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDERS FLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	COMPLETION DATE
W 231	Activities: (Individual the day. Support Indecides what she wand bedtime). 2. (In Staff provides supp Frequency: Daily. Activities: (Individual Support Instructions her toothbrush with brushes her teeth. 3's) teeth to ensure cleaned. 4. Staff passistance as need Amount: 15 minutes (Individual # 3) show Instructions: 1. (Incrails when entering (Individual # 3) prepand washes her boothe soap off her chosupport Instructions what household choothe chore of her chosupport and assistance as malt household choothe chore of her chosupport and assistance as meal to cook. 2. (grocery list and sho) (Individual # 3) followed. 4. Staff providual # 3)	ge 62  Ite her ADLs. Support al # 3) picks out her clothes for istructions: 1. (Individual # 3) vould like to wear (for the day individual # 3) gets dressed. 3. ort and assistance as needed. Amount: 30 minutes. Support al # 3) brushes her teeth.  Is: 1. (Individual # 3) prepares toothpaste. 2. (Individual # 3) 3. Staff check (Individual # 3) 3. Staff check (Individual # 3) 4. Support Activities: wer/bathes herself. Support and ed. Frequency: Daity.  Individual # 3) uses the hand and exiting the shower. 2. wares her wash cloth with soap dy. 3. (Individual # 3's) rinses dy. 4. Staff provides support needed. Frequency: Daily.  Individual # 3) chooses ore(s) she wants to do. 2. ws through with completing pice. 3. Staff provides ince as needed. Frequency: minutes. Support Activities: cipales in meal preparation.  Individual # 3) makes a ps for the needed items. 3. ws a recipe and prepares the ides support and assistance may Monthly. Amount: 30	W 2	!31			

minutes."

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	PROVIDER OR SUPPLIER			227	EET ADDRESS, CITY, STATE, ZIP CODE 55 SWEET ANDREA DRIVE HBURN, VA 20148		I file say the term of
(X4) ili PREFIX PAG	(EACH DEFICIENCY	VEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATITING	ID PREFI TAG		PROVIDER'S PLAN OF CORRE 1EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	OATE COMPLETRON (XX)
W 231	healthy lifestyle. Su 3) participates in a pexercise for 15-30 resercise for 15-30 resercises she would (Individual # 3) active exercises or physics support and assistated Daily. Amount: 30 resercises or physics support and assistated Daily. Amount: 30 resercises or physics support and assistated individual # 3) participated Outcome: social and living ski (Individual # 3) participated for medication social and living ski (Individual # 3) notification box out medication box out medication for that reviews her medication for that reviews her medication box to the support and assistated Daily. Amount: 30 resercises and counts (Individual # 3) man instructions: 1. (Individual # 3) choose would like to buy. 3 purchase and collect # 3) balances her medication daily. Amount: 6 (Individual # 3) participated in assistated weekly. Amount: 6 (Individual # 3) participated in a signal participat	(Individual # 3) enjoys a upport Activities: (Individual # physical activity and/or minutes. Support Instructions: decides what physical activity uld like to participate in. 2. vely participates in her all activity. 3. Staff provides ance as needed. Frequency:	W2	:31			

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evacuation drill. 2. (Individual # 3) makes sure she is dressed appropriately. 3. (Individual # 3)

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	. 0938-039 t E SURVEY PLETED		
		49G052	8. WINC	·	PRODUCTION OF THE STATE OF THE	01/	26/2017		
NAME OF I	PROVIDER OR SUPPLIER		L	នា	REET ADDRESS, CITY, STATE, ZIP CODE		**************************************		
BRAMBI	ETON GROUP HOME				755 SWEET ANDREA DRIVE SHBURN, VA 20148				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION;	IÐ PREF TAG		PROVIDER'S PLAN OF CORRECT IN [EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETXIN DATE		
W 23t	# 3) remains in the it is safe to return in provides support an Frequency: Monthly On 1/24/17 at 2:30 was conducted in the administrative staff manager of (Name clinical director of (Name clinical director of (Name clinical director) of (Name conductor) of (	ated safe zone. 4. (Individual safe zone until she is notified safe zone as needed.  Amount: 15 minutes."  p.m. a meeting and interview she presence of and with ASM member) # 1, program of Group Home), ASM # 2, Name of Group Home), OSM # 2, Name of Group Home), OSM # 1, the QIDP (Qualified see Professional) and OSM # 1 stated how outcomes SPs are developed. OSM # 1 stated, "To make and the individual." When asked of the ISP (Individual Service OSM # 1 stated, "To teach selop a level of independence otential." When asked about written/developed in ASM # 1, program manager Home) and ASM # 2, the lame of Group Home) stated the individual's ISPs were of them were written in They further stated that they is use.  D.m. ASM (administrative staff am manager of (Name of RM (registered nurse) # twere	W:	23 t					
	made aware of the a	above findings.							

No further information was provided prior to exit.

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

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STATEMENT OF DEFICIENCIES   IXI) PROVIDER/SUPPLIER/CLIA   IX2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING			IX3LDATE SURVEY COMPLETED		
		49G052	B WING		01/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME	-		STREET ADDRESS, GITY, STATE, ZIP GODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	
(X4) ID PREF(X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	(I) PREH NAG		DBE COMPLEOUN
W 231	References:  (1) Refers to a grouby a limited mental adaptive behaviors schedules and rout Intellectual disability 18 and may result fautism or cerebral grauses, such as lac responsiveness. Tr from the website: https://report.nih.got.aspx?csid=100.  (2) Stomach contenthe esophagus and was obtained from https://www.nlm.nih.	ap of disorders characterized capacity and difficulty with such as managing money, ines, or social interactions. It is originates before the age of rom physical causes, such as palsy, or from nunphysical causes, or from nunphysical ck of stimulation and adult his information was obtained anythin factsheets/ViewFactSheets to leak back, or reflux, into irritate it. This information the website:	Wá	231	
W 249	because of sudden the brain. This infor website: https://www.nlm.nih ml.  (4) Fear. This infor website: https://www.nlm.nih #summary.  483.440(d)(1) PRO As soon as the inteformutated a client's each client must retreatment program	brain problem. They happen, abnormal electrical activity in mation was obtained from the agov/medlineplus/seizures.ht mation was obtained from the gov/medlineplus/anxiety.html GRAM IMPLEMENTATION redisciplinary team has a individual program plan, ceive a continuous active consisting of needed ervices in sufficient number	W :	249	

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Facility 1D, VAICFIJIR60

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STATEMENT OF DEFICIENCIES ANITH AN OF CORRECTION (X1) PROVIDERSUPPLIENCIA IDENTIFICATION NUMBER:			1	TIPLE CONSTRUCTION	(X3) D	(X3) DATE SURVEY COMPLETED	
		49G052	B. WING		0	1/26/2017	
	PROVICIER OR SUPPLIER ETON GROUP HOME	<u> </u>		STREET AUDRESS, CITY, STAT 22755 SWEET ANDREA DRIV ASHBURN, VA. 20148		<del>1960 (Belle Medic De Living) (Bernell Medicons)</del>	
(X4) ID PREFEX TAG	(EACH DEPICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FILL SC IDENTIFYING INFORMATION(	id PREFI TAG	<b>*</b> =	ACTION SHOULD BE TO THE APPROPRIATE	IAS) EOLIFE FILON DAVE	
 W 249	Continued From pa	ge 66	W 2	249			
 and frequency to support the achievement of the objectives identified in the individual program plan.			W249	)		, , , , + (+++74 <b>044444444</b>	
				VRP will revise the ludividuals on tre that it accurately reflect their o		3/6/17	
		s not met as evidenced by: rview and clinical record	2: ADI	dal Skills, ADLs, and Medication A L's, Fine Motor - Skills, Restrocen agement			

review, it was determined that the residential staff failed to ensure an Individual was receiving services consistent with the Individual Support Plan for three of four Individuals in the survey sample, Individuals #1, #2 and #3.

- 1. The facility staff failed to implement individual # 1's ISP (Individual Support Plan) for social skills, ADLs (Activities for Daily Living) and medication administration.
- 2. The facility staff falled to implement Individual # 2's ISP (Individual Support Plan) for ADLs (Activities of Daily Living); fine motor skills; restroom use and medication management.
- 3. The facility staff failed to implement Individual #3's ISP (Individual Support Plan) for ADLs (Activities of Daily Living): Leisure Time; Communication; Activity; Money Management; Participate in House Meetings; medication Management; Evacuation Drills

The findings include:

1. The facility staff failed to implement Individual # 1's ISP (Individual Support Plan) for social skills, ADLs (Activities for Daily Living), community resources, personal control, medication administration and evacuation drills.

- 3: ADL's, Leisure Time, Communication, Activity, Money Management, and Evacuation Drills.

The Program ManageAQMRP will review all individual's outcomes/ objectives to ensure that it accurately reflects their needs and it is incorporated within the Person Center Plan.

The Program Manager/QMRP will provide training to all staff to review all individual's Person Center Plans within the next staff meeting. The pringram Manager will provide supervision to all staff to ensure that the person Center Plan accurately reflects the needs and is implemented appropriately.

The Program ManageriQMRP will conduct monthly assessments to ensure Itial all services and needs are met and are accurately reflected on the QMRP note,

The Clinical Director will review within supervision with the Program Manager the documentation to support the coordination of services for each individual needs

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CENTERS FOR MEDICARE & MEDICAID SERVICES					MB NO. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	'	TIFLE CONSTRUCTION	(X3) DATE SURVIEY COMPLETED
		49G052	8. WING		01/26/2017
	ROVIDER OR SUPFLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA. 20148	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFI TAG		DIBE COMPLETION
Ŵ 249	admitted to (Name Diagnoses in the clinot limited to: mode gastroesophageai r (3), history of seizur disorder (5) and and Individual # 1's curr through 07/01/2017  "Desired Outcome: social skills. "Supp practices appropriation increase his social skills. "Supp practices appropriation; active tone of voice, persocutores of voice, persocutores and assistance as r Amount: Continually (Individual # 1) engs Support Instructions an activity, i.e.: draw board games, video 1) invites his house to participate in the provides support an Frequency: Weekly  "Desired Outcome: ADLs to increase his Activities: (Individual # 1) keep (Individual #	a 35 year old male, who was of Group Home) on 7/19/11. inical record included but were trate intellectual disability (1), effux disease (2), dysphagiare disorder (4), impulse control kiety (6).	W 2	249	

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Event (0:30.44)1

Facility ID: VAICEMR60

If continuation sheet Page 68 of 103

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PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	<del></del>			MB NO. 0938-03	191
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION	(X3) OATE SURVEY COMPLETED	
		49G052	B. WING		No. 481. contains contained and the contained contained and contained an	01/26/2017	
	PROVIDER OR SUPPLIER LETON GROUP HOMI		****	2275	ET ADDRESS, CITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE BURN, VA 20148		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBC courre	ÓΝ
W 249	Daily. Amount: 15 (Individual # 1) con Support Instruction his toothbrush from 1) put water and too (Individual # 1) brus 1) flosses and rinso (Individual # 1) to e thoroughly cleaned 15 minutes. Support of the flow of the	minutes. Support Activities: minutes. Support Activities: minutes is oral hygiene, s: 1. (Individual # 1) retrieves is the cabinet. 2. (Individual # othpaste on his toothbrush. 3, whes his teeth. 4. (Individual # is. Staff follows up with msure his teeth have been. Frequency: Daily. Amount: int Activities: (Individual # 1) air. Support Instructions: 1, is es a style of facial hair, ie, beard, mustache, etc. 2, is his groomling supplies. 3, ons his facial hair. 4. Staff and assistance as needed. Amount: 15 minutes. Support all # 1) his laundry. Support lividual # 1) chooses when he undry. 2. (Individual # 1) ies to the laundry room and water. 3. (Individual # 1) iate cycle and soap amount. adds the soap and starts the ual # 1) puts his washed in 6. (Individual # 1) selects starts the dryer. 7. (Individual clothes to his room and puts aff provides support and ed. Frequency: Daily.	W	¥49			TO THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERT

communicates when he is ready to complete his

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CENTER	& MEDICAID SERVICES	OMB NO. 0938-0:					
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	IX3) DATE SURVEY COMPLETED	
		49G052	B. WING	i		01/26/2017	
	PROVIDER OR SUPPLIER			227	REET ADDRESS, CITY, STATE. ZIP COOE 755 SWEET ANDREA DRIVE SHBURN, VA. 20148		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	1X	PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	DBE CONFERTION	
W 249	his medication box out the correct med (Individual # 1) expl reason and dosage medication as press his medication as press his medication as press his medication as press his medication box supports and assist Daily. Amount: Correct Total Progress Not 01/01/2017 through with ASM (administration (Name of Group Horogram was implesseven opportunities implemented on onlopportunities; the macrogram was implessed opportunities. On 1/25/17 at 2:45 conducted with ASM program manager. documentation regaparticipation in their ASM # 1 stated, "Its statement and all paddes not reflect the active treatment program."	stration. 2. (Individual # 1) get tout. 3. (Individual # 1) takes dication for administration. 4. plains his medication times. 5. (Individual # 1) takes his scribed. (Individual # 1) puts away. 6. Staff provides away. 6. Staff provides atance as needed. Frequency: ntinually."  **Toximately 12:00 p.m. Individual tes" and data collection dated in 01/07/2017 were reviewed trative staff member) # 1, pome) program manager. The progress notes and data individual # 1's social skills emented on only five out of staff three out of seven needication administration emented on only three out of seven medication administration emented on only three out of		249			

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the time of its development. Components of the plan are fully implemented, with the consumer

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Facility ID: VAICEMR00

Il continuation sheet Page, 70 of 103

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	v <b>a</b>				D. 0938-0391
	OF DEFICIENCES OF CORRECTION	(X1) PROVIDER:SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUIL I		CONSTRUCTION	[X3] [X	VIE SURVEY IMPLETED
		49G052	B. WING	i		n.	1/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME			227	EET ADDRESS, CITY. STATE, ZIP CODE 55 SWEET ANDREA DRIVE HBURN, VA. 20148		( ) des ( ) des ( )
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION;	ID FREF TAG		PROVIDERS PLAN OF COURECT LEACH CORRECTIVE ACTION SHOL CROSS-REPERFINGED TO THE APPRO HEFICIENCY)	ILD BE	INTE CONFLETION (X2)
W 249	active engagement objective / desired of ISP."  On 1/25/17 at 4:40 member) # 1, progr Group Home) and f made aware of the No further informati References:  (1) Refers to a group by a limited mental adaptive behaviors schedules and routintellectual disability 18 and may result from the website: https://report.nih.got.aspx?csid=100.  (2) Stomach content the esophagus and was obtained from the well-the sillow, nim.nih (3) A swallowing disobtained from the well-the sillow, nim.nih disorders.html>.	earning environment and necessary to reach his or her putcomes as defined in the p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1were above findings.  on was provided prior to exit.  In of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions, originates before the age of rom physical causes, such as palsy, or from nonphysical check of stimulation and adult is information was obtained w/nihfactsheets/ViewFactShee ats to leak back, or reflux, into irritate it. This information he website:  .gov/medlineplus/gerd.html.  order. This information was	W	249			

because of sudden, abnormal electrical activity in

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

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

STATELIENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G052	B. WING	;		01/26/2017
	PROVIDER OR SUPPLIER			2275	EET ADDRESS, CITY, STATE. ZIP CODE IS SWEET ANDREA DRIVE IBURN, VA 20148	
(X4) ID PREFIX TAG	(EAGH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE COMPLETION
W 249	websile;	ge 71 mation was obtained from the n.gov/medlineplus/seizures.ht	W:	249		
	an inability to resist action that is harmful is a relatively new cand the most commexplosive disorder, compulsive gamblin trichotifomania. The from the website:	is information was obtained nary.thefreedictionary.com/lm				
	website:	mation was obtained from the .gov/medlineplus/anxiety.html				
	# 2's ISP (Individual (Activities of Daily Livisits with family; mo	failed to implement Individual Support Plan) for ADLs iving); fine motor skills; plan oney management; restroom nagement and evacuation				
	admitted to (Name of Diagnoses in the climot limited to: mild in spastic diplegia (2),	29 year old male, who was of Group Home) on 5/5/14. nical record included but were ntellectual disability (1), gastroesophageal reflux disorder (4), renat calcuti				

Individual #2's current ISP dated 07/01/2016

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0	938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		49G052	B. WING_	The state of the s	01/2€	5/2017
NAME OF F	ROVIDER OR SUPPLIER		-1	STREET ADDRESS, CITY, STATE, ZIP CO 22755 SWEET ANDREA DRIVE	ODE	72011
BRAMBL	ETON GROUP HOME			ASHBURN, VA 20148		
(X4) ID FREF(X TAG	(EACH DEFICIENCY	TELIENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING DIFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE U	IXS) SOMPLETION DATE
	Support Activities: ( teeth. Support Instructioner his toothbot (Individual # 2) appl toothbrush. 3. (Ind for 2 (two) minutes, and assistance as r Amount: 15 minutes (Individual # 2) part Support Instructions both arms and ches both arms and ches and assistance as r Amount: 30 minutes Support Instructions clothes that he would (Individual # 2) puts dresser. 3. Staff pr assistance as need Arnount: 30 minutes (Physical Therapies 1. (Individual # 2) u needed for PT (phys 2) completes a mini Staff provides support Frequency: Weekly.  "Desired Outcome: control in my life. Si 2) will increase his p restroom independe (Individual # 2) reconther restroom. 2. (In-	I will practice my ADLs daily. Individuat # 2) brushes his ructions: 1. (Individual # 2) rush from his room 2. lies toothpaste to his ividual # 2) brushes his teeth 4. Staff provides support needed. Frequency: Daily. s. Support Activities: icipates in his showering. st. 1. (Individual # 2) ronses at. 2. (Individual # 2) rinses at. 3. Staff provides support needed. Frequency: Daily. s. Support Activities: Laundry. s. Support Activities: Laundry. s. 1. (Individual # 2) folds his ad put into his dresser. 2. his clothes away in his	W 2	· · · · · · · · · · · · · · · · · · ·		
		4. (Individual #2) positions				

him accordingly. 5. Staff provides support and

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		49G052	B. WING	ž		047	26/2017
	PROVIDER OR SUPPLIFE ETON GROUP HOME		<b>.l.</b>	2275	EET ADDRESS, CITY, STATE, ZIP CODE 55 SWEET ANDREA DRIVE 1BURN, VA 20148	1 0 112	EU/EU I /
(X4) ID PREFIX TAG	(BACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  GC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIC {FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY;	DBE	(X5) COMPLETEN DATE
W 249	Continued From pa assistance as need Amount: 15 minutes	ed. Frequency: Daily.	W	249			,
	safety by participating administration proceed (Individual # 2) participating administration proceed (Individual # 2) state his medications, 2, private area he wand (Individual # 2) choose. (Individual # 2) choose medications, dosagninose medications, takes his medications to the same of the s	ess. Support Activities: cipates in his medication ess. Support Instructions: 1. es when he is ready to take (Individual # 2) chooses a ts to take his medications. 3. esses the correct medications. eviews the names of e and the reason for taking 5. (Individual # 2) safely hs. 6. (Individual # 2) returns he box. 7. Staff provides hoce as needed. Frequency:					
	# 2's "Progress Note 01/01/2017 through with ASM (administr (Name of Group Ho Further review of the collection revealed I was implemented or opportunities; the us implemented on three the medication admits the medication admits the collection of the collection admits the medication admits the medication admits the collection of the collection admits the collection admits the collection of the collection admits the collection admits the collection admits the collection admits the collection of the collection admits the collection admits the collection of the collection admits the collecti	eximately 12:55 p.m. Individual as and data collection dated 01/07/2017 were reviewed ative staff member) # 1, me) program manager, a progress notes and data ndividual # 2's ADL program a zero out of seven program was as out of seven opportunities; inistration program was out of seven opportunities.					
	conducted with ASM program manager. documentation rega	n.m. an interview was l # 1, (Name of Group Home) When asked about the rding Individual # 2's active treatment programs					-

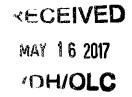
FORM CMS-2567(U2-99) Previous Versions Obsolete

ASM # 1 stated, "It should reflect the outcome

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Facility ID VAICEMREC

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	,			MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G052	B. WING			01/	26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME	È		227	EET ADDRESS, CITY, STATE, ZIP CODE 55 SWEET ANDREA DRIVE	-	***************************************
				18A	1BURN, VA 20148	***************************************	
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W 249	Continued From pa	de 74	W 2	} <b>∆</b> @			7777
	statement and all pl does not reflect the	arts of it. If the documentation outcome I cannot say that the ogram was implemented."	41 Z	.49			4
	member) # 1, progr	p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1were above findings.					TO TO THE TOTAL PROPERTY OF THE TOTAL PROPER
	No further informati	on was provided prior to exit.					
	References:						7 (All 18 )
	by a limited mental adaptive behaviors schedules and routi intellectual disability 18 and may result frautism or cerebral places, such as lac responsiveness. The from the website:	p of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. Foriginates before the age of comphysical causes, such as ealsy, or from nonphysical k of stimulation and adult is information was obtained ovinihfactsheets/ViewFactShe					
	condition that usuall childhood and perm and coordination. At muscle tone which I muscles and exagge. The arm muscles ar not affected at all. O may include delayed milestones (i.e. rollin walking on toes; and	al palsy, a neurological y appears in infancy or early anently affects muscle control fected people have increased eads to spasticity (stiff or tight erated reflexes) in the legs e generally less affected or ther signs and symptoms I motor or movement ag over, sitting, standing); I a "scissored" gait (style of when the portion of the brain					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

CENTER	& MEDICAID SERVICES		<del>03/o/roo/138</del> /occupation	MB NO. 0938-0391		
	OF DEFICIENCES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			CONSTRUCTION	(X3] DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER ETON GROUP HOME	=	wława.	2275	EET ADDRESS, CITY, STATE, ZIP CODE 55 SWEET ANDREA DRIVE HBURN, VA. 20148	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	JEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION!	ED PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
W 249	Continued From pa	oe 75	W 2	MQ		
	that controls moved abnormally. This in the website: https://rarediseases.pastic-diplegia-cere (3) Stomach content the esophagus and was obtained from thttps://www.nlm.nih (4) Symptoms of a because of sudden, the brain. This inforwebsite: https://www.nlm.nih.ml.	ment is damaged or develops formation was obtained from a.info.nih.gow/diseases/9637/s bral-palsy. hts to leak back, or reflux, into irritate it. This information				
	crystals. One or mo or ureter at the sam obtained from the w https://medlineplus.	re stones can be in the kidney le time. This information was rebsite: gov/ency/article/000458.htm.				
	# 3's ISP (Individual (Activities of Daily L Communication; Ac	failed to implement Individual ! Support Plan) for ADLs iving); Leisure Time; tivity; Money Management; e Meetings; medication uation Drills				
	admitted to (Name of Diagnoses in the clinot limited to: sever	28 year old female, who was of Group Home) on 9/22/11. nical record included but were e intellectual disability (1), eflux disease (2), seizure xiety (4).				

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CENTER	(S FUR MEDIUARE	: & MEDICAID SERVICES		(	<u> </u>
	OF DEFICIENCIES P CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G052	8. WING	warrow maken was an accompany of the control of the	01/26/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE, ZIP CODE	
BRAMBL	ETON GROUP HOME	<u>:</u>		22755 SWEET ANDREA DRIVE ASHBURN, VA. 20148	
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OFFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	IO PREFI TAG		DBE COMPLETION
W 249	through 09/30/2017 "Desired Outcome: her preferences to (Individual # 3) effe others. Support Inscommunicates her: 2. Staff provides staneeded. Frequency Support Activities: (variety of activities: (variety of activities: Support Instructions an activity she wand (Individual # 3) scheit. 3. At the end of shares her thoughts supports and assist Monthly. Amount: 3 (Individual # 3) cont house meetings. S (Individual # 3) atter (Individual # 3) atter (Individual # 3) conduring the house m support and assista Weekly. Amount: 3 (Individual # 3) part Support Instructions communicates what like to have for the support and assista Monthly. Amount: 3 "Desired Outcome: schedule to comple Activities: (Individual the day. Support Instructions comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule to comple Activities: (Individual the day. Support Instructions schedule the day. Support Instructions schedule the day.	ent ISP dated 10/01/2016 documented, (Individual # 3) communicates others. Support Activities: ctively communicates with structions: 1. (Individual # 3) wants her wants and needs apport and assistance as yr Daily. Amount: Continually. Individual # 3) chooses a end outings to participate in. s: 1. (Individual # 3) chooses is to participate in. 2. edules her activity and attends the activity, (Individual # 3) about it. 4. Staff provides ance as needed. Frequency: of minutes. Support Activities: tributes her ideas during upport Instructions: 1. Individual # 3) and the house meetings. 2. municates her preferences eeting. 3. Staff provides rice as needed. Frequency: of minutes. Support Activities: icipates in menu planning. it. (Individual # 3) the meals and snacks she would week. 2. Staff provides nce as needed. Frequency: of minutes."  (Individual # 3) has a flexible the her ADLs. Support (Individual # 3) picks out her clothes for structions: 1. (Individual # 3)	W 2	249	
		ould like to wear (for the day			

Staff provides support and assistance as needed.

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			ON	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1	TIPEL CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		49G052	8. WING	· · · · · · · · · · · · · · · · · · ·	İ	01/26/2017
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(XII) (D PREFIX TAG	(EACH DEFICIENC)	REMIENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	KCTION SHOULD E O THE APPROPRI	
W 249	Activities: (Individual Support Instructions her toothbrush with brushes her teeth. 3's) teeth to ensure cleaned. 4. Staff plassistance as need Amount: 15 minute: (Individual # 3) short Instructions: 1. (Incrails when entering (Individual # 3) pregand washes her both the soap off her both and assistance as Amount: 30 minute: (Individual # 3) follothe chore of her chosupport and assistate Daily. Amount: 30 in (Individual # 3) part Support Instructions a meal to cook. 2. grocery list and short (Individual # 3) follomeal. 4. Staff provas needed. Frequentially if estyle. Staff provas needed. Frequentially if estyle. Staff participates in a lexercise for 15-30 in 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1. (Individual # 3) of 1.	Amount: 30 minutes. Support al # 3) brushes her teeth. s: 1. (Individual # 3) prepares I loothpaste. 2. (Individual # 3) 3. Staff check (Individual # 4) they have been thoroughly provides support and led. Frequency: Daily. s. Support Activities: wer/bathes herself. Support dividual # 3) uses the hand and exiting the shower. 2. pares her wash cloth with soap dy. 3. (Individual # 3's) rinses dy. 4. Staff provides support heeded. Frequency: Daily. s. Support Activities: apietes household chores. s: 1. (Individual # 3) chooses one(s) she wants to do. 2. bows through with completing once. 3. Staff provides ance as needed. Frequency: minutes. Support Activities: dicipates in meal preparation. s: 1. (Individual # 3) chooses (Individual # 3) makes a pos for the needed items. 3. bows a recipe and prepares the prides support and assistance ency: Monthly. Amount: 30 (Individual # 3) enjoys a upport Activities: (Individual # 4) enjoys a upport Activities: (Individ	W 2	49		

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES					
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENYIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY
I		49G052	B. WING	;		LD BE COMPLET	J26/2017
	PROVIDER OR SUPPLIER			227	REET ADDRESS. CITY, STATE, ZIP CODE 55 SWEET ANDREA DRIVE HBURN, VA 20148		I LUI LUI I
(XII) (DI PREFIX IAG	(EACH DEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	JD PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BC	COMPLETION
	exercises or physic support and assistate Daily. Amount: 30 in "Desired Outcome: social and living ski (Individual # 3) part administration. Support administration. Support administration box out to take her medication box out medication for that it reviews her medication for that it reviews her medication. 6. medication box to the support and assistate Daily. Amount: 30 in (Individual # 3) man instructions: 1. (Individual # 3) choose would like to buy. 3 purchase and counts (Individual # 3) partitive evacuation drills. Si (Individual # 3) partitive evacuation drills. Si (Individual # 3) acknowledge.	ively participates in her cal activity, 3. Staff provides ance as needed. Frequency:	W 2	249			

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							NW WELLKOARD
CENTERS FO	OR MEDICARE	& MEDICAID SERVICES	4			<u>OMB</u>	NO. 0938-0391
STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		DATE SURVEY COMPLETED
		49G052	B WINC		e		01/26/2017
NAME OF PROVID	ER OR SUPPLIER			i	EET ADDRESS, CITY, STATE, ZIP COL	DE	***************************************
BRAMBLETON	GROUP HOME	=		i	55 SWEET ANDREA DRIVE HBURN, VA 20148		
	EACH DEFICIENC'	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION;	IO PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
On 1 # 3's 01/0 with (Nanh Furth colle comi mone imple the A seve was oppo On 1 cond progr docu partic ASM state does activ On 1 mem Grou made No fu	"Progress Not 1/2017 through ASM (administing of Group Hoter review of the ction revealed munication, mean mented on zeamented on zeamented on zeamented or zeamented or zeamented or zeamented or zeamented or zeamented or zeamented or zeamented or zeamented or zeamented or zeamentation regalization in their #1 stated, "It ment and all prot reflect the zeament produced with ASM and the zeament produced with the zeament produced with zeament zeament produced with zeament produced zeament zeam	oximately 1:35 p.m. Individual ites" and data collection dated in 01/07/2017 were reviewed rative staff member) # 1, ome) program manager, are progress notes and data Individual # 3's edication administration and int programs were ro out of seven opportunities; as implemented on one out of state healthy lifestyle program on two out of seven  p.m. an interview was with # 1, (Name of Group Home). When asked about the ording Individual # 3's active treatment programs, should reflect the outcome arts of it. If the documentation outcome I cannot say that the ordinal manager of (Name of RN (registered nurse) # 1were above findings.  In was provided prior to exit.	W	249			

schedules and routines, or social interactions. Intellectual disability originates before the age of

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

	OF DEFICIENCIES OF CORRECTION	(XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G052	B. WING	The state of the s	01/26/2017	
,	PROVIDER OR SUPPLIER			STREET ALIDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148		
(X4) ID PREFIX YAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NEORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
W 249	autism or cerebral causes, such as lar responsiveness. The from the website: https://report.nih.got.aspx?csid=100.  (2) Stomach content the esophagus and was obtained from https://www.nlm.nih  (3) Symptoms of a because of sudden the brain. This inforwebsite: https://www.nlm.nihml.	from physical causes, such as palsy, or from nonphysical ck of stimulation and adult his information was obtained by/nihfactsheets/ViewFactShee hts to leak back, or reflux, into firitate it. This information the website: h.gov/medlineplus/gerd.html. brain problem. They happen, abnormal electrical activity in mation was obtained from the h.gov/medlineplus/seizures.ht	W 24	9		
W 252	website: https://www.nlm.nih #summary. 483.440(e)(1) PRO Data relative to acc specified in client in objectives must be terms.  This STANDARD is Based on residentif day program record was determined tha	mation was obtained from the agov/medlineplus/anxiety.html GRAM DOCUMENTATION omplishment of the criteria adividual program plan documented in measurable as not met as evidenced by: all program record reviews, it review and staff interview, it it the QIDP (Qualified ies Professional) failed to	W 25	2		

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CENTERS FOR MEDICARE & MEDICAID SERVICES			3 OMB NO. 0938-0391					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	IX3) DATE SURVLY COMPLETED		
		49G052	8. WING			01/26/2017		
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET AOORESS, CITY, STATE, ZIP CODE			
BRAMBL	ETON GROUP HOME	<b>:</b>			5 SWEET ANDREA DRIVE IBURN, VA. 20148			
(X4) ID PRSFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES * MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO OEFICIENCY)	DBE CONFLETION		
W 252	Continued From pa	f	W:	252				
		onitor the individuals' active		*****************	(779a	***************************************		
		s for three of five individuals in Individuals # 1, # 2 and # 3.	W252					
	- ·	to ensure the data collection	The OM plan out	RP wilt i comest <u>i</u>	revise individuals #1, 2, and 3's Person C poals into measurable terms.	enter 3/8/17		
of the ISP (Individu outcomes/goals for measurable terms.	r Individual # 1 were in	The QMRP will update their goals to ensure that it is accurately reflect the needs of individuals #1,2,&3.						
	measurable terms.		The Pro	grant M	anagor/QMRP will review all other individ	ual's outcemes		
		. The QIDP failed to ensure the data collection fithe ISP outcomes/goals for Individual # 2 were		es to en:	sure that it accurately reflects their needs in Center Plan.			
	in measurable term		The Pro individu	gram Ma al's Pors	anager/QMRP will provide training to all s on Center Plans within the next staff med	ta# to reviewÚtt sting.		
		d to ensure the data collection s/goals for Individual # 3 were s.	The General Manager (OMD) will another a to averthe to the contract that all					
	of the (Name of Da outcomes/goals for	to ensure the data collection y Program) ISP Individual # 3's were in						
	measurable terms.							
	The findings include	<b>e</b> ;						
	of the ISP (Individu	to ensure the data collection al Service Plan) Individual # 2 were in	inrlividis n a time	al#3 co	complete a day program recont review to nsents "Behavioral Support Ptan" is curre seded.	ensure that 3/8/17 nt and signed i		
	Individual # 1 was a 35 year old male, who was admitted to (Name of Group Home) on 7/19/11. Diagnoses in the clinical record included but were			The QMRP will complete a day program renord review of all other individuals to ensure that the "Beltavioral Support Plan" is current and signed in a timely manner annually or as needed.				
	not limited to: mode gastroesophageal r	erate intellectual disability (1), reflux disease (2), dysphagia re disorder (4), impulse control	quarteri	gram fvl y record ty of car	anager/OMRP will conduct monthly day preview to ensure all consents is current, a.	rogram observations and up-to-date, Und to ensure		

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disorder (5) and anxiety (6).

The Program Manager will review this process to ensure compliance and to prevent further deficiencies. Wission Effectiveness/ Clinical Director will also conduct quarterly reay program record review to ensure compliance.

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENT/FICATION NUMBER)			ONSTRUCTION	(X3) DATE S COMPLE	
		49G052	B. WINC			01/26	/2017
	PROVIDER OR SUPPLIFIR LETON GROUP HOME	Ë	- Bernard	2275	ET ADDRESS, CITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE BURN, VA 20148	. , , , , , , , , , , , , , , , , , , ,	<del></del>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUILL SCIDENTILYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE C	IXS; OMPLETION DATE
W 252	O1/01/2017 through The progress notes documentation of the progress notes documentation of the 1's ISP outcome/gray of I's I's ISP outcome/gray of I's I's I's I's I's I's I's I's I's I's	e" for Individual # 1 dated in 01/070/2017 were reviewed, is failed to evidence he data collection of Individual goals in measurable terms.  p.m. a meeting and interview he presence of and with ASM if member) # 1, program of Group Home), ASM # 2, Name of Group Home), OSM et 1, the QIDP (Qualified ties Professional) and OSM # nasked about the progression being written/documented ms ASM # 1, program of Group Home) and ASM # to of Group Home) and ASM # to of (Name of Group Home) is notes for all the individuals that none of them were written ins. They further stated that the Issue.  "8.1 Qualified Intellectual ional" documented, "The pole for the integration, oring and development of the Plan, and to ensure quality the program." Under "8.1.2 all Disabilities Professional ides" it documented, "A records to include clinical, call to ensure prescribed ices are being implemented ted appropriately and that any ove been incorporated into	W	252			

On 1/25/17 at 4:40 p.m. ASM (administrative staff member) # 1, program manager of (Name of

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49G052	B. WING_		01/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME			STREET ADDRESS, CITY, STATE ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	1 01/20/2017
CII (4X) XEH4XIQ EAT	(EAGH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
W 252	made aware of the No further informati References: (1) Refers to a grouby a limited mental adaptive behaviors	RN (registered nurse) # 1werd above findings.  on was provided prior to exit.  p of disorders characterized capacity and difficulty with such as managing money.	W 28	52	
	Intellectual disability 18 and may result fr autism or cerebral p causes, such as lac responsiveness. Th from the website:	nes, or social interactions. coriginates before the age of rom physical causes, such as palsy, or from nonphysica) is of stimulation and adult is information was obtained w/nihfactsheets/ViewFactShee			
	the esophagus and was obtained from t	ts to leak back, or reflux, into irritate it. This information he website: gov/medlineplus/gerd.htmt.			
	obtained from the w	order. This information was ebsite: gov/medlineplus/swallowingdi			
	because of sudden, the brain. This information website:	orain problem. They happen abnormal electrical activity in mation was obtained from the gov/medlineplus/seizures.ht			
		disorders are characterized by the impulse to perform an			

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
		49G052	B. WING		Ŏ1	/26/2017
	PROVIDER OR SUPPLIER ETON GROUP HOME	Account Name and Account of the Acco		STREET ADDRESS, CITY, STATE, ZIP CO 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148		12012011
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECETIED BY FULL  SC IDENTIFYING INFORMATION)	id Prefi Tag		SHOULD BE	(XS) COMPLETION DATE
₩ 252	is a relatively new cand the most compexptosive disorder, compulsive gamblin trichotillomania. The from the website: http://medical-dictio pulse+Control+Discipulse+C	ul to one's self or others. This class of personality disorders, non of these are intermittent kleptomania, pyromania, ng disorder, and his information was obtained mary thefreedictionary com/lm orders.  Imation was obtained from the gov/medlineplus/anxiety.html  to ensure the data collection s/goals for Individual # 2 were s.  I 29 year old male, who was of Group Home) on 5/5/14. Inicat record included but were intellectual disability (1), gastroesophageal reflux disorder (4), renal calculi.  If for Individual # 2 dated 01/070/2017 were reviewed.	W 2	252		

(other staff member) # 1, the QIDP (Qualified

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONS		(X3) DATE SURVEY COMPLETED
		49G052	B. WING			01/26/2017
	PROVIDER OR SUPPLIER LETON GROUP HOME	- ^ ~		22755 S	ADDRESS, CITY, STATE, ZIP CODE WEET ANDREA DRIVE IRN, VA. 20148	- Salar
(X4) ID PREFIX DAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP OEFICIENCY)	BE COMPLETION
W 252	3, the QIDP. When notes or data collectin measureable termanager of (Name 2, the clinical direct stated that all the prindividuals were revivere written in meastated that they were crew and for the made aware of the No further information. References:  (1) Refers to a group by a limited mental adaptive behaviors schedules and routintellectual disability 18 and may result from the website: <a href="https://report.nih.get.aspx?csid=100">https://report.nih.get.aspx?csid=100</a> .  (2) A form of cerebrondition that usual childhood and permand coordination. A muscle tone which	ies Professional) and OSM # asked about the progress stion being written/documented ms ASM # 1, program of Group Home) and ASM # or of (Name of Group Home) rogress notes for all the riewed and that none of them isurable terms. They further re aware of the issue.  p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1were above findings.  on was provided prior to exit.  p of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions. r originates before the age of rom physical causes, such as palsy, or from nonphysical sk of stimulation and adult is Information was obtained ov/nihfactsheets/ViewFactShe	W	252		

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Facility ID: VAICEMR50

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

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THE REAL PROPERTY AND ADDRESS OF THE PARTY AND	C. C. Constitution of the		,		OMID 140, 0836-0381	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		49G052	B. WING		01/26/2017	
	PROVIDER OR SUPPLIER	and the state of t		STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148		
(X4) IU PRĆEIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FUIL  SCIDENT (FYING INFORMATION)	ID PRET FAG		MORESON DECIMA	
W 252	not affected at all. Of may include delayer mitestones (i.e. rolli walking on toes; an walking). It occurs that controls moven abnormally. This in the website: https://rarediseases pastic-diplegia-cere  (3) Stomach content the esophagus and was obtained from thitps://www.nlm.nih  (4) Symptoms of a the because of sudden, the brain. This infort website: https://www.nlm.nih.mit.  (5) A kidney stone is crystals. One or moor ureter at the sam obtained from the wind was allowed from the wind stone in the sam obtained from the wind stone is crystals. One or moor ureter at the sam obtained from the wind stone is crystals. The QIDP failed of the ISP outcomes in measurable terms.	re generally less affected or other signs and symptoms of motor or movement on over, sitting, standing); did a "scissored" gait (style of when the portion of the brain nent is damaged or develops formation was obtained frominfo.nin.gov/diseases/9637/s brai-palsy.  Its to leak back, or reflux, into irritate it. This information the website:gov/medlineplus/gerd.html, orain problem. They happen abnormal electrical activity in mation was obtained from thegov/medlineplus/seizures.ht  Is a solid mass made up of tiny re stones can be in the kidney e time. This information was ebsite: s.gov/ency/article/000458.htm  If to ensure the data collection s/goals for Individual # 3 were sec.	W	252		
		28 year old female, who was of Group Home) on 9/22/11.				

Diagnoses in the clinical record included but were

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0		
	OF DEFICIENCIES OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G052	B. WING	;	······································	01/26	/2017	
	PROVIDER OR SUPPLIER LETON GROUP HOME	2		2275	ET ADDRESS, CITY, STATE, ZIP CODE 5 SWEET ANDREA DRIVE IBURN, VA 20148			
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FUIL  SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI [EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY]	LD BE C	(Xn) OMPLETEIN TRAD	
W 252	gastroesophageal r disorder (3), and an disorder (3), and an The "Progress Note 01/01/2017 through The progress notes documentation of the 3's ISP outcome/s.  On 1/24/17 at 2:30 was conducted in the (administrative staff manager of (Name clinical director of (I (other staff member intellectual Disability 3, the QIDP. When notes or data collection measureable terminager of (Name 2, the clinical director stated that all the prindividuals were reviewere written in meastated that they were work were written in meastated that they were that they were that they were that they were that they were written in meastated that they were they were that they were they were that they were they were that they were they were they were that they were the	re intellectual disability (1), effux disease (2), seizure exiety (4).  effor Individual # 3 dated of 01/070/2017 were reviewed, falled to evidence the data collection of Individual goals in measurable terms.  p.m. a meeting and interview the presence of and with ASM of member) # 1, program of Group Home), ASM # 2, Name of Group Home), OSM of # 1, the QIDP (Qualified ites Professional) and OSM # asked about the progress ation being written/documented the ASM # 1, program of Group Home) and ASM # or of (Name of Group Home) regress notes for all the riewed and that none of them surable terms. They further the aware of the issue.  p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1 were	W	252				

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adaptive behaviors such as managing money,

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r'Eldici.	<u>va eon mediowize</u>	A MICDIOAID SERVICES				NAID IAM, CASO-CORT
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDERSUPPLIERVCIJA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL		(X3) DATE SURVEY COMPLETED	
		49G052	£, WING			01/26/2017
NAME OF F	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP COD€	
BRAMBI	ETON GROUP HOME	-			55 SWEET ANDREA DRIVE	
12 11 11 11 11				ASH	IBURN, VA 20148	
(X4) ID PRETIX 1AG	(EACH DEFIGIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (FACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	DBE ISOMPLETION
W 252	schedules and rout Intellectual disability 18 and may result fautism or cerebral pcauses, such as lac responsiveness. The from the website: https://report.nih.got.aspx?csid=100.  (2) Stomach contenthe esophagus and was obtained from https://www.nlm.nih.  (3) Symptoms of a because of sudden, the brain. This inforwebsite: https://www.nlm.nih.ml.  (4) Fear. This inforwebsite: https://www.nlm.nih.#summary.	ines, or social interactions. It originates before the age of rom physical causes, such as palsy, or from nonphysical calse, or from nonphysical cals, or from nonphysical cals, or from nonphysical cals, or from nonphysical cals, or from and adult its information was obtained within the calculation of the website:  In gov/medlineplus/gerd.html.  In the problem. They happen abnormal electrical activity in mation was obtained from the electrical activity in mation was obtained from the electrical activity in mation was obtained from the electrical activity in mation was obtained from the electrical activity in mation was obtained from the electrical activity in mation was obtained from the electrical activity in mation was obtained from the electrical activity in mation was obtained from the electrical activity in the electrical activity in mation was obtained from the electrical activity in the electrical activity in mation was obtained from the electrical activity in the electric	W	252		
	measurable terms.	Individual # 3's were in				
	(Name of Day Prog through 01/07/2017	" for Individual # 3 from ram) dated 01/01/2017 were reviewed. The id to evidence documentation				

of the data collection of Individual # 3's ISP

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G052	B. WING			01.	/26/2017
,	ROVIDER OR SUPPLIER ETON GROUP HOME	*		2275	EET ADDRESS, CITY, STATE, ZIP CODE IS SWEET ANDREA DRIVE IBURN, VA 20148		
(X4) ID PREFIX IAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFOHMATION)	iD PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIECTION)	OBE	(X5) COMPLETION DATE
W 252	Continued From pa	_	W:	252			
	conducted with OS (Name of Day Prog # 4 was asked to re Individual # 3. Whe written in measurab "No." When asked developed OSM # 4 ID (interdisciplinary members from the Group Home).  On 1/25/17 at 11:20 Group Home) prog	D a.m. an interview was M (other staff member) # 4, gram) program manager. OSM eview the outcomes for en asked if the outcomes were ble terms OSM # 3 stated, how the outcomes were 4 stated it was done with the ) team which included staff day program and (Name of oram manager and OSM # 1, the (Name of Day Program)					
	ISP outcomes/goals asked if the outcom terms ASM # OSM On 1/25/17 at 4:40 member) # 1, progr Group Home) and I made aware of the	s for Individual # 3. When hes were written in measurable # 1 stated, "No."  p.m. ASM (administrative staff ram manager of (Name of RN (registered nurse) # 1were above findings.					
W 255	483.440(f)(1)(i) PROCHANGE	OGRAM MONITORING &	W:	255			
	least by the qualified professional and response but not limited to sit successfully completentified in the indicates STANDARD in the standard standard in the standard standa	ram plan must be reviewed at dintellectual disability wised as necessary, including, tuations in which the client has eted an objective or objectives widual program plan, a not met as evidenced by: fal record review and staff			·		

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB NO. 0938-0391	
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) OATE SURVEY COMPLETIED	
	!	49G052	B. WING	3		01/26/2017	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<u>[</u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	VII EULED 11	
BRAMBL	ETON GROUP HOME	Ē	,	ł	755 SWEET ANDREA DRIVE SHBURN, VA 20148		
(XI) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECT TEACH CORRECTIVE ACTION SHOLD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE COMPLETION	
W 255	Continued From page		W	255			
		termined that the QIDP	W255	~~~		-	
ı		al Disabilities Professional)					
failed to revise the ISP (Individual Service Plan) for one of four individuals in the survey sample, Individual # 2.		ensure 'Family	that il : Conta;	ill revise the Individuals outcomes/objectiv accurately reflect their needs: ct evacuation drifts	res 3/8/17		
		d Intellectual Disabilities	· ·		Manager/QMRP will review all individual's	···	
		to review Individual # 2's ISP Plan) to revise outcomes for	objectiv	res to c	chaute that it accurately reflects their need	; outcomes: is and [I is	
		emergency evacuation drills.	insorpa	rated v	within the Porson Center Plan		
	•	,	The Pro	ogram "- "o	Manager/QMRPhvill provide training to all	I staff to review all	
	The findings include	£	progran	n Mana	อเรอก Center Plans within the next staff mo อดูอา will provide supervision to all staff to	ensure that the	
	Professional) failed	d Intellectual Disabilities to review Individual # 2's ISP	person Center Pian accurately reflects the needs and is implemented apatopriately.				
	family contact and e	Plan) to revise outcomes for emergency evacuation drills.	The Pro that all : QMRP	service	Manager\QMRP will conduct monthly assess and needs are met and are accurately i	essments to ensure reflected on the	
	admitted to (Name of Diagnoses in the clit not limited to: mild in spastic diplegia (2),	i 29 year old male, who was of Group Home) on 5/5/14. inical record included but were intellectual disability (1), gastroesophageal reflux disorder (4), renal calculi	The Clin the dec individu	umenk	Director will review within supervision with alson to support the coordination of servic ds	the Program Manager os for each	
		ent ISP dated 07/01/2016 documented, "Desired				·	
		when I would like to make			**		
	contact with my mon	m, dad and sister. Support				İ	
		il # 2) schedules visits with his upport Instructions: 1.					
	(Individual # 2) coord	dinates when he wants to					
	make plans to visit h	nis family via (by) phone calls					
		2. (Individual # 2) dials the (Individual # 2) reviews his					
	family visit schedule.	. 4. After the event					
		usses how the outing went Staff provides support and					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOR MEDICADE & MEDICAD SERVICES

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C		. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NULLBER:	(X2) MU A. BUILI		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
-		49G052	B. WING	;		01:	/26/2017	
	PROVIDER OR SUPPLIER			2275	EET ADDRESS, CITY, STWIE, ZIP CODE 55 SWEET ANDREA DRIVE HBURN, VA 20148			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES LINES BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREE TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULT CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 255	participating in mondrills. Support Activup and gets ready for drill; wearing appropriate	I will manage my safety by othly emergency evacuation vities: 1. (Individual # 2) gets for the emergency evacuation oriate clothing for the weather to the designated safety one designated safety and designated safety. 4. The emergency were to ensure safety. 4. The shis home when the sion drill is completed and it is Staff provides supports and ed."  I will plan when I would like to my morn, dad and sister. Met."  I will manage my safety by thly emergency evacuation	W	255				
	and the outcome wo	ould be revised. The tSP anjended. When asked if						

Individual # 2's ISP was revised OSM # 4 stated.

PRINTED: 02/07/2017

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		(	FURM APPROVED 1 0938-0391 <u>- DMB NO</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G052	B. WING	and the state of t	01/26/2017
NAAR, OF F	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE	
BRAMBL	ETON GROUP HOME			2755 SWEET ANDREA DRIVE ISHBURN, VA 20148	
(84) ah Pagaix Tag	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD GENERAL CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROVIDERICIENCY)	DBE COMPLETION
W 255	Continued From pa	ge 92	W 255		
	Disabilities Professi OMRP is responsib coordination, monite Individual Service P active trealment in the Qualified Intellectual Monitoring Of Service Review consumer of financial and medic treatment and service treatment and services has program services."  On 1/25/17 at 4:40 p member) #1, progra Group Home) and F made aware of the a No further information References:  (1) Refers to a group by a limited mental of adaptive behaviors and schedules and routin hytellectual disability 18 and may result frautism or cerebral p causes, such as lac responsiveness. The from the website:	"8.1 Qualified Intellectual ional" documented, "The le for the integration, oring and development of the Plan, and to ensure quality the program." Under "8.1.2 of Disabilities Professional ces" it documented, "A. ecords to include clinical, all to ensure prescribed ces are being implemented ed appropriately and that any we been incorporated into p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1 were above findings.  on was provided prior to exit.  p of disorders characterized capacity and difficulty with such as managing money, nes, or social interactions, originales before the age of rom physical causes, such as ealsy, or from nonphysical k of stimulation and adult is information was obtained w/nihfactsheets/ViewFactShee			

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

CLIVILLI	13 LOW MEDICHIE	A MEDICAID SERVICES			- UNIO 1	1 <del>0. 0000-000</del> 1	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	1, ,	(X3) OATE SURVEY COMPLETED	
		49G052	B. WING			1/26/2017	
	PROVIOER OR SUPPLIER LETON GROUP HOME	≣		STREET AOORESS, CITY, STATE, ZIP C 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	OOE		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IO PREF TAG		I SHOULO BE	(X5) COMPLETION DATE	
	condition that usual childhood and permand coordination. A muscle tone which muscles and exagg The arm muscles an ot affected at all. Of may include delayer milestones (i.e. rolling walking on toes; and walking). It occurs that controls moven abnormally. This in the website: https://rarediseases pastic-diplegia-cere (3) Stomach content the esophagus and was obtained from the https://www.nlm.nih (4) Symptoms of all because of sudden, the brain. This information website: https://www.nlm.nihml.  (5) A kidney stone is crystals. One or moor ureter at the sam obtained from the westined f	ral palsy, a neurological ly appears in infancy or early nanently affects muscle control ffected people have increased leads to spasticity (stiff or tight erated reflexes) in the legs. re generally less affected or Other signs and symptoms d motor or movement ng over, sitting, standing); d a "scissored" gait (style of when the portion of the brain nent is damaged or develops formation was obtained from sinfo.nih.gov/diseases/9637/s bral-palsy.  Its to leak back, or reflux, into irritate it. This information he website: .gov/medlineplus/gerd.html.  Drain problem. They happen abnormal electrical activity in mation was obtained from the .gov/medlineplus/seizures.ht  as a solid mass made up of tiny re stones can be in the kidney e time. This information was rebsite: s.gov/ency/article/000458.htm	W	255			
W 408	483.470(a)(2) CLIE	NT LIVING ENVIRONMENT	W 4	108			

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

PR(NTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,			<u>MB NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ` '		CONSTRUCTION		E SURVEY IPLETEO
		49G052	B. WING			01/	26/2017
	PROVIOER OR SUPPLIER			227	REET ACORESS, CITY, STATE, ZIP COOE 55 SWEET ANDREA DRIVE HBURN, VA 20148		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	D BE	IX5I COMPLETION DATE
W 408	the basis of their ph	t segregate clients solely on sysical disabilities. It must	W	108			
	who are deaf, blind	o have ambulation deficits or or have seizure disorders, comparable social and ment.					
	Based on observat resident interview a determined that the access to all the are	s not met as evidenced by: ion, residential record review, nd staff interview, it was facility staff failed to provide eas of the (Name of Group or one of four individuals in the vidual # 2.			·		
	access to the secor	ed to provide unrestricted nd floor and the activity area in ame of Group Home) for					
	The findings include	<b>Э</b> :					
	admitted to (Name Diagnoses in the clinot limited to: mild i spastic diplegia (2),	29 year old male, who was of Group Home) on 5/5/14. nical record included but were ntellectual disability (1), gastroesophageal reflux disorder (4), renal calculi					
	the days of the survicentained the kitche Individual # 2's bed exits and access in which was accesse	ame of Group Home) during bey revealed a main floor that en, laundry room, bathroom, room, front and back door to the garage. A second floor, d by a staircase, contained a ffice, four bedrooms, hallway					

bathroom and an open area that contained

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

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039			
	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		49G052	B. WING_		01/26/2017			
NAME OF E	PROVIDER OR SUPPLIER		<u>'                                    </u>	STREET ADDRESS, CITY, STATE, ZIF				
BRAMBL	ETON GROUP HOME	<u> </u>		22755 SWEET ANDREA DRIVE				
· · · · · · · · · · · · · · · · · · ·	2.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0			ASHBURN, VA 20148				
(X4  ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE OATE			
W 4 <b>0</b> 8	Continued From page		W 40	18				
		ercise equipment, a treadmill,	W408		E IE IA 7			
	stair climber, station	nary bike and a trampoline.	1		5/5/17			
	Further observations revealed a basement that was accessible by a staircase that was carpeted. The basement contained an area approximately 35 feet long by 25 feet wide that was finished with carpet, furniture, an arcade size air hockey game, full size ping-pong table, flat screen television, DVD player and VHS player.							
				The Program Manager/QMRP will ensure that these services/activities are provided to individual #2 on the main in which he has access to. For example individual #2 will be able to participate in Medication				
		vidual # 2 during the days of Individual # 2's mobility	Administration, Laundry, Activities, and access to the TV. Individual #2 will have access to the same services as all other individuals.					
	consisted of independent activation and steering of a motorized wheelchair. Individual # 2 was observed moving throughout the main floor of the group home that contained the kitchen, laundry			The Program Manager/QMRP will also ensure that individual #2 has the opportunity to participate in these services/activities with his peers. Ex. having visitors, inviting house mates to participate in activities, and integrating within the program.				
	door exits and acces Observation of Indiv	idual # 2 also revealed that	The QMRP will revise the individuals outcomes/objectives to ensure the it is accurately reflected in their Person Center Plan.  The Program Manager/QMRP will review this process for all other individuals to ensure compliance and to prevent further deficiencies.					
		cess the activity room in the ond floor of the residence.						
	Observations of the other five individuals who resided at (Name of Group Home) revealed they were accessing the second floor by walking up			The Program Manager/QMRP will provide training to review the upo Person Center Plan.				
	assistance.	ndependently or with staff	The Prog ensure th on the QI	t monthly assessments to t and are accurately reflected				
	Review of the (Name of Group Home) clinical record for Individual # 2 revealed a signed consent dated 1/25/16 by the guardian for a copy of the facility's "Consumer / Human Rights Policy and Procedures." Further review of the (Name of Group Home) clinical record for Individual # 2 revealed a signed consent dated 5/5/14 by the guardian for a copy of the facility's "Individual Rights and Informed Consent Handbook."			The Clinical Director will review within supervision with the Progra Manager the documentation to support the coordination of service each individual needs.				

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The facility's "Individual Rights and Informed

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Facility ID: VAICFMR60

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# DEPARTMENT OF HEALTH AND HU. IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2017 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391		
	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		X3) DATE SURVEY COMPLETEO	
		49G052	B. WING				01/26/2017	
NAME OF PROVIDER OR SUPPLIER  BRAMBLETON GROUP HOME				2275	EET ADDRESS, CITY, STATE, ZIP CO 55 SWEET ANDREA DRIVE HBURN, VA 20148	DE	0 1/20/20 17	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE		
	4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		W 4	08				

asked if Individual # 2 should have access to the basement and the second floor, ASM # 1 stated, "Yes." ASM # 1 further stated that Individual # 2

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391					
STAIDHENLOF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLICE/CLIA IDENTIFICATION NUMBER:	•	NG	(X3) DATE SURVEY COMPLETED			
		49G052	B WING		01/26/2017			
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BDAMRI	ETON GROUP HOME	:	1	22755 SWEET ANDREA DRIVE				
DIVUNDE	LION ONOUT HOME	•		ASHBURN, VA 20148				
(X4) ILI PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MIST SE PRECEDED BY FULL SC (CIENTIFYING INFORMATION)	IO PREFID TAC	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPETION			
W 408	Continued From pa	ge 97	W 4	08				
		he stairs and was unable to						
		o floors of the home.						
	member) # 1, progr	p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1were above findings.						
W 420	No further information was provided prior to exit. 483.470(b)(4)(iv) CLIENT BEDROOMS  The facility must provide each client with functional furniture, appropriate to the clients needs.			20				
				gram klarrager/OMRP will complete a maintena Loudoun County OSB to repair the piece of flo	oring that			
	This STANDARD is	s not met as evidenced by:	is inissa	ig at the base of the staticase on the main floor.				
	Based on observations and staff interview, it was determined that the facility staff failed to ensure the environment was in good repair.  A piece of flooring measuring approximately five and a half inches long and two and a half inches wide was missing creating a hole in the flooring at the base of the staircase on the main floor.			gram Manager and the Property Manager will o of the program to Identify potential hazardous an ed to ensure the safety of the individuals	omplete a walk sas that needs to be			
				gram Manager and OMRP will complete weelily n the program.	erwhonmental			
				Loudoun County CSB maintenance department is scheduled to repair the flooring at the residences.				
	The findings include	<b>:</b> :	The Pro program of the pr	perly Director and the Clinical Director will comp assessment to evaluate and address the envir- ogram.	olote bi-annual onmental needs			
	During the days of t	he survey individuals who	•	-				
	resided at the home	were observed walking up						
	and down the stairs	independently.						
	On 1/26/17 at approximately 3:45 p.m. an interview was conducted with ASM # 1, (Name of Group Home) program manager regarding the missing piece of flooring at the bottom of the stairs on the main floor. On 1/26/17 at			1797 C 10 148 W W W W W W W W W W W W W W W W W W W				
approximately 3:45 p.m. an interview was								

FORM ClifS-2567(02-99) Previous Versions Obsolele

Event ID: 30J411

Facility ID: VAICEMR00

If continuation sheet Page 98 of 103



CELAFE	<u>VO LOV MEDIĆVIVE</u>	& MEDICAID SERVICES				OMR	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ION		DATE SURVEY COMPLETED
	A STATE OF THE PROPERTY PROPER	49G052	B. WING		44.4		01/26/2017
NAME OF	PROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE		
BRAMBI	BRAMBLETON GROUP HOME			22755 SWEET A ASHBURN, VA			
(X4) ID PREFIX TAG	(EACH OFFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IC PREF TAG	X (EACH)	MIDER'S PLAN OF CORRECTIVE ACTION SHO CORRECTIVE ACTION SHO REFERENCED TO THE APP DEFICIENCY:	DUILD BE	COMPLETION COMPLETION DATE
W 420	program manager r flooring at the botto floor. ASM # 1 stat missing piece of flo "I mentioned the mi bottom of the stairs	ge 98  ## 1, (Name of Group Home) egarding the missing piece of m of the stairs on the main ed she was aware of the oring. ASM # 1 further stated, ssing piece of flooring at the to maintenance when the eing replaced and they haven't	W	.20			V (Mahalama)
W 455	483,470(I)(1) INFEC	ctive program for the and investigation	W	55			
	Based on observati was determined that implement infection medication administ	s not met as evidenced by: ions and staff interviews it the facility staff failed to control practices during the ration for one of one e medication administration uat #4.					
	The facility staff failed to provide utensits, two spoons, for medication administration in a sanitary manner for Individual # 2.						
	The findings include	;					
	admitted to (Name of Diagnoses in the climated to: mild in the climated	29 year old male, who was of Group Home) on 5/5/14, nical record included but were ntellectual disability (1), gastrocsophageal refux					

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		MID HOMMIN OF MICEO			FORM APPROVED
CENTER	₹S FOR MEDICARE	& MEDICAID SERVICES		***************************************	OMB NO. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZHWULH A. BUILDIN	PLE CONȘTRUCTION G	(X3) DATE SURVEY COMPLETED
		49G052	EL WING	and the state of t	01/26/2017
NAVE OF F	ROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP CODE	
BRAMBL	ETON GROUP HOME			22755 SWEET ANDREA DRIVE ASHBURN, VA 20148	
(X4) ID PRSEIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	FD SE CONTRETION
W 4 <b>5</b> 5	(right) side (5).	ge 99 disorder (4), renal calculi ne medication administration	W 45	5	
	was conducted on (direct support profisupplies for Individual administration in the the second floor of two metal teaspoon bare hands and plaplastic basket without the bottom of the basket. DSP # 1 al applesauce, a paper Individual # 2's medications in the streng proceeded to ladminister his medimedication from the small plastic bag ar # t tried to pour the plastic bag into the the bag would not be a spoon from the bag would not be a spoon from the bag contain then placed the spouring the crushed applesauce DSP # and used it to scool applesauce and the # 2. DSP # 1 then the supposition in the plastic bag in the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spoon to spouring the crushed applesauce and the # 2. DSP # 1 then the placed the spouring the crushed applesauce and the # 2. DSP # 1 the placed the spouring the crushed applesauce and	1/25/17 at 7:05 a.m. DSP essional) # 1 gathered	and prof MAR.  The Nur and prof The Pro- as outlin All staff in medicat observa The QM stall to d Annual The Clin line frain	gram Nurse will review Individual #2 and 4 Physicals to ensure that they are documented consing Coordinator will review/audit all individual ocols to ensure they are documented correctly gram Nurse will complete training regarding *i ed in the CR Medicalism Management Policy awill sign to acknowledging their awareness foliation administration.  Gram Manager/ Nurse will observe each staff rions. Those who do not successfully complete tion will be required to comptele the Medication will be required to comptele the Medication RP will continue to perform unannounced Macassine the compliance of the Medication Administration Irainitical Director will review to onsure that all staffing in a timely manner.	really on the  Is Physician order's  y on the MAR.  Infection central  and Procedure.  Their responsibilities  member passes  the medication  n refresher training.  Itication observations for  nistration policy.  Ing is required by all statt.

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

gummy from the medicine bottle and

administered it to Individual #2, then using the same spoon, DSP #1 scooped out one

multivitamin gummy, administered it to Individual

Event ID: 30J411

Facility IO MAICEMIS60

# continuation sheet Page | 100 of 103

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CL(A IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SIJR COMPLETE		
		49G052	B WING	;		n.	1/26/2017	
	ROVIDER OR SUPPLIER ETON GROUP HOME		£	2275	EET ADDRESS, CITY, STATE, ZIP CODE 15 SWEET ANDREA DRIVE IBURN, VA 20148	<u></u>		
(X-I) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIEVING INFORMATION	iji PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOR CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) (COMIFI E INDA DAFE	
	tablets from anothe administered it to In On 1/25/17 at 8:20 conducted with DSI administration for Ir she had placed the cleaning or disinfect barrier in the bottom On 1/25/17 at approinterview was condupractical nurse) # 1 DSP # 1 dursing # 1 DSP # 1 dursing # 1 nurse a clean barrie or wrap the spoons contamination.  On 1/25/17 at 4:40 member) # 1, progragoup Home) and France aware of the No further information.  References:  (1) Refers to a group by a limited mental adaptive behaviors schedules and routintellectual disability 18 and may result frautism or cerebral pauses, such as lace	ed out three fiber gummy or medicine bottle and advidual # 2.  a.m. an interview was P#1 regarding the medication advidual # 2. DSP #1 stated spoons in the basket without ting it or providing a clean of the basket.  Eximately 8:25 a.m. an accept with LPN (licensed regarding the observation of medication administration for if # 1 stated the staff should in the bottom of the basket to prevent possible  p.m. ASM (administrative staff am manager of (Name of RN (registered nurse) # 1 were	W	455				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES.

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		(XI) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G052	B. WING	·		01	/26/2017
NAME OF PROVIDER OR SUPPLIER  BRAMBLETON GROUP HOME				2275	EET ADDRESS, CITY, STATE, ZIP CODE IS SWEET ANDREA DRIVE IBURN, VA 20148		
(X4) (D PREFIX TAG	(DACH DEFICIENCY	NEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION:	iD PREF TAG	lx	PROVIDER'S PLAN OF CORRECTH (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
W 455	Continued From page 101 https://report.nih.gov/nihfactsheets/ViewFactShee t.aspx?csid=100.  (2) A form of cerebral palsy, a neurological condition that usually appears in infancy or early childhood and permanently affects muscle control and coordination, Affected people have increased muscle tone which leads to spasticity (stiff or tight muscles and exaggerated reflexes) in the legs. The arm muscles are generally less affected or not affected at all. Other signs and symptoms may include delayed motor or movement milestones (i.e. rolling over, sitting, standing); walking on toes; and a "scissored" gait (style of walking). It occurs when the portion of the brain that controls movement is damaged or develops abnormally. This information was obtained from the website: https://rarediseases.info.nih.gov/diseases/9637/s			455			
	the esophagus and was obtained from https://www.nlm.riih  (4) Symptoms of a because of sudden the brain. This inforwebsite: https://www.nlm.nihml.  (5) A kidney stone it crystals. One or mo or ureter at the same	brain problem. They happen, abnormal electrical activity in mation was obtained from the agov/medlineplus/seizures.ht is a solid mass made up of tiny pre stones can be in the kidney to time. This information was					
	obtained from the v <https: medlineplu<="" td=""><td>vebsite: s.gov/ency/article/000458.htm</td><td></td><td></td><td></td><td></td><td></td></https:>	vebsite: s.gov/ency/article/000458.htm					

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#### PRINTED: 02/07/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MINTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 49G052 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE **BRAMBLETON GROUP HOME** ASHBURN, VA 20148 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION Ю (XS) COMPLETION DATE

PREFIX

TAG

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY)

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