PRINTED: 01/27/2020 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------|---|--|--|---|----------------------|--|--|
| | | 49G052 | B. WING | | 01/15/2020 | | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLETION | | |
| E 000 | Initial Comments | | E 000 | | | | |
| | survey was conduct The facility was in | Emergency Preparedness sted 1/14/20 through 1/15/20. substantial compliance with 42 Requirement for Long-Term | | | | | |
| W 000 | INITIAL COMMEN | TS | W 000 | | | | |
| | Intermediate Care Intellectual Disabili 1/14/20 through 1/ compliance with 42 for Intermediate Ca | annual Medicaid survey for Facilities for Persons with ties (ICF/ID) was conducted 15/20. The facility was not in CFR Part 483 Requirements are Facilities for the led. The Life Safety Code ollow. | | | | | |
| W 111 | time of the survey. | | W 111 | | | | |
| | recordkeeping syst | evelop and maintain a sem that documents the client's treatment, social information, ne client's rights. | | | | | |
| | Based on staff inte and clinical record the facility staff faile clinical record for o survey sample, Ind failed to accurately | s not met as evidenced by: erview, facility document review review, it was determined that ed to maintain an accurate ne of three individuals in the ividual #1. The facility staff document the amount of time brush his teeth on the | , | | CXALDATE | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: TOHF11 Facility ID VAICEMR60

2/4/202

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| CENTER | S FUR MEDICARE | & MEDICAID SERVICES | | | OMB N | O. 0938-0391 |
|--|---|--|--------------------------|--|-------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. 49G052 | | | (X2) MULTI A. BUILDIN | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 49G052 | B, WING_ | | 01 | /15/2020 |
| NAME OF P | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 0, | 113/2020 |
| DDAMO | | | - 1 | 22755 SWEET ANDREA DRIVE | | |
| BRAMBL | ETON GROUP HOME | | | ASHBURN, VA 20148 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| W 111 | Continued From pa | | | | | |
| ** 111 | A contract of the contract of | The same of the sa | VV 1 | 11 The QIDP will revise Individual # | | 2/20/2020 |
| | individual's PCP (pe | erson centered plan). | | Independence Outcome to accu | | |
| | The findings include | 2. | | reflect the time needed to comp | | |
| | The initiality's include | s. | 1 | goal in order for it to capture me | | |
| | Individual #1 was a | dmitted to the group home on | | data from the Person Center Pla | an (PCP) | |
| | | 1's diagnoses included but | | The Program Manager/QIDP wil | المستنمين ماا | |
| | | moderate mental retardation | | other individuals PCP outcomes | | |
| | | re disorder). Individual #1's | | that the outcomes are accurately | | |
| | | and reviewed on 1/1/20, | | reflect and capture measurable | | |
| | | red Outcome: Independence. | | Tenedi and dupture measurable | aata. | |
| | | iges in activities of daily living | | The Program Manager will comp | lete | |
| | | pendenceSupport Activities: ushes his teeth twice daily for | | weekly audits of Progress Notes | | |
| | | consecutive months by June | 340 | that the completed outcomes are | | |
| | | Instructionsc. (Individual #1) | | accurately reflecting the supports | | |
| | | and brushes his teeth for | | PCP. | | |
| | | eaching all areas of his | | | | |
| | mouth" | | | The Program Manager will comp | | |
| | | | | process for all individuals to prev | ent further | |
| | | p.m., an interview was | | deficiencies. | | |
| | | A (administrative staff | | | | |
| | | DP [qualified intellectual onal]), in the presence of ASM | | The Clinical Director will review | | |
| | | nager) and ASM #3 (the | | supervision with the Program Ma | | |
| | | ASM #2 confirmed she was | | documentation to support the co- of services for each needs | ordination | |
| | | eloping Individual #1's PCP. | | or services for each needs | | |
| | | aware that Individual #1's | | and the second second second second | | |
| | PCP documented for | or the individual to brush his | | | | |
| | | s in one sentence and to | | | | |
| | | ne minute in another | | | | |
| | | stated this was an oversight | | | | |
| | | sentences in the PCP | | | | |
| | | r Individual #1 to brush his . ASM #1, ASM #2 and ASM | | the state of the state of | | |
| | #3 was made aware | | | and the second second second second | | |
| | Hus made aware | or and correctif. | | a management of | | |
| | The home policy title | ed, "4.1 Individual Service | | · · · · · · · · · · · · · · · · · · · | To the party | |
| | | own as PCP) documented, | | | 100 | |
| | | red outcomes will be | | | | |

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

PRINTED: 01/27/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X* | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL' IDENTIFICATION NUMBER: A. BUILDI | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---------------------|--|---|--|
| | | 49G052 | B. WNG | | 01/15/2020 | |
| | ROVIDER OR SUPPLIER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 12755 SWEET ANDREA DRIVE ASHBURN, VA 20148 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION | |
| W 159 | provide measurable objectives/desired of way that demonstratowards achievement goal/outcome" No further information QIDP CFR(s): 483.430(a) Each client's active integrated, coordinate qualified intellectual This STANDARD is Based on staff intellectual This STANDARD is Based on staff intellectual failed professional) failed active treatment for survey sample, Individual's PCP (per QIDP (qualified intellectual failed to accurately for Individual #1 to be individual's PCP (per QIDP (qualified intellectual failed intell | that are behavioral and indexes of progressThe butcomes will be written in a tes the steps necessary not of the overall on was presented prior to exit. It reatment program must be sted and monitored by a disability professional. In not met as evidenced by: view, facility document review eview, it was determined that intellectual disabilities to monitor and coordinate two of three individuals in the viduals #1 and #2. The QIDP I disabilities professional) document the amount of time or the intellectual disabilities to ensure a copy of Individual of plan was provided to the | W 111 | The QIDP will revise Individual #1's Independence outcome and update outcome to ensure that it accurately reflects the needs of Individual #1. The Program Manager / QIDP will rall individuals' outcomes to ensure they accurately reflect their needs at they are incorporated within the PC. The Program Manager will provide training and supervision to all the stall individuals' PCPs during the new meeeting and also ensure that the flaccurately reflect the individuals' nead are implemented appropriately. The Program Manager will conduct monthly assessments to ensure that services and needs are met and are accurately reflect on monthly QIDP. The Clinical Director will review with supervision with the Program Manadocumentation to support the coord of services for each individual. | e this / review that and that Ps. aff on kt staff PCPs eds it all e notes. nin ger the | |

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|--|--|----------------------------|
| | | 49G052 | B. WNG | | 01 | /15/2020 |
| | OVIDER OR SUPPLIER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 2755 SWEET ANDREA DRIVE ISHBURN, VA 20148 | | 710/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDESICIENCY) | SHOULD BE | (XS) COMPLETION DATE |
| | to increase his indep 1. (Individual #1) bru two minutes for six c 30, 2020. Support Ir holds his toothbrush one minutes (sic) rea mouth" On 1/15/20 at 4:35 p conducted with ASM member) #2 (the QID disabilities profession #1 (the program mar clinical coordinator). responsible for devel ASM #2 was made a PCP documented for teeth for two minutes brush his teeth for or sentence. ASM #2 s on her part and both should document for teeth for one minute. #3 was made aware The home policy title Retardation Profession documented, "8.1.2 (Professional Monitor the following: A. Revi include clinical, finan | ges in activities of daily living pendence Support Activities: shes his teeth twice daily for onsecutive months by June instructionsc. (Individual #1) and brushes his teeth for aching all areas of his .m., an interview was (administrative staff DP [qualified intellectual hal]), in the presence of ASM mager) and ASM #3 (the ASM #2 confirmed she was loping Individual #1's PCP. Individual #1's or the individual to brush his is in one sentence and to the minute in another stated this was an oversight sentences in the PCP Individual #1 to brush his ASM #1, ASM #2 and ASM of this concern. d, "8.1 Qualified Mental conal" (also known as QIDP) Qualified Mental Retardation ing of Services. Adhere to cial and medical to ensure and services are being | W 159 | The QIDP will immediately profindividual #2's Behavior Sthe day program The Program Manager will enother Individuals' day program complete copies of their Persplan, which includes the Behaplan. The Program Manager/QIDP monthly day program visits to individuals' records to ensure needed documentations are an arrespondent of the Day Program Monitor/ Concept Director will also conduct qual observations and record review compliance. | nsure that all ms have son Centered avior Support will conduct or review all e that all avaliable. | 2/20/2020 |

2. Individual #2 was admitted to the group home

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| CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938 | | | | | | |
|---|--|---|--------------------|---|-----------------|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED |
| | | 49G052 | B. WING | | | 01/15/2020 |
| | PROVIDER OR SUPPLIER | 3 15 15 15 15 15 15 15 15 15 15 15 15 15 | | STREET ADDRESS, CITY, STATE, ZIP 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT | THE APPROPRIATE | |
| W 159 | were not limited to and vitamin D defice with a start date of 1/1/20, documented Management. (Indiappropriate social in awareness skills | al #2's diagnoses included but moderate mental retardation iency. Individual #2's PCP 7/17/11 and reviewed on d, "Desired Outcome: Behavior ividual #2) increases his nteractions and self See Attached Behavioral Individual #2's clinical record resupport plan revised on ented behaviors including but ally inappropriate behaviors aging staff, disrobing in public and physical aggression rethe television. The plant goals and procedures | W | 159 | | |
| | | o.m., an interview was I (administrative staff oup home program | | | | |

coordinator) and ASM #3 (the group home clinical

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

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| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CON | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|--|---|--------------------|--|
| | | 49G052 | B. MNG | | 01/15/2020 | |
| NAME OF PROVIDER OR SUPPLIER BRAMBLETON GROUP HOME | | | STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY) | OULD BE COMPLETION | |
| W 159 | support plan is a pashould be provided ASM #1 and ASM # above concern. On (the QIDP) entered she is responsible f has individuals' beh stated she hand de faxes plans to the diprograms to confirm ASM #1 reviewed thad ASM #2 review. The home policy titl Retardation Profess documented, "8.1.1 company) QMRPs services to ensure sare complimentary. | #3 confirmed the behavior art of the PCP and a copy to the day program staff. 3 were made aware of the 1/15/20 at 4:35 p.m., ASM #2 the room. ASM #2 confirmed or ensuring the day program avior support plans. ASM #2 livers plans or if possible, any programs and calls the at they received the plans. In they received they rec | W 159 | | | |
| | no further informatic INDIVIDUAL PROG CFR(s): 483.440(c) A copy of each clien made available to a of other agencies w | RAM PLAN | W 248 | | | |
| | | s not met as evidenced by: rview and clinical record | | | | |

Facility ID: VAICEMR60

CENTERS FOR MEDICADE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G052 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | B. WNG | | | //15/2020 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 01 | 1/15/2020 | |
| | | | | 22755 SWEET ANDREA DRIVE | | | |
| BRAMBL | ETON GROUP HOME | | - 1 | ASHBURN, VA 20148 | | | |
| OVA) ID | SIMMARY S | TATELLE AS DESIGNATIONS | | | | | |
| PREFIX TAG | (EACH DEFICIENCE | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (XS) COMPLETION DATE | |
| W 248 | failed to ensure a co- (person centered plate program staff for one survey sample, Individual to provide a co- support plan to the dot of the findings include: Individual #2 was adde/2/11. Individual #2 were not limited to mand vitamin D deficie with a start date of 7/1/1/20, documented, Management. (Individual #2 wareness skillsSe Plan" Review of Intrevealed a behavior staff to sexually such as kissing/huggiareas of the home and towards others over the further documented gregarding the behavior on 1/15/20 at 9:40 a. Individual #2 was conday program. Review the day program failed individual's behavior staff memory of the staff memory of the survey of | mined that the facility staff implete copy of the PCP in) was provided to the day is of three individuals in the idual #2. The facility staff ipy of Individual #2's behavior ay program staff. mitted to the group home on is diagnoses included but oderate mental retardation incy. Individual #2's PCP 17/11 and reviewed on "Desired Outcome: Behavior dual #2) increases his eractions and self is Attached Behavioral dividual #2's clinical record support plan revised on inted behaviors including but in inappropriate behaviors ing staff, disrobing in public d physical aggression he television. The plan ioals and procedures ors. m., an observation of ducted at the individual's of Individual #2's record at d to reveal a copy of the support plan. On 1/15/20 at ew was conducted with inber) #1 (a program in program). OSM #1 was | W 24 | The QIDP will immediately provided of Individual #2's Behavior Supports the day program. The Program Manager will ensure other Individuals' day programs in complete copies of their Person of plan, which including the Behavior plan. The Program Manager/QIDP will monthly day program visits to revindividuals' records to ensure that needed documentations are available to the Day Program Monitor/ Clinical will also conduct quarterly observed day programs and record reviews compliance. | e that all ave Centered or Support conduct iew all able. | | |

behavior support plan. OSM #1 stated the day

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|---|--|---|--|---|----------------------|--|--|
| | | 49G052 | B. MNG | | 01/15/2020 | | |
| NAME OF PROVIDER OR SUPPLIER BRAMBLETON GROUP HOME | | | STREET ADDRESS, CITY, STATE, ZIP CODE 22755 SWEET ANDREA DRIVE ASHBURN, VA 20148 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETION | | |
| W 248 | #2's mother and sta a month ago. OSM #2's behavior suppo | ge 7 ded a meeting with Individual ff from the group home about #1 was aware of Individual ort plan but confirmed the id not provided a copy of the | W 248 | | | | |
| | conducted with ASM member) #1 (the gracoordinator) and ASC coordinator). ASM support plan is a pashould be provided ASM #1 and ASM # above concern. AS delivery receipts and | M #3 (the group home clinical #3 confirmed the behavior rt of the PCP and a copy to the day program staff. 3 were made aware of the M #1 reviewed document d had the QIDP (qualified es professional) review | | | | | |
| | | o.m., ASM #3 stated the home regarding documents programs. | | | | | |
| | On 1/15/20 at 5:19 p no further information | o.m., ASM #1 stated she had in to present. | | | | | |