STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G052	A. BUILDING _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAMBLETON GROUP HOME	22755 SWEET ANDREA DRIVE ASHBURN, VA 20148

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/7/2022 through 9/8/2022. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency	E 009	E 009: The Program Manager will immediately reach out to the the local Emergency Officials (Police, Fire Department, Department of Health, etc) to inviting them to collaborate and cooperate in a testing activity. The Clinical Director will ensure that other facilities reach out to the the local Emergency Officials (Police, Fire Department, Department of Health, etc) to inviting them to collaborate and cooperate in a testing activity. Bi-annually the Emergency Response Team leader will review Emergency Plans to ensure that local emergency officials have been contacted to participate or engage in test activities. The Risk Management Team will annually review Emergency Plans to ensure that are fully updated and are in compliance.	10/20/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bernice Meanchop

TITLE: Clinical Director

(X6) DATE: 9/20/2022

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

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E 009	Continued From page 1 preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of the facility's efforts to contact emergency officials and, when applicable, its participation in collaborative and cooperative planning efforts. The findings include: A review of the facility emergency preparedness plan failed to reveal evidence of the facility's efforts to contact emergency officials and, when applicable, its participation in collaborative and cooperative planning efforts since prior to the last standard survey. On 9/8/22 at 7:58 a.m., ASM (administrative staff member) #1 (the clinical director) stated she could not find evidence of the facility's efforts to contact emergency officials and, when applicable, its participation in collaborative and cooperative planning efforts since prior to the last standard survey. ASM #1 stated the former manager may have contacted emergency officials but she did not have access to the former manager's emails. No further information was provided prior to exit.	E 009		
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):]	E 035		

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E 035	Continued From page 2 [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of a system in place to inform individuals' representatives about the facility's emergency plan. The findings include: A review of the facility emergency preparedness plan failed to reveal the process for how the plan would be communicated to individuals' representatives. On 9/8/22 at 7:58 a.m., an interview was conducted with ASM (administrative staff member) #1 (the clinical director). ASM #1 stated the facility process was to communicate the plan to representatives annually during family	E 035	E 035: The Program Manager will immediately update the facility's Emergency Plan, to outline the process to annually communicate the plan and updates made to individuals' families and representatives, which will be during family meetings. The Clinical Director will ensure that other facilities Emergency Plans are updated to outline the process to annually communicate the plan and updates made to individuals' families and representatives, during family meetings. Bi-annually the Emergency Response Team leader will review Emergency Plans to ensure that the outlined process are being followed and individuals' families and representatives are being communicated updates updates made to the plans after family meetings. The Risk Management Team will annually review Emergency Plans to ensure that are fully updated and are in compliance	10/20/22

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E 035	Continued From page 3 meetings but she did not have evidence that this was done during this year. ASM #1 stated the plan needed to be revised because it does not identify how the plan is going to be communicated with representatives. No further information was provided prior to exit.	E 035		
W 000	INITIAL COMMENTS An unannounced Focused Fundamental Medicaid re-certification survey was conducted 9/7/2022 through 9/8/2022. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 6 certified bed facility was 5 at the time of the survey. The survey sample consisted of 3 Individual reviews.	W 000		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure that all medications were administered in compliance with physician's orders for one of three Individuals in the survey sample, Individual #3. The facility staff failed administered Valproic Acid (1) to Individual #3 without accurately measuring the physician prescribed dose of 8 ml (milliliters).	W 368		

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W 368	Continued From page 4 The findings include: Individual #3 was admitted to the facility on 5/5/14. Individual #3's diagnoses included but were not limited to moderate intellectual disabilities and epilepsy. A review of Individual #3's clinical record revealed a physician's order dated 8/12/20 for liquid Valproic Acid 250mg (milligrams)/5ml- 8ml by mouth twice daily for convulsions. On 9/8/22 at 6:17 a.m., DSP (direct support professional) #2 was observed preparing and administering Individual #3's medications. DSP #2 poured liquid Valproic Acid into a medication cup. The cup contained measurement lines that included 7.5 ml and 10 ml. There was no measurement line for 8 ml. DSP #2 drew a line slightly above the 7.5 ml measurement line and poured the liquid Valproic Acid to the drawn line. DSP #2 administered the Valproic Acid to Individual #3. On 9/8/22 at 7:52 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (the facility nurse). LPN #1 stated a medication cup should not be used to measure Individual #3's Valproic Acid because it does not have a measurement line for 8 mls. LPN #1 stated DSPs should use a syringe with an 8 ml measurement lines to measure and administer Individual #3's Valproic Acid. On 9/8/22 at 9:24 a.m., ASM (administrative staff member) #1 (the clinical director) was made aware of the above concern. The facility policy regarding medication	W 368	W 368 DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The Program Nurse will immediately train all program staff during staff meeting, to use the syringe with 8ml measurement to measure individual #3's Liquid Valproic Acid 250mg, during medication administration. The Program Nurse will retrain program staff during staff meeting, to properly administer all other individuals' liquid medications using the right measuring equipment to match their doctors' orders. The Program Manager and Program Nurse will conduct random weekly observations during medication administration to ensure that the right measuring equipment are used to ensure medications are dispensed per doctor's orders. The Nurse Coordinator will conduct quarterly random medication pass observations to ensure that the right measuring equipment are being used to measure medications.	10/20/22

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W 368	Continued From page 5 management documented, "Staff can safely administer medication without error to the individuals, consistent with Health Care Practitioner (HCP) orders..." No further information was presented prior to exit. Reference: (1) Valproic Acid is used to treat seizures. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682412.html	W 368		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or	W 508		

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W 508	Continued From page 6 other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section;	W 508	W508: COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) The Human Resources Department immediately place DSP #1 on administrative leave to allow him to provide documentation to establish an exemption or start the vaccination process by 9/16/2022. On 9/19/2022, the Human Resource Department will approve or deny the request and appropriate action taken based on the staff's decision, including termination The Human Resources Department will immediately put all unvaccinated DSPs who have not established an exemption or have not started the vaccination process on administrative leave, and provide them with a concrete timeline to establish an exemption/start the vaccination process or face possible termination. The Human Resources Department in accordance with CRi Policy HR Policy 3.5.1 COVID Policy, which states that all employees must fall into one of three categories (1) fully vaccinated, (2) partially vaccinated, or (3) has been approved for a religious or medical accommodation, will be fully enforced. The Human Resources Department will continue to meet on a weekly basis to review the vaccination status of all employees. Weekly, they will ensure any employees that are partially vaccinated with an assigned date for fully vaccination status are testing weekly for COVID per Policy 3.5.1 (COVID Policy).	10/20/22

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W 508	Continued From page 7 (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and	W 508		

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considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
(ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This STANDARD is not met as evidenced by:
Based on staff interview and facility document review, the facility staff failed to ensure all staff were fully vaccinated for COVID-19.

The facility staff failed to ensure DSP (direct support professional) #1 (hired on 11/20/17) was vaccinated for COVID-19 or was granted an exemption.

The findings include:

On 9/7/22 at approximately 11:00 a.m., an interview was conducted with ASM (administrative staff member) #1. ASM #1 stated all staff were fully vaccinated for COVID-19 except for DSP #1. ASM #1 stated DSP #1 had a medical exemption. DSP #1's medical exemption was requested.

On 9/7/22 at 3:41 p.m., a telephone interview was conducted with OSM (other staff member) #1 (the

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human resources director). OSM #1 stated he did not have a medical exemption form completed for DSP #1. OSM #1 stated DSP #1 has been on and off of work during the year due to medical issues so he was working with DSP #1 to complete a medical exemption. OSM #1 stated the company has not received documentation per company standards for a medical exemption. OSM #1 stated DSP #1 is being tested for COVID-19 every week and is following all safety protocols per company policy.

A review of DSP #1's timesheet revealed DSP #1 most recently worked at the facility on 9/5/22.

On 9/7/22 at 5:18 p.m., an interview was conducted with ASM #1. ASM #1 stated DSP #1 has continued to have contact with Individuals but is tested for COVID-19 every week and is required to wear an N-95 mask at all times.

On 9/8/22 at 9:24 a.m., ASM #1 was made aware of the above concern.

The facility COVID-19 policy documented, "After January 4, 2022, all active employees must be fully vaccinated or have been approved for a reasonable accommodation to this policy."

No further information was presented prior to exit.