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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			OATE SURVEY COMPLETED
		49G022	B. WING _			R 09/06/2017
NAME OF PROVIDER OR SUPPLIER CONRAD ICF				STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
{K 000}	standard survey cond conducted on 9/06/20 Code of federal Regul to 480: Requirements Facilities for Persons (ICF/ID). The facility values the 2012 Life S regulations. The Faci	e Safety Code revisit to the lucted on 07/25/2017 was 117 in accordance with 42 lation, Part 483.150 and 410 for Intermediate Care with Intellectual Disability was surveyed for compliance afety Code existing lity was in compliance with Participation for Medicare cted deficiencies are	{K 0	00)		
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ε	TITLE		(X6) DATE

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

08/18/2017

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.

Facility ID: VAICFMR04