	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	CONSTRUCTION	1, ,	E SURVEY PLETED
		49G022	B. WING		08	/28/2019
NAME OF	PROVIDER OR SUPPLIER  DICF		4	TREET ADDRESS, CITY, STATE, ZIP CODE 123 CONRAD STREET ALEXANDRIA, VA 22312		
(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 SHOUL) CROSS-REFERENCED TO THE APPROPROPROPERTY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments  An unannounced Esurvey was conduct 08/28/19. Correctic compliance with 42 Requirement for Interpretation Persons with Intellet Development of EPCFR(s): 483.475(b)  (b) Policies and prodevelop and implement policies and procedures and procedures and the communication this section. The porreviewed and updational Require Facilities:  *[For PACE at §460 procedures. The PACE and procedures must accommend to the paragraph (c) of this procedures must accommend and nonmend but not limited to: Fewater failure; care-resultation of the particity of the particity of the particity of the particity and paragraph of the particity of the particity of the particity and paragraph of the particity of the particity of the particity of the particity and paragraph of the particity of the particity of the particity of the particity and paragraph of the particity of the	cFR Part 483.73, ermediate Care Facilities for ectual Disabilities. Policies and Procedures  cedures. [Facilities] must ment emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of elicies and procedures must be ted at least annually.  ments for PACE and ESRD  0.84(b):] Policies and ACE organization must ment emergency preparedness ures, based on the torth in paragraph (a) of this ment at paragraph (a) of this ment at paragraph (a)(1) of ecommunication plan at as section. The policies and didress management of edical emergencies, including, ire; equipment, power, or related emergencies; and ely to threaten the health or coants, staff, or the public. The ures must be reviewed and	E 000	E 013(b)  1. A facility based and commurrisk assessment, utilizing an hazards approach was compuly 2018 and utilized when developing the Emergency Preparedness Plan for the CICF. Community Living Alter utilizes The Kaiser Permane Medical Center Hazard and Vulnerability Analysis Tool a reassesses annually. CLA vathe facility's Emergency Preplan to further detail the processing the process of the programs within CLA and eveloped utilizing a facility and community based risk assessing by October 11, 2019. The Apolicy #20 will also be amendetail the process in which Ended the programs within CLA and eveloped utilizing the facility community based risk assessing the programs within CLA and eveloped utilizing the facility community based risk assessing the procedures #20 vareviewed and revised at least to reflect any change in indivinceds or risks as well as any significant change to environ factors. Any changes to the will be detailed in the EPP and and revised at least of the process of the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the will be detailed in the EPP and the process of the process of the will be detailed in the EPP and the process of the process of the process of the process of the	all oleted in conrad rnatives nte nd vill amend paredness cess and y as in fact and sment. gency ded to EPP's for are y and sment. ncy does Emergency will be at annually riduals / mental process	SEP 2.5 2019

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STATEMENT OF DEFICIENCIES	(X1)	PROVIDER/SUPPLIER/CLIA		(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATIO	N NUMBER:	(X2) MULTIPLE CONSTRUCTION	COMPLETED
			A. BUILDING	
			A. DOILDING	
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DÎRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director

(X6) DATE

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		49G022	B. WING		00/	20/2040
NAME OF P	ROVIDER OR SUPPLIER	49G022	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	28/2019
CONRAD	ICF		41	123 CONRAD STREET LEXANDRIA, VA 22312		
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E 013	procedures. The dialy implement emergency procedures, based on forth in paragraph (a) assessment at paragrand the communication this section. The policity reviewed and updated emergencies include, equipment or power factories and include emergencies, water sometimes and include emergencies, water sometimes and include emergencies, water sometimes and include and i	at §494.62(b):] Policies and sis facility must develop and a preparedness policies and the emergency plan set of this section, risk aph (a)(1) of this section, on plan at paragraph (c) of ies and procedures must be at least annually. These but are not limited to, fire, sillures, care-related apply interruption, and a to occur in the facility's not met as evidenced by: and facility document need that the facility staff lete emergency  to provide documentation procedures were developed and-community based risk munication plan, utilizing an image. If, the home the facility's emergency led to evidence e policies and procedures don a facility- based and assessment and utilizing ch. ASM #1 was made	E 013	3. In order to maintain these conthe risk assessment and Emeroparedness Plan will be recand updated annually by the Manager, Project Director, and to ensure ongoing evaluation facility-based and community risks. Likewise, the agency Procedures #20 will be review updated as needed by the ageneutive Team. However, so there be a facility, agency, so environmental change, the rist assessment and subsequents Emergency Plan and Policy and Procedures will be updated immediately to ensure these deficiencies do not recur.  4. The QIDP, Home Manager are Project Director will meet qual monitor the accuracy of the rist assessments and any update need to be made. If changes made to the individual risk assessments, those changes be reflected in the Emergency Preparedness Plan as applicated Barring no mid-year changes, Assessments and Emergency Preparedness Plan will be revealed updated annually in order sustain this solution.	ergency viewed Home d QIDP of all -based olicy and ved and ency hould cial or sk y the and rterly to sk s that are will also y the Risk	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION		TE SURVEY MPLETED
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 87FS11

Facility ID: VAICFMR04

If continuation sheet Page 3 of 33

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NAME OF P	ROVIDER OR SUPPLIER		ļ	STREET ADDRESS, CITY, STATE, ZIP CODE	
CONRAD	ICF			4123 CONRAD STREET ALEXANDRIA, VA 22312	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
	Policies/Procedures for CFR(s): 483.475(b)(5)  [(b) Policies and procedure policies and procedure policies and procedure plan set forth in paragrand the communication this section. The policies address the following:  (5) A system of medicies address the following:  (5) A system of medicies address the following:  (5) A system of medicies and maintains available and maintains available and maintains available that preserves patient confidentiality of paties and maintains available.  *[For RNHCIs at §403 procedures. (5) A system of the following (i) Preserves patient confidentiality of paties and maintains available.  *[For RNHCIs at §403 procedures. (5) A system of the following (ii) Preserves patient does the following (iii) Protects confinformation. (iiii) Secure availability of records.  *[For OPOs at §486.3 procedures. (2) A system of the following of the f	was obtained prior to exit. or Medical Documentation  edures. The [facilities] must nt emergency preparedness es, based on the emergency raph (a) of this section, risk aph (a)(1) of this section, on plan at paragraph (c) of ies and procedures must be if at least annually. At a and procedures must  al documentation that rmation, protects nt information, and secures ility of records. [(5) or if medical documentation information, protects nt information, and secures ility of records.  748(b):] Policies and tem of care documentation  itient information. dentiality of patient es and maintains the  60(b):] Policies and tem of medical eserves potential and actual tects confidentiality of	E 01	1. Community Living Alternative amend its Policy #20 and the Emergency Preparedness Pl Conrad ICF to include details on how the facility and agency preserve patient information confidentiality and secure armaintain availability of record October 11, 2019.  2. To insure this deficiency doe recur the Program Manager, and Compliance Manager and Director will review adherency procedures on a quarterly base a part of the Quality Assureview which takes place twice Adherence will be reviewed a of monthly evacuation drills, annual simulated relocation case a part of everyday activities staff will demonstrate the ability preserve patient information, confidentiality of patient informand secure and maintain avarecords. Challenges with add to these procedures will be a in staff meetings and supervifindings from these reviews maintained by the Training and Compliance Manager.  3. In order to maintain this correstaff will be trained in the proand provided multiple opports adhere to the procedures the monthly evacuation drills, an relocation drill and as a part of everyday business transaction Project Director, Training and Compliance Manager, and Homanager will review these accompliance with the policies approcedures. Any challenges adherence will be addressed are observed, through month	lan for he ed plans cy will protect and dis by  s not Training and Project are to these asis and rance as a part the drill and as where lity to protect mation, aliability of herence addressed asion.  will be and  ection all cedures unities to ough annual of ons. The districtions and with as they

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	4.	supervision, annual performance evaluations, and staff meetings. an Procedures will be reviewed and updated annually, as needed; therefore, the deficient practice will not recur.  Monitoring of this will take place on a daily basis through observation of staff by the Home Manager; quarterly through the review of evacuation drills and other documentation by the home manager, Training and Compliance Manager, and Project Director; biannually through the Quality Assurance Review which identifies any challenges with protecting confidentiality of patient information, and the securing and maintenance of records; and annually through the review of an annual relocation drill. These actions will adequately monitor performance of the procedures and ensure adequate solutions are maintained.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED		
			B. WING				
NAME OF D	ROVIDER OR SUPPLIER	49G022			08	/28/2019	
CONRAD				STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312			
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E 023	Based on staff intervice review it was determined failed to have a compute preparedness plan.  Facility staff failed to oprocedures of how the information, protects of information, and secula availability of records.  The findings include:  On 08/28/19 at 8:00 apreparedness plan was [administrative staff manager. Review of the preparedness plan fair procedures of how the information, protects of information, and secula availability of records. No further information Policies/Procedures-VCFR(s): 483.475(b)(6)  [(b) Policies and procedure policies and procedures and procedure policies and procedure plan set forth in paragents assessment at paragrants.	not met as evidenced by: ew and facility document ned that the facility staff lete emergency  develop policies and e facility preserves patient confidentiality of patient res and maintains  a.m., the facility's emergency as reviewed with ASM member] #1, the home the facility's emergency led to evidence policies and e facility preserves patient confidentiality of patient res and maintains  ASM #1 stated that it was ency plan.  was obtained prior to exit. Volunteers and Staffing	E 023	, in the second	he facility d risk lunteers in	10/11/19	
	this section. The polic reviewed and updated	ies and procedures must be I at least annually. At a and procedures must		Emergency Plan will be upon October 11, 2019. The policy procedures in the emergence describe the facility's role in care and treatment at alteresites under an 1135 waiver.	ated by cies and cy plan that providing	VDH/OLC	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G022	D. WIIIQ		08/28/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CONRAD	ICF			4123 CONRAD STREET ALEXANDRIA, VA 22312	
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TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	~~   CATE
E 024			E 024	on utilizing volunteers as an a	gency in
	Continued From page	4		the event of an emergency.	_
	address the following:	1		2. The Emergency Preparedness	
		•		will identify the use and role of volunteers in the event of an	
	(6) [or (4), (5), or (7) a	s noted above] The use of		emergency for all individuals in	the
	volunteers in an emer	gency or other emergency		facility. It will utilize the individ	
		luding the process and role		assessment to determine the t	
		and Federally designated		of volunteers for each individu	al.
		nals to address surge needs		Therefore, no other individuals	will be
	during an emergency.			affected by this deficiency.	
	*[For RNHCIs at §403	748/h):1 Policies and		3. A policy and procedure for utili	
	procedures. (6) The u			volunteers in emergency situate be developed and included in	
	emergency and other			Agency Policy and Procedures	
		surge needs during an		and the Facility's Emergency	7720
i i	emergency.			Preparedness Plan. It will ider	ntify best
ŀ				practices and processes for us	ing
	*[For Hospice at §418			volunteers at this facility with the	
		se of hospice employees in		specific individuals who live the	
		ner emergency staffing		Both documents will be review	i .
		ne process and role for		updated annually to ensure thi deficiency does not recur.	5
	health care profession	d Federally designated		4. The Home Manager, QIDP and	4
	needs during an emer	_ ,		Project Director will maintain c	
	-	ot met as evidenced by:		with potential volunteers and n	1
		ew and facility document		the effectiveness of using volu	
		ned that the facility staff		during the annual drills. Amen	
	failed to have a compl	ete emergency		will be made to the policies an	1 1
	preparedness plan.			procedures based on monitorial ensure these solutions are ma	
	Facility staff failed to d	levelop policies and			
		e of volunteers and other			
	staffing strategies in th	ne emergency plan.			
	The findings include:				
	On 08/28/19 at 8:00 a	.m., the facility's emergency			
	preparedness plan wa				
	[administrative staff m			RE	*
		he facility's emergency			riven
	preparedness plan fail	led to evidence policies and		SED.	
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X2) MULTIF	(X3) DATE SURVEY COMPLETED					
		'	A. BUILDING	3				
		49G022	B. WING		· · · · · · · · · · · · · · · · · · ·	00	12012040	
NAME OF P	PROVIDER OR SUPPLIER	430022	L	STREET ADI	DRESS, CITY, STATE, ZIP CODE	<u> </u>	/28/2019	
CONRAD				4123 CONR	RAD STREET DRIA, VA 22312			
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E 024	Continued From page	je 5	E 02	:4				
E 026	staffing strategies in ASM #1 stated that it emergency plan.  No further information Roles Under a Waive CFR(s): 483.475(b)(8)  [(b) Policies and procedure plans and procedure plans at forth in paragand the communication this section. The policies address the following (8) [(6), (6)(C)(iv), (7) [facility] under a waive in accordance with seprovision of care and care site identified by officials.  *[For RNHCIs at §400 procedures. (8) The rewaiver declared by the with section 1135 of at an alternative care management officials. This STANDARD is Based on staff intervi	on was obtained prior to exit. er Declared by Secretary 8)  cedures. The [facilities] must ent emergency preparedness ares, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of icies and procedures must be ed at least annually. At a es and procedures must g:]  ), or (9)] The role of the ver declared by the Secretary, ection 1135 of the Act, in the d treatment at an alternate by emergency management  13.748(b):] Policies and role of the RNHCI under a the Secretary, in accordance Act, in the provision of care a site identified by emergency s.  not met as evidenced by: riew and facility document ined that the facility staff	E 02	3.	The Facility's Emergency Preparedness Plan will be upda include a process for providing and treatment at alternate care should the need arise under an Waiver. This plan will include procedures that delineates staf in providing care and services of Individuals at the ICF at an alte facility, with whom it has establ connection with and able to sup the needs of the Individuals.  The Emergency Preparedness will include processes that ensi safety of all individuals in the he the event of an 1135 Waiver or emergency situation that requir relocation of individuals to anot facility. Therefore, no other ind will be affected by this deficience CLA will identify a potential par which we could relocate individ the event we needed to provide supports at an alternate locatio beyond a 50 mile radius of our location. We will develop a for procedure and agreement and continue to conduct annual drill ensure this deficiency does not The QIDP, Home Manager, and Project Director will maintain ar agreement with the partner and conduct annual drills in which feedback will be obtained. The Emergency Preparedness Plan updated annually and will reflect changes found to be necessary	care e sites in 1135 iff's role to the ernate lished a pport  Plan ure the ome in other res the ther lividuals cy.  tner in luals in e in current mal  ls to t recur. d in d in the in t	10/11/19 VDH/OC	SEP 2.5 2019

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

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			the annual drill or as a result in any other changes. This will ensure these solutions are maintained.	
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDIN B. WING	NG		
		49G022	B. WIIVG_		08/	28/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312		
(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 CORRECT ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
E 026	Continued From particle Facility staff failed procedures in the earth the facility's role in at altered care site. The findings include On 08/28/19 at 8:0 preparedness plan [administrative staff manager. Review preparedness plan procedures in the earth of facility's role in at altered care site #1 stated, "We don No further informated."	age 6  to develop policies and emergency plan that describe providing care and treatment s under an 1135 waiver.  e:  0 a.m., the facility's emergency was reviewed with ASM f member] #1, the home of the facility's emergency failed to evidence policies and emergency plan that describe providing care and treatment s under an 1135 waiver. ASM i't have anything."	ΕC	DEFICIENCY)		
E 039	RNHCIs and OPOstest the emergency [facility, except for all of the following:  *[For LTC Facilities The LTC facility must the emergency plaunannounced staff procedures. The LT following:]  (i) Participate in a formunity-based of the emergency plaunannounced staff procedures. The LT following:]		EO	1. The facility will develop a a plan to participate in a full-scale exercise in the yearly by October 11, 20 will document and the Howill review the facility's exanalysis, and response. be amended to reflect an learned from the exercises.  2. The Emergency Prepared will include the policy and documentation on participatabletop or full-scale exercises will take place annually and lessons lear implemented through the Emergency Preparedness and on-going thorugh supother opportunities. Then deficiency will not re-cur.  3. CLA will ensure we main compliance with this stan scheduling drills at least a 10/11/19, and annually the	and implement tabletop or community 19. The QIDP ome Manager exercise The EPP will explay lessons e(s). dness Pland pating in rcise. These at least rned will be a EPP, in as Training pervision and efore, this tain dard by annually by	SEP 2.5 2019 VDH/OLC

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 The scheduled drill dates and successful completion of the drills will be a part of the bi-annual Quality Review conducted by the Training and Compliance Manager. 4. Adherence to this standard will be monitored by the Home Manger, Project Director and Trainig and Compliance Manager. When the drill(s) occur verification and lessons learned from the drills will be documented and submitted to the Project Director, Training and Compliance Manager, and Executive Director so necessary edits can be made to the EPP. The bi-annual Quality Assurance Reviews will monitor compliance and be submitted to the Executive Director as a part of the performance evaluation for the Home Manager and Project Director

for the facility.



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FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN OF CORRECTION  (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		A. BUILDING					
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NAME OF P	ROVIDER OR SUPPLIER	49G022		STREET ADDRESS, CITY, STATE, ZIP CODE	08/	28/201	9
CONRAD				4123 CONRAD STREET ALEXANDRIA, VA 22312			
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E 039	actual natural or man requires activation of [facility] is exempt fro based or individual, fa for 1 year following the (ii) Conduct an a include, but is not lim second full-scale exe based or individual, fatabletop exercise that discussion led by a facilinically-relevant emory problem statement prepared questions demergency plan.  (iii) Analyze the maintain documentatic exercises, and emergency [facility's] emergency  *[For RNHCls at §403 §486.360] (d)(2) Test must conduct exercise plan. The [RNHCl and following:  (i) Conduct a patable at least annually. A tadiscussion led by a facilinically relevant emory problem statement prepared questions demergency plan.  (ii) Analyze the presponse to and maintain of problem statement prepared questions demergency plan.  (iii) Analyze the presponse to and maintain document for the prepared questions demergency plan.  (iii) Analyze the presponse to and maintain following:	Ifacility] experiences an in-made emergency that the emergency plan, the immengaging in a community-acility-based full-scale exercise in eonset of the actual event. In additional exercise that may itted to the following: (A) A roise that is community-acility-based. (B) A roise that messages, or esigned to challenge an roise that may be roise that messages are roise and opposite that is community-acility-based full roise that may be roise th	E 03	Both exercises will be docum reviewed and updated annua ensure this deficiency does n	lly to	SEP 2.5 2019	R C C C C C C C C C C C C C C C C C C C

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
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		49G022	D. 141110		08	/28/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1123 CONRAD STREET ALEXANDRIA, VA 22312		
(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 CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
E 039	Based on staff inter review it was determ failed to have a compreparedness plan.  Facility staff failed to tabletop or full scale the facility's exercise the facility updated on the exercise ana The findings include On 08/28/19 at 8:00 preparedness plan (administrative staff manager. Review of preparedness plan (administrative staff	s not met as evidenced by: view and facility document nined that the facility staff nplete emergency  o provide evidence of a e exercise, documentation of e analysis, response; and how its emergency program based lysis.  a.m., the facility's emergency was reviewed with ASM member] #1, the home of the facility's emergency failed to evidence of a e exercise, documentation of e analysis, and response. ated its emergency program, se analysis. ASM #1 stated, thing."  on was obtained prior to exit.  S  nnual Medicaid survey for facilities for Persons with es (ICF/ID) was conducted b/28/19. The facility was not in CFR Part 483 Requirements re Facilities for the ed. The Life Safety Code	E 039			SEP 2.5 2018

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	NG_	CONSTRUCTION	1	SURVEY PLETED
		49G022	B. WilkG			08	/28/2019
NAME OF P	ROVIDER OR SUPPLIER			41	TREET ADDRESS, CITY, STATE, ZIP CODE 123 CONRAD STREET LEXANDRIA, VA 22312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICENCY)	D BE	(X5) COMPLETION DATE
W 111	the time of the surve consisted of two cu (Individuals #1 and CLIENT RECORDS CFR(s): 483.410(c)  The facility must derecordkeeping systemalth care, active and protection of the This STANDARD is Based on staff interreview it was deterrealled to ensure the for two of two individual #1 and #1. The facility behavioral support record.  2. The facility medication administ the clinical record and Individual #2 was continued to the findings included the findings inc	four bed facility was three at ey. The survey sample rrent individual reviews, #2).  (1)  Evelop and maintain a em that documents the client's treatment, social information, e client's rights.  Is not met as evidenced by: views and clinical record mined that the facility staff clinical record was accurate duals in the survey sample, 12.  Is staff failed to maintain a current plan in Individual# 1's clinical staff failed to ensure a tration, release form, located in the Individual# 1's clinical staff failed to maintain a current plan in Individual# 1's clinical etc.  Ecc.  Failed to maintain a current plan in Individual# 1's clinical etc.	W	**************************************	1. The Training and Comp Manager will develop a Documents and Conser Checklist for each progragency and this facility that checklist to ensure required forms and consup to date. These forms consents will include (but limited to) Behavioral Standard medication administration releases, internally and at the Day 2. The Home Manager with the QIDP to actively documentation at both the and day programs by 10 and on a quarterly basis Quarterly reviews with din addition to bi-annual Assurance Reviews will that this deficiency does 3. This standard will be made by using the Signed Documentary reviews and bit Quality Assurance Reviews will as conquarterly reviews and bit Quality Assurance Reviews and bit Assurance Reviews and	Signed onts arm in the will utilize that all sents are and ut not be upport both y Program. ill work y review he facility 0/11/19 is lue dates Quality ensure anot recur. aintained cuments at annual ducting fannual ews to sents and etely. are added lso be cuments a conitored signed onts	SEP 2.5 2019

			annual Quality Assurance Review.	
		W		
	: 			
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		49G022	B. WING		08	/28/2019
NAME OF P	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 123 CONRAD STREET ALEXANDRIA, VA 22312	· . *	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	) BE	(X5) COMPLETION DATE
W 111	not limited to: model (1), self-injurious be disorder (3), and bed (4).  On 08/26/19 at approf Individual# 1's clir Group Home] reveal "Behavioral Treatmet, signed and dated staff member] # 2, b  On 08/26/19 at appropring the staff member] # 1, home of Individual # 1's "B Program." At appropriated that they did in "Behavioral Treatmet" on 08/27/19 at 9:10 conducted with OSM regarding the behave Individual # 1. OSM and it should have be the year. "When ast current assessments 2 stated, "I attend the meetings and that the update it. I get reminant in get reminant in the professional were infindings.	oximately 1:00 p.m. a review nical record at [Name of ed a document entitled ent Program" for Individual # on "6'19/18" by OSM [other ehavioral specialist.  oximately 1:20 p.m., a po ASM [administrative staff manager for a current copy ehavioral Treatment eximately 1:25 p.m., ASM # 1 not have a current copy of the	W 111		SEP 2.5 209	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING _		
			B. WING		
		49G022			08/28/2019
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
CONRAD	ICF			123 CONRAD STREET LEXANDRIA, VA 22312	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
W 111			W 111		
	Continued From page	<b>2</b> 11			
	References:		•		
		roup of disorders			
		nited mental capacity and			
	difficulty with adaptive	e behaviors such as			
		nedules and routines, or			
		tellectual disability originates			
		and may result from physical			
		m or cerebral palsy, or from			
		such as lack of stimulation ness. This information was			
	obtained from the wel				
		n.gov/NIHfactsheets/ViewFa			
	ctSheet.aspx?csid=10				
		ers to a person's harming			
	obtained from the wel	rpose. This information was			
	https://medlineplus.go				
	- · · -	al and developmental			
		early in childhood and lasts s life. It affects how a person			
		h others, communicates, and			
	learns. This informati	on was obtained from the			
	website:				
	https://www.nlm.nih.g rumdisorder.html.	ov/medlineplus/autismspect			
	(4) An enlarged was obtained from the	prostate. This information			
		ov/medlineplus/enlargedpro			
	2. The facility staff fa administration, releas	iled to ensure a medication e form, located in the			
	clinical record at [Nan Individual # 2 was cor	ne of Day Program], for mpleted.			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		TE SUF		
			A. BUILDIN	IG				
		1	B. WING					
		49G022			0	8/28/2	2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
CONRAD	ICF			4123 CONRAD STREET ALEXANDRIA, VA 22312				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOL  CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	co	(X5) MPLETIC DATE	)N
W 111			W 1	11				
W 111	admitted to (Name o Diagnoses in the clir not limited to: moder obsessive compulsive disorder (3), and tare of Day Program] was record revealed a "M Release" form signed three small square be the form for check medications which he physician in charge of the second box it does that any medication of Program] must be in legible pharmacy lab given otherwise. I me physician's order to be	67 year old male, who was f Group Home) on 12/16/02. ical record included but were ate intellectual disability (1), e disorder (2), autistic live dyskinesia (4).  eximately 11:00 a.m., a f 2's clinical record at [Name s conducted. Review of the ledication Administration d on 08/22/18. The form had exist on the left hand side of arks. Next to the first box it exize staff to assist me with a non-prescription ave been approved by a of my medical care." Next to cumented, "I acknowledge I take at [Name of Day the original container with a el. Medication cannot be ust also provide a written have the Nurse on site be	W 1					
	prescription medicati documented, "I author to me over-the-count needed (PRN) basis (e.g., headaches, mo a current PRN Medic have any suspicion to a physician's attention communicated to mo counsellor." Further evidence a check ma	oth prescription and non- cons." Next to the third box it corize staff to make available ter medications on an as- for minor medical aliments construal cramps) only if I have cation Release on file. If staff that my condition may require on, then this would be e, and my parent, guardian or review of the form failed to cark in any of the three boxes.				ADH/OLG	SEP 2.5 2019	東市の市区市の

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		49G022	B. WING		08/28/2	2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CONRAD	ICF			4123 CONRAD STREET ALEXANDRIA, VA 22312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) MPLETION DATE
W 111	Individual # 2's "Medinal Release" form OSM is was complete and if sheing authorized. OS was incomplete, one been checked and the what was authorized. On 08/27/19 at approximaterview was conducted [Qualified Intellectual and ASM [administra manager. After reviee "Medication Administ 1 and ASM # 1 was a complete and if they authorized. OSM # 1 that the form was incomplete and if they authorized. OSM # 1 that the form was incomplete and if they authorized. OSM # 1 that the form was incomplete and if they authorized in the form was incompleted in the form was incompleted in the form was incompleted. OSM # 1 that the form was incompleted in the form was incompleted in the form was incompleted. OSM # 1 that the form was incompleted in the form was incompleted in the form was incompleted in the form was incompleted. OSM # 1 that the form was incompleted in the form was incompleted in the form was incompleted in the form was incompleted. OSM # 1 that the form was incompleted in the form was incompleted	[other staff member] # 4, ort specialist at m]. After reviewing cation Administration # 4 was asked if the form she could tell what was SM # 4 stated that the form of the boxes should had at you could not determine eximately 1:45 p.m., an exted with OSM # 1, QIDP Disabilities Professional] tive staff member] # 1, home wing Individual # 2's ration Release" form, OSM # isked if the form was could tell what was being and ASM # 1 acknowledged omplete.  In was provided prior to exit.  In was provided prior to exit.	W 1	·		
	(2) A common, o disorder	chronic and long-lasting				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING_		
		49G022	B. WING		08/28/2019
NAME OF P	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 123 CONRAD STREET ALEXANDRIA, VA 22312	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	i DATE
W 111	uncontrollable, reocci (obsessions) and beh (compulsions) that he repeat over and over obtained from the we http://www.nimh.nih.g ompulsive-disorder-o  (3) A neurologic disorder that begins of throughout a person's acts and interacts wit learns. This informat website: https://www.nlm.nih.g rumdisorder.html.  (4) Characterize purposeless moveme may include grimacin smacking, puckering blinking. Rapid move trunk may also occur. the fingers may be pr obtained from the we http://www.ninds.nih.g htm. QIDP CFR(s): 483.430(a)  Each client's active tr integrated, coordinate qualified intellectual of This STANDARD is it Based on staff intervic it was determined tha Intellectual Disabilities	aviors or she feels the urge to This information was besite: lov/health/topics/obsessive-c cd/index.shtml.  al and developmental early in childhood and lasts is life. It affects how a person h others, communicates, and ion was obtained from the lov/medlineplus/autismspect  d by repetitive, involuntary, hts. Features of the disorder g, tongue protrusion, lip and pursing, and rapid eye ments of the arms, legs, and Involuntary movements of lesent. This information was besite: lov/disorders/tardive/tardive.  eatment program must be ad and monitored by a lisability professional. linot met as evidenced by: lews and clinical record review	W 159		and am in ize that d forms se ut not Plans eases, gram. h the ation at by

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0011112077077		A. BUILDING		COMPLETED
		49G022			08/28/2019
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
CONRAD	ICF		1	123 CONRAD STREET ALEXANDRIA, VA 22312	
(X4) ID		ATEMENT OF DEFICIENCIES	GI	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
W 159			W 159		
	Continued From page survey sample, Indivi	e 15 two individuals in the dual # 1 and # 2.			
	1. The QIDP [Q	ualified Intellectual Disabilities			
	•	tain a current behavioral dual# 1's clinical record.			
	2. The QIDP [Q Professional] failed to	ualified Intellectual Disabilities ensure a medication			
		e form, located in the clinical ay Program], for Individual # 2			
	The findings include:				
	Professional] to main	ed Intellectual Disabilities tain a current behavioral dual# 1's clinical record.			
	admitted to (Name of	. ,			
	included but were not	es in the clinical record limited to: moderate 1), self-injurious behavior			
	- 1	3), and benign prostatic			
	of Individual# 1's clini	ximately 1:00 p.m. a review cal record at [Name of			, , , , , , , , , , , , , , , , , , ,
	"Behavioral Treatmer	d a document entitled  tt Program" for Individual #			
	1, signed and dated of staff member] # 2, be	on "6'19/18" by OSM [other havioral specialist.			
	On 08/26/19 at appro	ximately 1:20 p.m., a ASM [administrative staff			
		nanager for a current copy			
		mately 1:25 p.m., ASM # 1			***

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G022	B. WING		08	/28/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
W 159	Continued From page	16	W 15	59			
	stated that they did no "Behavioral Treatment	t Program."				Continuent	
	conducted with OSM	a.m., an interview was # 2, behavioral specialist pral treatment program for					
		eviewing the behavior					
		SM # 2 stated, "It is out of ve been revised/reviewed		*			
	interview was conduc	ximately 1:45 p.m., an				The same of the sa	
	responsibilities of the "Participate in develor	When asked to describe the QIDP, OSM # 1 stated, ping the ISP [individual					
	and choices are respe	ur their [Individual's] goals ected. Make sure individuals make sure they have their					
	medications on time a physician, implement	as prescribed by the					
	being implemented by the active treatment, r	y staff. Review the record for review clinical records at					
	is in the record, signe	es to make sure everything d and dated." After for 1 is behavior treatment				***************************************	
		knowledged that it was not					
	The facility's policy 'Di Professional/QIDP" do	ocumented in part,					
		d documentation in logs and nthly and quarterly reports."					
		ximately 2:00 p.m., ASM nember] # 1, home manager ne above findings					

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION NUMBER:			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		49G022	B. WING		00/00/0040
NAME OF P	ROVIDER OR SUPPLIER	433022	STR	REET ADDRESS, CITY, STATE, ZIP CODE	08/28/2019
CONRAD	ICF			3 CONRAD STREET EXANDRIA, VA 22312	
(X4) ID		ATEMENT OF DEFICIENCIES	l ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
W 159			W 159		
	Continued From page	e 17			***************************************
	No further information	n was provided prior to exit.			
	References:				
	• •	roup of disorders			
		nited mental capacity and			
	difficulty with adaptive	e benaviors such as hedules and routines, or			***
		tellectual disability originates			
		and may result from physical			
		sm or cerebral palsy, or from			
		such as lack of stimulation			
	obtained from the wel	ness. This information was			
		n.gov/NIHfactsheets/ViewFa			
	ctSheet.aspx?csid=10				
		ers to a person's harming			
		rpose. This information was			
	obtained from the wel				
	https://medlineplus.go	ov/sennarm.ntmi.	***************************************		
		al and developmental			
		early in childhood and lasts			
		s life. It affects how a person			
		h others, communicates, and ion was obtained from the			
	website:				
	https://www.nlm.nih.g rumdisorder.html.	ov/medlineplus/autismspect			
	(4) An enlarged	prostate. This information			
	was obtained from the	e website:			
	https://www.nlm.nih.g statebph.html.	ov/medlineplus/enlargedpro			
		iled to ensure a medication	-		
	administration, releas	e form, located in the	***************************************		
	[Name of Day Program		***************************************		
	Individual # 2 was cor	прієтеа.			



	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		001111 221 22	
			B. WING			
		49G022			08/28/2019	
CONRAD	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SE COMPLETION	
W 159			W 15	9		
	Continued From pag	e 18				
	admitted to (Name o Diagnoses in the clin not limited to: moder obsessive compulsive disorder (3), and tare of Day Program] was record revealed a "M Release" form signed three small square be the form for check medications which he physician in charge of the second box it does that any medication I Program] must be in legible pharmacy lab given otherwise. I me physician's order to hable to administer be prescription medication of the order of the second box it does that any medication I program] must be in legible pharmacy lab given otherwise. I me physician's order to hable to administer be prescription medication documented, "I author to me over-the-count needed (PRN) basis (e.g., headaches, me a current PRN Medical have any suspicion to a physician's attention communicated to me counsellor." Further	eximately 11:00 a.m., a  2's clinical record at [Name seconducted. Review of the sedication Administration of the sedication as the sedication of the sedication of the sedication of the sedication cannot be sedicated as the sedication cannot be sedicated as the sedication of the				



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY	
AND I DIVO	OGRACOTION	IDENTI TOATION NOMBER.	1 ' '		COMPLETED	
			B. WING			
		49G022	D. WING		08/28/2019	
NAME OF PI	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
				123 CONRAD STREET		
CONRAD	ICF		_   <i>*</i>	ALEXANDRIA, VA 22312		
(X4) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B		NC
IAG	NEGOLATOR LONG	SCIDENTIFYING HAPORIMATION)	IAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
W 159			VA 4 CO			
W 159			W 159			
	Continued From page	19				
		ximately 11:15 a.m., an				
		ted with OSM [other staff				
		program support specialist at				
	[Name of day Program					
	Individual # 2's "Medi	cation Administration				
	Release" form OSM #	4 was asked if the form				
		he could tell what was				
		M # 4 stated that the form				
		of the boxes should had				
	what was authorized.	at you could not determine			***************************************	
	what was authorized.				***************************************	
	On 08/27/19 at approx	ximately 1:45 p.m., an				
		ted with OSM [other staff				
	member] # 1, QIDP. 1	When asked to describe the				
	•	QIDP, OSM # 1 stated,				
		ping the ISP [individual				
		ur their [Individual's] goals				
		ected. Make sure individuals nake sure they have their				
	medications on time a					
	physician, implement				200	
		e active treatment, is being			***************************************	
	implemented by staff.	Review the record for the			***************************************	
		ew clinical records at home			**************************************	
		nake sure everything is in			THE STATE OF THE S	
		d dated." After reviewing				
		ation administration release "I have only been here for				
		n February 13, 2019. When				
		procedure he follows for			ļ	
		records at the day programs				
	OSM # 1 stated, "[Nai					
		en here for three months				
		ths before he got here I was				
	•	I had the role as QIDP. The			Į	
		s only here for two days and				
		about reviewing the records				
	at the day program."	When asked if he received				



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  IG	COMPLETED				
LILLE OF O	NOTIFIED OF SUPPLIES	49G022			0	8/28/20	19	
CONRAD	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMP	X5) PLETION ATE	-
W 159	"Yes."  The facility's policy 'I Professional/QIDP" ("Maintains all require and records, includin reports."  On 08/27/19 at appro [Administrative staff manager was made No further information."  References: (1) Refers to a group by a limited mental conductive behaviors and schedules and routing Intellectual disability 18 and may result from autism or cerebral pacauses, such as lack responsiveness. This from the website: https://www.report.nictSheet.aspx?csid=1  (2) A common, chror in which a person has reoccurring thoughts (compulsions) that he repeat over and over obtained from the web http://www.nimh.nih.gc ompulsive-disorder.	Direct Support documented in part, ed documentation in logs ag monthly and quarterly  eximately 2:00 p.m., ASM member] # 1, home aware of the above findings. In was provided prior to exit.  of disorders characterized apacity and difficulty with such as managing money, les, or social interactions. originates before the age of om physical causes, such as alsy, or from nonphysical of stimulation and adult is information was obtained  th.gov/NIHfactsheets/ViewFa  00  lic and long-lasting disorder is uncontrollable, (obsessions) and behaviors e or she feels the urge to This information was elsoite: gov/health/topics/obsessive- cod/index.shtml.  d developmental disorder	W 1	59		STO/BIDY	SEP 2 5 2019	20 Char 12 1200 8 1 1 1

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

STATEMENT OF DEFICIENCIES	(X1)	PROVIDER/SUPPLIER/CLIA		(X3) DATE SURVEY
AND PLAN OF CORRECTION	TION IDENTIFICATIO	N NUMBER:	(X2) MULTIPLE CONSTRUCTION	COMPLETED
				COMPLETED
!			A. BUILDING	1
<u> </u>	1			1

		49G022	B. WING_				08	/28/2	<b>019</b>	
NAME OF P	ROVIDER OR SUPPLIER		<u>-1</u>	STR	EET ADDRES	SS, CITY, STATE, ZIP CODE			010	$\dashv$
CONRAD ICF					3 CONRAD S EXANDRIA	STREET , VA 22312				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)		СО	(X5) MPLETIC DATE	)N
W 159	Continued From page	21	W 1	159						
W 444	obtained from the wel https://www.nlm.nih.g rumdisorder.html.  (4) Characterized by a purposeless moveme may include grimacing smacking, puckering a blinking. Rapid mover trunk may also occur. the fingers may be proobtained from the wel http://www.ninds.nih.ghtm.  EVACUATION DRILL CFR(s): 483.470(i)(1)  The facility must hold the effectiveness of elplans and procedures  This STANDARD is respectively. The finding include:  Review of the facility forms dated 07/2018 forms dated 07/20	eacts with others, earns. This information was easite: ov/medlineplus/autismspect repetitive, involuntary, each statures of the disorder g, tongue protrusion, lip eand pursing, and rapid eye ments of the arms, legs, and Involuntary movements of resent. This information was easite: pov/disorders/tardive/tardive.  S (iii)  revacuation drills to evaluate mergency and disaster  recot met as evidenced by: ment review and staff mined that the facility failed or each shift quarterly.	W 4	144	the Confinence of the Confinen	The Home Manager will work with the QIDP to create a schedule by October 11, 2019 that insures the drill is conducted each month allows for each shift to participate drill at least quarterly. The schedule revisions will take lace for all of the individuals in the cility. Therefore no other individuals will be affected by this efficiency. Each drill will be eviewed by the Home Manager project Director to ensure adhere to the rotation of shifts as well as ther requirements. The Monthly Fire and Evacuation of the Monthly Fire and Evacuation of the updated with the "each shift uarterly" policy to ensure the efficiencies do not recur. In monthly review will be conduct by the QDIP and signed off by the lome Manager ensuring the policy to the monitored through bi-annual Quassurance Reviews.	tata a that that that the the that the the that the the that the the the the the the the the the th		SEP 2.5 2019	



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY PLETED	
			B. WING			
NAME OF P	ROVIDER OR SUPPLIER	49G022		STREET ADDRESS CITY STATE 710.00		28/2019
CONRAD ICF				STREET ADDRESS, CITY, STATE, ZIP CO 4123 CONRAD STREET ALEXANDRIA, VA 22312	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU			
W 455	shift, between the methrough July 2019. If revealed that fire drill through July 2019 we p.m. to 11:00 p.m. shift on the staff member) # 1, he informed of the missiabove, ASM # 1 revirance acknowledged that the conducted quarterly. The facility's policy "I documented, "2d. Exconducted on a differ of each quarter, each fire drill."  On 08/27/19 at approximation (administrative staff in manager was made and the staff in manager was made and communicable document review it we will be sased on observation document review it we will be said to the sased on observation document review it we will be said to the said of the said o	ne 11:00 p.m. to 7:00 a.m. onths of February 2019 Further review of the forms Is dated February 2019 ere all conducted on the 3:00 nift.  Distribution of the forms Is dated February 2019 ere all conducted on the 3:00 nift.  Distribution of the dates of the fire drill forms and of the fire drill forms and of the fire drill forms and of the fire drill should be rent shift so that, by the end of shift will have completed a  Distribution of the findings.  In was provided. OL  OL  OL  Output  The fire drill should be rent shift so that, by the end of shift will have completed a  Distribution of the findings.  In was provided. OL  OL  OL  OL  Output  The fire drill should be rent shift so that, by the end of shift will have completed a  Distribution of infection	W 45	1. The Home Mana the PD, Complian Executive Director food safety training put laminated graining graining put laminated graining put laminated graining graini	ger will work with nee Manager and or to develop ng reviews and aphics in the October 11, 2019 safety and practices will be all staff. Any ring to these addressed he home ng and agger or Project	SEP 2.5 2019



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				be affected by this deficien	псу.	
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	77.000000					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49G022	B. WING		08/	28/2019
NAME OF PROVIDER OR SUPPLIER		i i	STREET ADDRESS, CITY, STATE, ZIP CODE			
CONRAD			1	1123 CONRAD STREET ALEXANDRIA, VA 22312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE

SEP 2.5 200



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W 455 W 455 Food Safety and infection control will be maintained by observation Continued From page 23 practices when and regular feedback as well as preparing dinner for the individuals resident at on-going support through monthly supervision. Random [Name of Group Home]. The facility staff unannounced reviews will be failed to change their gloves before handling conducted by the Training and and buttering the Individual's slices of bread Compliance Manager and signed and touching the inside of the vegetable off by the Home Manager monthly bowls. ensuring the policy is sustained. Deficiencies will be addressed in The findings include: supervision, through additional training and performance On 08/26/19 at approximately 5:10 p.m., an evaluations. observation of ASM [administrative staff member] Meals will be monitored as a part #1, home manager and OSM Jother staff of the bi-annual Quality member] # 1, QIDP [Qualified Intellectual Assurance review and Disabilities Professional participating in the documented for compliance. dinner preparation for the individuals was conducted in the [Name of Group Home] kitchen. ASM # 1 was observed putting on a clean pair of plastic gloves, and opening a loaf of sliced white bread. ASM #1 removed three slices of bread and placed them on three clean plates sitting on the kitchen island. While wearing the same gloves ASM # 1 opened a kitchen drawer, removed a butter knife, opened the refrigerator, removed a stick of butter, and returned to the kitchen island. ASM #1 picked up each slice of bread while still wearing the same gloves and buttered each slice of bread and placed it back on the plates. OSM # 1 was observed putting on a clean pair of plastic gloves, tieing up a bag of potatoes sitting on the kitchen island, and then carrying the bag of potatoes out of the kitchen, after opening the sliding glass door into an enclosed patio area. OSM #1 was then observed opening a cabinet, and placing the potatoes on the shelf in the cabinet. OSM #1 then closed the cabinet door. closed the sliding door, and re-entered the kitchen. OSM #1 opened a kitchen cabinet, and removed a stack of three bowls with his thumbs placed on the food surface of the top bowl. While STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY

COMPLETED

**IDENTIFICATION NUMBER:** 

AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION

A. BUILDING



			B. WING _				
		49G022					08/28/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP CODE	-	
				4123 CONRA	D STREET		
CONRAD	ICF			ALEXANDR	RIA, VA 22312		
(X4) ID	CI IMMADV CT	ATEMENT OF DEFICIENCIES			5501/5550 51 11 67 6 55		
PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SH		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		OSS-REFERENCED TO THE APP		DATE
			-		DEFICIENCY)		
VALACE	Continued Francis	0.4					
W 455	Continued From page	24	W 4	55			
	=	gloves, OSM # 1 then					
	placed each bowl on	the kitchen island one by					
	one, and was observe	ed placing his gloved thumb					
	on the food surface of	f each bowl. OSM #1 then		l			
	placed a scoop of coo	ked green peas into each					
		y 5:20 p.m. the individuals		}			
	residing in the group	-					
		of bread and plates with					
		m to the dining room table					
		in to the dining room table					
	and ate heir dinner.						
				ľ			
		ximately 1:21 p.m., an					
		ted with ASM # 1 and OSM					
		of gloves and handling of					
	individual's food. Who	en asked to describe the					
	purpose for wearing g	loves during meal					
	preparation, ASM #1:	stated, "To keep our germs					
	from our hands off the						
l	When ASM #1 was in						
	observation, ASM #1			}			
		and then put the gloves on					
ŀ	to prepare the food" a						
	should have changed	· · · · · · · · · · · · · · · · · · ·					
	SHOULD HAVE CHANGED	my gioves.					
	Ala firmita a information	was mandal d					
	No further information	was provided.					
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