STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G022	A. BUILDING ______ B. WING ______	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONRAD ICF	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/26/19 through 08/28/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Intermediate Care Facilities for Persons with Intellectual Disabilities.	E 000		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.	E 013	E 013(b) 1. A facility based and community based risk assessment, utilizing an all hazards approach was completed in July 2018 and utilized when developing the Emergency Preparedness Plan for the Conrad ICF. Community Living Alternatives utilizes The Kaiser Permanente Medical Center Hazard and Vulnerability Analysis Tool and reassesses annually. CLA will amend the facility's Emergency Preparedness Plan to further detail the process and evidence that the Emergency Preparedness Plan (EPP) was in fact developed utilizing a facility and community based risk assessment. by October 11, 2019. The Agency Policy #20 will also be amended to detail the process in which EPP's for of the programs within CLA are developed utilizing the facility and community based risk assessment. 2. In order to insure this deficiency does not recur, the assessment, Emergency Preparedness Plan, and Agency Policy and Procedures #20 will be reviewed and revised at least annually to reflect any change in individuals needs or risks as well as any significant change to environmental factors. Any changes to the process will be detailed in the EPP and Policy #20 as relevant.	10/11/19

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Executive Director 9/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date 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 013	Continued From page 1 *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation that the policies and procedures were developed based on the facility-and-community based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: On 08/28/19 at 8:00 a.m., the facility's emergency preparedness plan was reviewed with ASM [administrative staff member] #1, the home manager. Review of the facility's emergency preparedness plan failed to evidence documentation that the policies and procedures were developed based on a facility- based and community-based risk assessment and utilizing an all-hazards approach. ASM #1 was made aware of this concern.	E 013	3. In order to maintain these corrections, the risk assessment and Emergency Preparedness Plan will be reviewed and updated annually by the Home Manager, Project Director, and QIDP to ensure ongoing evaluation of all facility-based and community-based risks. Likewise, the agency Policy and Procedures #20 will be reviewed and updated as needed by the agency Executive Team. However, should there be a facility, agency, social or environmental change, the risk assessment and subsequently the Emergency Plan and Policy and Procedures will be updated immediately to ensure these deficiencies do not recur. 4. The QIDP, Home Manager and Project Director will meet quarterly to monitor the accuracy of the risk assessments and any updates that need to be made. If changes are made to the individual risk assessments, those changes will also be reflected in the Emergency Preparedness Plan as applicable. Barring no mid-year changes, the Risk Assessments and Emergency Preparedness Plan will be reviewed and updated annually in order to sustain this solution.	

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	49G022	B. WING	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONRAD ICF	**4123 CONRAD STREET** **ALEXANDRIA, VA 22312**

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E 013	Continued From page 2 No further information was obtained prior to exit.	E 013		
E 023	Policies/Procedures for Medical Documentation CFR(s): 483.475(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information.(iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.	E 023	E 023 1. Community Living Alternatives will amend its Policy #20 and the Emergency Preparedness Plan for he Conrad ICF to include detailed plans on how the facility and agency will preserve patient information protect confidentiality and secure and maintain availability of records by October 11, 2019. 2. To insure this deficiency does not recur the Program Manager, Training and Compliance Manager and Project Director will review adherence to these procedures on a quarterly basis and as a part of the Quality Assurance review which takes place twice a year. Adherence will be reviewed as a part of monthly evacuation drills, the annual simulated relocation drill and as a part of everyday activities where staff will demonstrate the ability to preserve patient information, protect confidentiality of patient information, and secure and maintain availability of records. Challenges with adherence to these procedures will be addressed in staff meetings and supervision. Findings from these reviews will be maintained by the Training and Compliance Manager. 3. In order to maintain this correction all staff will be trained in the procedures and provided multiple opportunities to adhere to the procedures through monthly evacuation drills, an annual relocation drill and as a part of everyday business transactions. The Project Director, Training and Compliance Manager, and Home Manager will review these activities for compliance with the policies and procedures. Any challenges with adherence will be addressed as they are observed, through monthly	10/11/19

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supervision, annual performance evaluations, and staff meetings. an Procedures will be reviewed and updated annually, as needed; therefore, the deficient practice will not recur.

4. 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; bi-annually 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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E 023	Continued From page 3 This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to develop policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The findings include: On 08/28/19 at 8:00 a.m., the facility's emergency preparedness plan was reviewed with ASM [administrative staff member] #1, the home manager. Review of the facility's emergency preparedness plan failed to evidence policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. ASM #1 stated that it was not part of the emergency plan. No further information was obtained prior to exit.	E 023		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.475(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must	E 024	E 024(b) 1. The facility Emergency Preparedness Plan will be updated using the facility based and community-based risk assessment and will include procedures for the use of volunteers in the event of an emergency. The Emergency Plan will be updated by October 11, 2019. The policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver.	10/11/19

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E 024	Continued From page 4 address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to develop policies and procedures for the use of volunteers and other staffing strategies in the emergency plan. The findings include: On 08/28/19 at 8:00 a.m., the facility's emergency preparedness plan was reviewed with ASM [administrative staff member] #1, the home manager. Review of the facility's emergency preparedness plan failed to evidence policies and	E 024	on utilizing volunteers as an agency in the event of an emergency. 2. The Emergency Preparedness Plan will identify the use and role of volunteers in the event of an emergency for all individuals in the facility. It will utilize the individual risk assessment to determine the best use of volunteers for each individual. Therefore, no other individuals will be affected by this deficiency. 3. A policy and procedure for utilizing volunteers in emergency situations will be developed and included in both the Agency Policy and Procedures #20 and the Facility's Emergency Preparedness Plan. It will identify best practices and processes for using volunteers at this facility with the specific individuals who live there. Both documents will be reviewed and updated annually to ensure this deficiency does not recur. 4. The Home Manager, QIDP and Project Director will maintain contact with potential volunteers and monitor the effectiveness of using volunteers during the annual drills. Amendments will be made to the policies and procedures based on monitoring to ensure these solutions are maintained.	

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E 024	Continued From page 5 procedures for the use of volunteers and other staffing strategies in the emergency plan. ASM #1 stated that it was not part of the emergency plan. No further information was obtained prior to exit.	E 024		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 026	1. The Facility's Emergency Preparedness Plan will be updated to include a process for providing care and treatment at alternate care sites should the need arise under an 1135 Waiver. This plan will include procedures that delineates staff's role in providing care and services to the Individuals at the ICF at an alternate facility, with whom it has established a connection with and able to support the needs of the Individuals. 2. The Emergency Preparedness Plan will include processes that ensure the safety of all individuals in the home in the event of an 1135 Waiver or other emergency situation that requires the relocation of individuals to another facility. Therefore, no other individuals will be affected by this deficiency. 3. CLA will identify a potential partner in which we could relocate individuals in the event we needed to provide supports at an alternate location beyond a 50 mile radius of our current location. We will develop a formal procedure and agreement and continue to conduct annual drills to ensure this deficiency does not recur. 4. The QIDP, Home Manager, and Project Director will maintain an agreement with the partner and conduct annual drills in which feedback will be obtained. The Emergency Preparedness Plan will be updated annually and will reflect any changes found to be necessary during	10/11/19 SEP 2 5 2019 VDH/OLC

the annual drill or as a result in any other changes. This will ensure these solutions are maintained.

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E 026	Continued From page 6 Facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 08/28/19 at 8:00 a.m., the facility's emergency preparedness plan was reviewed with ASM [administrative staff member] #1, the home manager. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM #1 stated, "We don't have anything." No further information was obtained prior to exit.	E 026		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual,	E 039	E 039 1. The facility will develop and implement a plan to participate in a tabletop or full-scale exercise in the community yearly by October 11, 2019. The QIDP will document and the Home Manager will review the facility's exercise analysis, and response. The EPP will be amended to reflect any lessons learned from the exercise(s). 2. The Emergency Preparedness Plan will include the policy and documentation on participating in tabletop or full-scale exercise. These exercises will take place at least annually and lessons learned will be implemented through the EPP, in Emergency Preparedness Training and on-going thorugh supervision and other opportunities. Therefore, this deficiency will not re-cur. 3. CLA will ensure we maintain compliance with this standard by scheduling drills at least annually by 10/11/19, and annually thereafter.	10/11/19

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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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E 039	Continued From page 7 facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as	E 039	Both exercises will be documented, reviewed and updated annually to ensure this deficiency does not recur.	

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E 039	Continued From page 8 needed. This STANDARD is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of a tabletop or full scale exercise, documentation of the facility's exercise analysis, response; and how the facility updated its emergency program based on the exercise analysis. The findings include: On 08/28/19 at 8:00 a.m., the facility's emergency preparedness plan was reviewed with ASM [administrative staff member] #1, the home manager. Review of the facility's emergency preparedness plan failed to evidence of a tabletop or full scale exercise, documentation of the facility's exercise analysis, and response. How the facility updated its emergency program, based on the exercise analysis. ASM #1 stated, "We don't have anything." No further information was obtained prior to exit.	E 039		
W 000	INITIAL COMMENTS An unannounced annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted 08/26/19 through 08/28/19. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. The Life Safety Code survey report will follow.	W 000		

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W 000	Continued From page 9 The census in this four bed facility was three at the time of the survey. The survey sample consisted of two current individual reviews, (Individuals #1 and #2).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on staff interviews and clinical record review it was determined that the facility staff failed to ensure the clinical record was accurate for two of two individuals in the survey sample, Individual # 1 and # 2. 1. The facility staff failed to maintain a current behavioral support plan in Individual# 1's clinical record. 2. The facility staff failed to ensure a medication administration, release form, located in the clinical record at [Name of Day Program], for Individual # 2 was completed. The findings include: 1. The facility staff failed to maintain a current behavioral support plan in Individual# 1's clinical record. Individual # 1 was a 62 year old male, who was admitted to (Name of Group Home) on 06/01/2000. Diagnoses in the clinical record	W 111	W 111 1. The Training and Compliance Manager will develop a Signed Documents and Consents Checklist for each program in the agency and this facility will utilize that checklist to ensure that all required forms and consents are up to date. These forms and consents will include (but not be limited to) Behavioral Support Plans and medication administration releases, both internally and at the Day Program. 2. The Home Manager will work with the QIDP to actively review documentation at both the facility and day programs by 10/11/19 and on a quarterly basis. Quarterly reviews with due dates in addition to bi-annual Quality Assurance Reviews will ensure that this deficiency does not recur. 3. This standard will be maintained by using the Signed Documents and Consents Checklist at annual meetings as well as conducting quarterly reviews and bi-annual Quality Assurance Reviews to verify that 100% of consents and plans are signed completely. When new documents are added to the needs, they will also be added to the Signed Documents and Consents Checklist. 4. This standard will be monitored through the use of the Signed Documents and Consents Checklist on an annual and quarterly basis as well as a bi-	10/11/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 10 included but were not limited to: moderate intellectual disability (1), self-injurious behavior (2), autistic disorder (3), and benign prostatic hyperplasia (4). On 08/26/19 at approximately 1:00 p.m. a review of Individual# 1's clinical record at [Name of Group Home] revealed a document entitled "Behavioral Treatment Program" for Individual # 1, signed and dated on "6'19/18" by OSM [other staff member] # 2, behavioral specialist. On 08/26/19 at approximately 1:20 p.m., a request was made to ASM [administrative staff member] # 1, home manager for a current copy of Individual # 1's "Behavioral Treatment Program." At approximately 1:25 p.m., ASM # 1 stated that they did not have a current copy of the "Behavioral Treatment Program." On 08/27/19 at 9:10 a.m., an interview was conducted with OSM # 2, behavioral specialist regarding the behavioral treatment program for Individual # 1. OSM # 2 stated, "It is out of date and it should have been revised/reviewed within the year." When asked how she maintains current assessments in the clinical record OSM # 2 stated, "I attend the ISP [individual support plan] meetings and that tends to be the trigger to update it. I get reminders from the program manager." On 08/27/19 at 2:00 p.m. ASM [administrative staff member] # 1 and OSM [other staff member] # 1, QIDP [Qualified Intellectual Disabilities Professional] were made aware of the above findings. No further information was provided prior to exit.	W 111		

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W 111		W 111		

Continued From page 11

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) Self-harm refers to a person's harming their own body on purpose. This information was obtained from the website: https://medlineplus.gov/selfharm.html.

(3) A neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html.

(4) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

2. The facility staff failed to ensure a medication administration, release form, located in the clinical record at [Name of Day Program], for Individual # 2 was completed.

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W 111	Continued From page 12 Individual # 2 was a 67 year old male, who was admitted to (Name of Group Home) on 12/16/02. Diagnoses in the clinical record included but were not limited to: moderate intellectual disability (1), obsessive compulsive disorder (2), autistic disorder (3), and tardive dyskinesia (4). On 08/27/19 at approximately 11:00 a.m., a review of Individual # 2's clinical record at [Name of Day Program] was conducted. Review of the record revealed a "Medication Administration Release" form signed on 08/22/18. The form had three small square boxes on the left hand side of the form for check marks. Next to the first box it documented, "I authorize staff to assist me with both prescription and non-prescription medications which have been approved by a physician in charge of my medical care." Next to the second box it documented, "I acknowledge that any medication I take at [Name of Day Program] must be in the original container with a legible pharmacy label. Medication cannot be given otherwise. I must also provide a written physician's order to have the Nurse on site be able to administer both prescription and non-prescription medications." Next to the third box it documented, "I authorize staff to make available to me over-the-counter medications on an as-needed (PRN) basis for minor medical aliments (e.g., headaches, menstrual cramps) only if I have a current PRN Medication Release on file. If staff have any suspicion that my condition may require a physician's attention, then this would be communicated to me, and my parent, guardian or counsellor." Further review of the form failed to evidence a check mark in any of the three boxes. On 08/27/19 at approximately 11:15 a.m., an	W 111		RECEIVED SEP 2 5 2019 VDH/OLC

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W 111	Continued From page 13 interview was conducted with OSM [other staff member] # 4, senior program support specialist at [Name of day Program]. After reviewing Individual # 2's "Medication Administration Release" form OSM # 4 was asked if the form was complete and if she could tell what was being authorized. OSM # 4 stated that the form was incomplete, one of the boxes should had been checked and that you could not determine what was authorized. On 08/27/19 at approximately 1:45 p.m., an interview was conducted with OSM # 1, QIDP [Qualified Intellectual Disabilities Professional] and ASM [administrative staff member] # 1, home manager. After reviewing Individual # 2's "Medication Administration Release" form, OSM # 1 and ASM # 1 was asked if the form was complete and if they could tell what was being authorized. OSM # 1 and ASM # 1 acknowledged that the form was incomplete. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A common, chronic and long-lasting disorder	W 111		

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W 111	Continued From page 14 in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml. (3) A neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html. (4) Characterized by repetitive, involuntary, purposeless movements. Features of the disorder may include grimacing, tongue protrusion, lip smacking, puckering and pursing, and rapid eye blinking. Rapid movements of the arms, legs, and trunk may also occur. Involuntary movements of the fingers may be present. This information was obtained from the website: http://www.ninds.nih.gov/disorders/tardive/tardive.htm.	W 111		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on staff interviews and clinical record review it was determined that the QIDP [Qualified Intellectual Disabilities Professional] failed to ensure the clinical record was accurate for two of	W 159	1. The Training and Compliance Manager will develop a Signed Documents and Consents Checklist for each program in the agency and this facility will utilize that checklist to ensure that all required forms and consents are up to date. These forms and consents will include (but not be limited to) Behavioral Support Plans and medication administration releases, both internally and at the Day Program. 2. The Home Manager will work with the QIDP to actively review documentation at both the facility and day programs by 10/11/19 and on a quarterly basis. Quarterly reviews with due dates in addition to bi-annual Quality Assurance Reviews will ensure that this deficiency	10/11/19

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Continued From page 15 two individuals in the survey sample, Individual # 1 and # 2.

1. The QIDP [Qualified Intellectual Disabilities Professional] to maintain a current behavioral support plan in Individual# 1's clinical record.

2. The QIDP [Qualified Intellectual Disabilities Professional] failed to ensure a medication administration release form, located in the clinical record at [Name of Day Program], for Individual # 2 was completed.

The findings include:

1. The QIDP [Qualified Intellectual Disabilities Professional] to maintain a current behavioral support plan in Individual# 1's clinical record.

Individual # 1 was a 62 year old male, who was admitted to (Name of Group Home) on 06/01/2000. Diagnoses in the clinical record included but were not limited to: moderate intellectual disability (1), self-injurious behavior (2), autistic disorder (3), and benign prostatic hyperplasia (4).

On 08/26/19 at approximately 1:00 p.m. a review of Individual# 1's clinical record at [Name of Group Home] revealed a document entitled "Behavioral Treatment Program" for Individual # 1, signed and dated on "6'19/18" by OSM [other staff member] # 2, behavioral specialist.

On 08/26/19 at approximately 1:20 p.m., a request was made to ASM [administrative staff member] # 1, home manager for a current copy of Individual # 1's "Behavioral Treatment Program." At approximately 1:25 p.m., ASM # 1

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stated that they did not have a current the "Behavioral Treatment Program."

On 08/27/19 at 9:10 a.m., an interview was conducted with OSM # 2, behavioral specialist regarding the behavioral treatment program for Individual # 1. After reviewing the behavior treatment program OSM # 2 stated, "It is out of date and it should have been revised/reviewed within the year."

On 08/27/19 at approximately 1:45 p.m., an interview was conducted with OSM [other staff member] # 1, QIDP. When asked to describe the responsibilities of the QIDP, OSM # 1 stated, "Participate in developing the ISP [individual service plan], make sur their [Individual's] goals and choices are respected. Make sure individuals eat nutritious meals, make sure they have their medications on time as prescribed by the physician, implement the active treatment [programs], and ensure the active treatment, is being implemented by staff. Review the record for the active treatment, review clinical records at home and the day sites to make sure everything is in the record, signed and dated." After reviewing Individual # 1's behavior treatment program OSM # 1 acknowledged that it was not current.

The facility's policy 'Direct Support Professional/QIDP" documented in part, "Maintains all required documentation in logs and records, including monthly and quarterly reports."

On 08/27/19 at approximately 2:00 p.m., ASM [Administrative staff member] # 1, home manager was made aware of the above findings

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No further information was provided prior to exit.

References:

(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100

(2) Self-harm refers to a person's harming their own body on purpose. This information was obtained from the website: https://medlineplus.gov/selfharm.html.

(3) A neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html.

(4) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

2. The facility staff failed to ensure a medication administration, release form, located in the [Name of Day Program] clinical record, for Individual # 2 was completed.

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W 159	Continued From page 18 Individual # 2 was a 67 year old male, who was admitted to (Name of Group Home) on 12/16/02. Diagnoses in the clinical record included but were not limited to: moderate intellectual disability (1), obsessive compulsive disorder (2), autistic disorder (3), and tardive dyskinesia (4). On 08/27/19 at approximately 11:00 a.m., a review of Individual # 2's clinical record at [Name of Day Program] was conducted. Review of the record revealed a "Medication Administration Release" form signed on 08/22/18. The form had three small square boxes on the left hand side of the form for check marks. Next to the first box it documented, "I authorize staff to assist me with both prescription and non-prescription medications which have been approved by a physician in charge of my medical care." Next to the second box it documented, "I acknowledge that any medication I take at [Name of Day Program] must be in the original container with a legible pharmacy label. Medication cannot be given otherwise. I must also provide a written physician's order to have the Nurse on site be able to administer both prescription and non-prescription medications." Next to the third box it documented, "I authorize staff to make available to me over-the-counter medications on an as-needed (PRN) basis for minor medical aliments (e.g., headaches, menstrual cramps) only if I have a current PRN Medication Release on file. If staff have any suspicion that my condition may require a physician's attention, then this would be communicated to me, and my parent, guardian or counsellor." Further review of the form failed to evidence a check mark in any of the three boxes.	W 159		

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On 08/27/19 at approximately 11:15 a.m., an interview was conducted with OSM [other staff member] # 4, senior program support specialist at [Name of day Program]. After reviewing Individual # 2's "Medication Administration Release" form OSM # 4 was asked if the form was complete and if she could tell what was being authorized. OSM # 4 stated that the form was incomplete, one of the boxes should had been checked and that you could not determine what was authorized.

On 08/27/19 at approximately 1:45 p.m., an interview was conducted with OSM [other staff member] # 1, QIDP. When asked to describe the responsibilities of the QIDP, OSM # 1 stated, "Participate in developing the ISP [individual service plan], make sur their [Individual's] goals and choices are respected. Make sure individuals eat nutritious meals, make sure they have their medications on time as prescribed by the physician, implement the active treatment [programs], ensure the active treatment, is being implemented by staff. Review the record for the active treatment, review clinical records at home and the day sites to make sure everything is in the record, signed and dated." After reviewing Individual # 2's medication administration release form OSM # 1 stated, "I have only been here for six months, I stated on February 13, 2019. When asked to describe the procedure he follows for reviewing the clinical records at the day programs OSM # 1 stated, "[Name of ASM # 1, home manager] has only been here for three months and for the three months before he got here I was running the home and had the role as QIDP. The previous manager was only here for two days and she didn't instruct me about reviewing the records at the day program." When asked if he received

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W 159	Continued From page 20 a copy of the job description for QIDP, stated, "Yes." The facility's policy 'Direct Support Professional/QIDP" documented in part, "Maintains all required documentation in logs and records, including monthly and quarterly reports." On 08/27/19 at approximately 2:00 p.m., ASM [Administrative staff member] # 1, home manager was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/obsessive-c ompulsive-disorder-ocd/index.shtml. (3) A neurological and developmental disorder that begins early in childhood and lasts	W 159		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 21 throughout a person's life. It affects how a person acts and interacts with others, communicates, and learns. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/autismspectrumdisorder.html. (4) Characterized by repetitive, involuntary, purposeless movements. Features of the disorder may include grimacing, tongue protrusion, lip smacking, puckering and pursing, and rapid eye blinking. Rapid movements of the arms, legs, and trunk may also occur. Involuntary movements of the fingers may be present. This information was obtained from the website: http://www.ninds.nih.gov/disorders/tardive/tardive.htm.	W 159		
W 444	EVACUATION DRILLS CFR(s): 483.470(i)(1)(iii) The facility must hold evacuation drills to evaluate the effectiveness of emergency and disaster plans and procedures. This STANDARD is not met as evidenced by: Based on facility document review and staff interview, it was determined that the facility failed to conduct fire drills for each shift quarterly. The finding include: Review of the facility's "Monthly Fire and Evacuation Drill and Fire Inspection Report" forms dated 07/2018 through 08/2019 failed to evidence that fire drills were conducted on the 11:00 p.m. to 7:00 a.m. shift between October 2018 and December 2018. On the 7:00 a.m. to	W 444	W 444 1. The Home Manager will work with the QIDP to create a schedule by October 11, 2019 that insures that a fire drill is conducted each month that allows for each shift to participate in a drill at least quarterly. 2. The schedule revisions will take place for all of the individuals in the facility. Therefore no other individuals will be affected by this deficiency. Each drill will be reviewed by the Home Manager and Project Director to ensure adherence to the rotation of shifts as well as other requirements. 3. The Monthly Fire and Evacuation Drill and Fire Inspection Report will be updated with the "each shift quarterly" policy to ensure the deficiencies do not recur. 4. A monthly review will be conducted by the QDIP and signed off by the Home Manager ensuring the policy is sustained. Adherence will be monitored through bi-annual Quality Assurance Reviews.	10/11/19

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

PRINTED: 09/04/201
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONRAD ICF	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 444	Continued From page 22 3:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift, between the months of February 2019 through July 2019. Further review of the forms revealed that fire drills dated February 2019 through July 2019 were all conducted on the 3:00 p.m. to 11:00 p.m. shift. On 08/26/19 at approximately 1:20 p.m., an interview was conducted with ASM (administrative staff member) # 1, home manager. When informed of the missing fire drills on the dates above, ASM # 1 reviewed the fire drill forms and acknowledged that the fire drills were not conducted quarterly for each shift. The facility's policy "Fire and Evacuation" it documented, "2d. Each fire drill should be conducted on a different shift so that, by the end of each quarter, each shift will have completed a fire drill." On 08/27/19 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the home manager was made aware of the findings. No further information was provided.	W 444		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that the facility staff failed to implement infection control	W 455	W 455 1. The Home Manager will work with the PD, Compliance Manager and Executive Director to develop food safety training reviews and put laminated graphics in the menu binder by October 11, 2019. 2. Training on food safety and infection control practices will be implemented for all staff. Any challenges adhering to these practices will be addressed immediately by the home manager, Training and Compliance Manager or Project Director, as appropriate. Therefore, no other individuals will	

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be affected by this deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G022	A. BUILDING ______ B. WING ______	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONRAD ICF	4123 CONRAD STREET ALEXANDRIA, VA 22312

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W 455	Continued From page 23 practices when preparing dinner for the individuals resident at [Name of Group Home]. The facility staff failed to change their gloves before handling and buttering the Individual's slices of bread and touching the inside of the vegetable bowls. The findings include: On 08/26/19 at approximately 5:10 p.m., an observation of ASM [administrative staff member] # 1, home manager and OSM [other staff member] # 1, QIDP [Qualified Intellectual Disabilities Professional] participating in the 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	W 455	3. Food Safety and infection control will be maintained by observation and regular feedback as well as on-going support through monthly supervision. Random unannounced reviews will be conducted by the Training and Compliance Manager and signed off by the Home Manager monthly ensuring the policy is sustained. Deficiencies will be addressed in supervision, through additional training and performance evaluations. 4. Meals will be monitored as a part of the bi-annual Quality Assurance review and documented for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______	(X3) DATE SURVEY COMPLETED

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	49G022	B. WING ________	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONRAD ICF	4123 CONRAD STREET ALEXANDRIA, VA 22312

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W 455	Continued From page 24 still wearing the same gloves, OSM # 1 then placed each bowl on the kitchen island one by one, and was observed placing his gloved thumb on the food surface of each bowl. OSM #1 then placed a scoop of cooked green peas into each bowl. At approximately 5:20 p.m. the individuals residing In the group home, picked up their bowls of peas, plates of bread and plates with their entrees, took them to the dining room table and ate heir dinner. On 08/27/19 at approximately 1:21 p.m., an interview was conducted with ASM # 1 and OSM # 1 regarding the use of gloves and handling of individual's food. When asked to describe the purpose for wearing gloves during meal preparation, ASM #1 stated, "To keep our germs from our hands off the food, for sanitation." When ASM #1 was informed of the above observation, ASM #1 stated, "I should have gotten everything out and then put the gloves on to prepare the food" and OSM # 1 stated, "I should have changed my gloves." No further information was provided.	W 455		

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