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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9U5B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: VAICFMR04

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **49G022**
2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CONRAD ICF**
(L4) **4123 CONRAD STREET**
(L5) **ALEXANDRIA, VA** (L6) **22312**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 11/17/21

6. DATE OF SURVEY ~~11/04/2021~~ (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 11 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds **4** (L18)
13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date: 1/27/22
Wiebke Edwards for Karen Edwards (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 1/27/22
Wiebke Edwards (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **04/20/1989** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30) **00**
VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS
Health: 11/3 - 11/4/21
Life: 11/17/21

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

Form Approved
OMB No. 0938-0062

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES
SURVEY REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code
Conrad ICF	4123 Conrad Rd	Alexandria/Ffx	VA	223

6. Medicaid Provider No.	7. Name of CEO	8. Telephone No
49-6022	Susan Keenan	703 3520388 x 271 W1

9. State/Region code	10. State/County code	11. Dates of Survey (Begin)	(End)
VA W2	011 W3	11/3/21 Month / Day / Year W4	11/4/21 Month / Day / Year W5

12. Type of Ownership or Control (enter number in box below
- [x] 1. Private (non-profit)
- [ ] 2. Private (proprietary)
- [ ] 3. State
- [ ] 4. City/Town
- [ ] 5. County
- [ ] 6. City/County
- [ ] 7. Other (specify)_____ W6

13. Is this ICF/IID a distinct part of a Hospital, SNF or NF?
- [ ] Yes
- [x] No W7

14. If "Yes" to block 13, indicate either
- A. Hospital Provider No. .....
- B. SNF Provider No. .....
- C. NF Provider No. W8

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in column 1 represented on the Survey team, indicate the number who also qualify as a QIDP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse		1
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify)		
N. Total number of Surveyors onsite	W13	1
O. Total number of QIDP Surveyors onsite	W12	

17. Staffing: List the full time equivalents who function in this capacity:
- A. Direct Care Personnel W23 (483.430(d)(3)) 8.71
- B. Registered Nurse W24 (483.480(d)(3)) ..... .16
- C. Licensed Voc./Practical Nurse W25 (483.480(d)(2)) 0.00
- D. Total Personnel W26 ..... 13.00

(List the Full Time Equivalent for all employees)

16. Facility Data

A. Is this ICF/IID a residential unit within a larger organization or agency in the State that provides residential services to individuals with intellectual disabilities? (check one) [x] Yes [ ] No
If "No", proceed to item C. W13

B. If "Yes," indicate name and address of larger organization.

Name Community Living Alternatives

Address 9401 Lee Hwy Ste 406

City Fairfax | State VA | ZIP Code 22031

Name of CEO Susan KEENAN

- Total Number of Beds W14: 39
- Total Number of Clients W15: 38
  (including ICF/IID clients directly served)
- C. Total Number of ICF/IID Clients W16: 3
- D. Is this ICF/IID community-based? *(check one)* ..... W17: [x] Yes [ ] No
- E. Total number of ICF/IID beds under this Provider No W18: 004
- F. Total number of discrete living units under this Provider No.. W19: 1
- G. Age range of clients served.....from W20: 36 to W21: 64
- H. Total number of off-campus day program sites used by ICF/IID clients W22: 0

18. Off-Campus Day Programs:
- A. How many clients in the sample attend off-campus day programs? W27: 0
- B. In how many off-campus day program sites was an observation done by the Surveyor? W28: 0

FORM CMS-3070G (03/13)

Sheena 11/4/21 EXECUTIVE DIRECTOR

20. Individual Characteristics (Note: The total number in Items B-L (Col.(a)) may exceed the facility's population because some clients have multiple disabilities)

A.		
(1) Age		
under 22(a)	W29	
22-45 (b)	W30	2
46-65 (c)	W31	1
66+ (d)	W32	
[redacted] Total	W33	3
(2) SEX		
Male	W34	3
Female	W35	0
[redacted] Total	W36	3

B. DISABILITIES		
(1) Intellectual Disability		
Mild	W37	
Moderate	W38	1
Severe	W39	2
Profound	W40	
[redacted] Total	W41	3
(2) Autism	W42	2
(3) Cerebral Palsy	W43	
(4) Epilepsy		2
Controlled	W44	2
Uncontrolled	W45	
[redacted] Total	W46	4

C. OTHER DISABILITIES		
(1) Non-ambulatory		
Mobile	W47	3
Non-Mobile	W48	
[redacted] Total	W49	3
(2) Speech/Language Impairment	W50	2
(3) Hearing Impairment		
Hard of Hearing	W51	
Deaf	W52	
[redacted] Total	W53	2
(4) Visual Impairment		
Impaired	W54	1
Blind	W55	
[redacted] Total	W56	1
D. MEDICAL CARE PLAN	W57	3
E. DRUGS TO CONTROL BEHAVIOR	W58	2
F. PHYSICAL RESTRAINTS	W59	0
G. TIME-OUT ROOMS	W60	0
H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI	W61	
I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS	W62	0
J. NUMBER OF COURT ORDERED ADMISSIONS	W63	0
K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT	W64	3
L. OTHER (specify)		
(1)	W65	
(2)	W66	
(3)	W67	

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES SURVEY REPORT

M. ALLEGATIONS OF ABUSE AND NEGLECT	Ø	
no. of allegations of abuse investigated (a)	Ø	W68
no. of allegations of neglect investigated (b)	Ø	W69
[redacted] Total		W70
N. NUMBER OF DEATHS	Ø	
no. of deaths related to unusual incidents (a)	Ø	W71
no. of deaths related to restraints (b)	Ø	W72
no. of deaths for any reason (c)	Ø	W73
[redacted] Total	Ø	W74

ALLEGATIONS OF ABUSE AND NEGLECT AND NUMBER OF DEATHS DATA ENTRY INSTRUCTIONS

M. Allegation of abuse and neglect

(W68) Number of allegations of abuse investigated.
(W69) Number of allegation of neglect investigated.

According to 42CFR §488.301:

Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Consistent with the referenced definitions, enter the number of allegations of abuse and or neglect investigated, including investigations resulting from complaints, follow ups, initials or recertifications.

If there is no information to report, leave the field blank.

(W70) Total
This field represents a combined total of W68 (allegations of abuse investigated) and W69 (allegations of neglect investigated). The total for this field is program generated therefore, no data input is necessary.

N. Number of Deaths

(W71) Number of deaths related to unusual incidents.
Insert the number of deaths that occurred as a result of unusual incidents. This includes all unexpected or unanticipated deaths not included in W72 or W73.

(W72) Number of death related to restraints.
Insert the number of deaths that occurred as a result of the use of restraints.

(W73) Number of deaths for any reason.
Insert the number of deaths occurring for any reason. Do not include information contained is W71 and W72 above.

(W74) Total
This field represents a combined total of W71 (number of deaths related to unusual incidents), W72 (number of deaths related to restraints), and W73 (number of deaths for any reason).
The total for this field is program generated; therefore, no data input is necessary.

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

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 _____	11/04/2021

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 000	INITIAL COMMENTS An unannounced annual Medicaid survey for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) was conducted 11/3/21 through 11/4/21. Corrections are required for compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. The Life Safety Code survey report will follow. 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 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 who- This STANDARD is not met as evidenced by: Based on residential program record review, medical record review, facility document review and staff interview, it was determined that the QIDP [Qualified Intellectual Disabilities Professional] failed to integrate the PCP (person-centered plan) and to monitor implementation of the nursing plan of care for one of two individuals in the survey sample, Individual #2. The QIDP failed to integrate Individual #2's nursing care plan into the PCP and failed to monitor implementation of the nursing plan for the individual's indwelling urinary catheter. The findings include:	W 159	W159 1. This deficiency will be corrected by an addendum being made to the plan that incorporates the nursing plan and can therefore be monitored as a part of the ISP/PCP the new plan will be entered into Therap so progress can be tracked. 2. The Home Manager and QIDP will develop and provide the final review of all ISP/PCP goals in the future to ensure that the nursing plan is incorporated into the ISP/PCP in the future, if needed thereby ensuring this deficiency does not reoccur. 3. Compliance with this plan will be maintained by the House Manager. A QIDP will be providing a final review of the ISP/PCP prior to the ISP/PCP being sent out and signed by all parties. 4. Compliance with this regulation will be monitored on a weekly, monthly, quarterly, and annual basis. Progress on the nursing	By 12/15/2021

Gena Bunney Project Director 11/19/2021

			plan that is incorporated into the ISP/PCP will be monitored on a weekly basis by the Home Manager as a part of their program oversight and by the Nurse as a part of their contract with the ICF. Each month, the Training and Compliance Manager and Project Director will monitor progress as a part of their monthly review of billing sheets. Each quarter, a Quarterly report will be developed which monitors progress on all goals, including the nursing plan. Additionally, the Nurse will submit a quarterly regarding progress on the nursing plan. Finally, annual progress will by reviewed by the entire team at the annual meeting. 5. Date. By December 15, 2021.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gena Bunney | TITLE: Project Director | (X6) DATE: 11/19/2021

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.

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 _____	11/04/2021

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W 159	Continued From page 1 Individual #2 was admitted to the group home with diagnoses including moderate intellectual disability, autism, and an enlarged prostate. A review of Individual #2's medical record revealed the following physician's order most recently signed 8/30/21: "18 Fr (French) indwelling Foley Catheter changed out every month." A review of Individual #2's Annual Nurses Care Plan dated 8/30/21 revealed, in part: "Monitor kidney and bladder health. Uses an 18 Fr Indwelling Foley Catheter, changed out patient (sic) every month, drain bag and record volume through day, monitor for blood in urine or if pain, discomfort is noted. Keep [primary care physician] advised of changes in urological status." A review of Individual #2's PCP dated 9/1/21 through 8/31/22 failed to reveal any information related to the use of an indwelling catheter. Further review of the data collection documents for Individual #2's PCP for September and October 2021 failed to reveal evidence that the urine output had been recorded each day. On 11/4/21 at 12:13 p.m., OSM (other staff member) #1, the QIDP, was interviewed. When asked about Individual #2's use of an indwelling urinary catheter, OSM #1 stated the individual empties his bag independently. She stated he does not allow staff members to accompany him into the bathroom, so the staff is unable to determine the volume of urine output each day. On 11/4/21 at 12:16 p.m., ASM (administrative staff member) #1, the project director, joined the	W 159		

Gena Bunny Project Dir.
11/19/2021

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 _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 159	Continued From page 2 interview. ASM #1 stated the facility used to record the urine output volume for Individual #2. However, he is now independent with the use of the catheter, and he "knows how to do it." She confirmed the staff is not recording the urinary output volume. When asked how the nursing care plan is integrated into an individual's PCP, ASM #1 stated, "Everyone is invited to the annual meeting - DSPs (direct support personnel), too." She stated the Q (QIDP) trains the staff after the individual's plan is formulated. She stated the training should include the nursing care plan. ASM #1 also stated, "Each discipline has their own outcomes. Nursing. Social Work. Dietary." ASM #1 stated, "We have lots of different outcomes for each individual." When asked if the Q is ultimately responsible for integration and implementation of each individual's whole PCP, ASM #1 stated, "Yes." On 11/4/21 at 12:31 p.m., OSM #1 was interviewed. When asked about the training she provides to all staff regarding each individual 's plans for care, OSM #1 stated, "I guess I haven't done the training on this plan yet." When asked why she had not yet done the training, she stated she was not sure. When asked if she ordinarily integrates a nursing plan into an individual's PCP, OSM #1 stated she was not sure. When asked who is responsible for integrating nurse care plans and outcomes into an individual's PCP, and for monitoring implementation of the entire plan, OSM #1 stated, "The house manager. And all of us." On 11/4/21 at 12:50 p.m., ASM #1, ASM #2, the compliance and training director, and OSM #2, the house manager were informed of these concerns. Policies regarding the role of the Q	W 159		

Gena Bunney Project Director 11/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 159	Continued From page 3 were requested. A review of the document, "QIDP Job Description" revealed, in part: "Implements or ensures the implementation of the particular requirements of the ISP [Individual Service Plan] on a daily basis. In the ICF [intermediate care facility], ensures compliance with all pertinent federal regulations applicable to community ICFs. Applies quality improvement principles, tools and techniques; assists in data collection; identifies processes for improvement in daily work; educate new staff in a new process. Ensures required plan documentation, reports, and other...records are maintained." No further information was provided prior to exit.	W 159		
W 321	PHYSICIAN SERVICES CFR(s): 483.460(a)(2) The medical care plan of treatment must be integrated in the individual program plan. This STANDARD is not met as evidenced by: Based on residential program record review, medical record review, facility document review and staff interview, it was determined that the residential home staff failed to implement the nursing plan of care for one of two individuals in the survey sample, Individual #2. For Individual #2, the staff failed to follow the nursing care plan to record the daily urine output volume from the individual's indwelling urinary catheter. The findings include: Individual #2 was admitted to the group home with diagnoses including moderate intellectual disability, autism, and an enlarged prostate.	W 321	W321 1. Corrective action: The Nurse will revise her plan to meet the recommendation of the Urologist. The staff will closely monitor and document. 2. Provision of deficiency: A protocol will be developed and conducted by the manager and or the QIDP after each plan has been revised or newly written. In the process, the recommendations from the Urologist will be followed. The staff will be trained, and each	By 12/15/2021

Gena Burney Project Director
11/19/2021

will sign a training acknowledge form that they have been trained and understood the revised plan with Doctor's directives.

3. Measures to be taken. The staff will follow the protocols and the manager will conduct weekly checks in the home to ensure that the protocols are adhered to. Training will be documented on new plans, & protocols and signed to document by all staff have been trained. Training will be conducted by a QIDP

4. Monitoring Compliance with this regulation will be monitored on a weekly, monthly, quarterly, and annual basis. Progress on the nursing plan that is incorporated into the ISP/PCP will be monitored on a weekly basis by the Home Manager as a part of their program oversight duties and by the Nurse as a part of their contract with the ICF. Each month, the Training and Compliance Manager and Project Director will monitor progress as a part of their monthly review of billing sheets. Each quarter, a Quarterly report will be developed which monitors progress on all goals, including the consultant plans. Additionally, all consultants will submit a quarterly report regarding progress on the consultant plans. Finally, annual progress will be reviewed by the entire team at the annual meeting or when the plan is revised as needed.

Gina Bunny Project Director
11/19/2021

			5. Date. **By December 15 2021.**	

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 _____	11/04/2021

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

Gene Bunney Project Direct 11/19/2021

(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 321	Continued From page 4 A review of Individual #2's medical record revealed the following physician's order most recently signed 8/30/21: "18 Fr (French) indwelling Foley Catheter changed out every month." A review of Individual #2's Annual Nurses Care Plan dated 8/30/21 revealed, in part: "Monitor kidney and bladder health. Uses an 18 Fr Indwelling Foley Catheter, changed outpatient (sic) every month, drain bag and record volume through day, monitor for blood in urine or if pain, discomfort is noted. Keep [primary care physician] advised of changes in urological status." A review of Individual #2's PCP dated 9/1/21 through 8/31/22 failed to reveal any information related to the use of an indwelling catheter. Further review of the data collection documents for Individual #2's PCP for September and October 2021 failed to reveal evidence that the urine output had been recorded each day. On 11/4/21 at 12:13 p.m., OSM (other staff member) #1, the QIDP, was interviewed. When asked about Individual #2's use of an indwelling urinary catheter, OSM #1 stated the individual empties his bag independently. She stated he does not allow staff members to accompany him into the bathroom, so the staff is unable to determine the volume of urine output each day. On 11/4/21 at 12:16 p.m., ASM (administrative staff member) #1, the project director, joined the interview. ASM #1 stated the facility used to record the urine output volume for Individual #2. However, he is now independent with the use of	W 321		

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 321	Continued From page 5 the catheter, and he "knows how to do it." She confirmed the staff is not recording the urinary output volume. On 11/4/21 at 12:42 p.m., RN (registered nurse) #1 was interviewed. When asked if she was aware that Individual #2's urinary output was not being measured each day, she stated she was not. RN #1 stated, "They should be. I thought they had been." She stated the urinary output has to be an "adequate" amount to prevent a urinary tract or kidney infection. She stated the individual's urine should be poured into a graduated cylinder and measured each time his indwelling catheter bag is empties. RN #1 stated, "We want to make sure his outcome is adequate to maintain [Individual #2's] urinary health." She Individual #2 has a history of a kidney infection, and the staff needs to make sure the urine is clear, has no odor, and has no blood. On 11/4/21 at 12:50 p.m., ASM #1, ASM #2, the compliance and training director, and OSM #2, the house manager was informed of these concerns. Policies regarding following a nursing care plan were requested. A review of the facility-provided policy, "Documentation and Records Management," revealed no information related to implementing and following a nursing care plan. No further information was provided prior to exit.	W 321		

Gena Burney Project Director 11/19/2

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120

9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

MEMORANDUM

November 22, 2021

TO: Kourtney Hales-Richards, Director
Division of Long Term Care

FROM: Joyce Walker, Life Safety Coordinator
Division of Life Safety Code

SUBJECT: Conrad in Alexandria, Virginia CMS #49G022, Event ID #9U5B21, Survey Date 11/17/2021, Highest Scope/Severity: N/A

The attached report forwarded to you with the following comments:

I. SURVEY [X]

[X] Recommend certification based on compliance with Life Safety Code.
[ ] Recommend certification based on acceptable POC.
[ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[ ] Recommend certification based on compliance with LSC by requested continuous waiver.
[ ] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[ ] Recommend certification based on satisfactory results from application of the FSES.
[ ] Do not recommend certification.

II. POST SURVEY [ ]

[ ] All deficiencies corrected:
[ ] Not all deficiencies corrected:
- [ ] Recommend certification based on acceptable POC
- [ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
- [ ] Recommend certification based on approved or requested continuous waiver.
- [ ] Recommend certification based on approved or requested Time Limited waiver.
- [ ] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at (804) 367-2129.

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

2012 LIFE SAFETY CODE
Form approved OMB Exempt

FIRE SAFETY SURVEY REPORT – 2012 LIFE SAFETY CODE
Intermediate Care Facilities for Individuals with Intellectual Disabilities
SMALL FACILITIES

1. (A) PROVIDER NO.	1. (A) MEDICAID I.D. NO.
49G022 K1	K2

PART I – Instructions for Completing the Form (CMS-2786V)
PART II – Existing Resident Board & Care Occupancies Requirements (NFPA 101, Chapter 33)
PART III – New Residential Board & Care Occupancies Requirements (NFPA 101, Chapter 32)
PART IV – Building Services (New and Existing Facilities)
PART V – Operating Features (New and Existing Facilities)
PART VI – Crucial Data Extract
Optional – Fire Safety Evaluation System for Board and Care Occupancies (CMS-2786Y, NFPA 101A, Chapter 7)

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACULTY (STREET, CITY, STATE, ZIP CODE)	
Conrad House	A. BUILDING 1 B. WING C. FLOOR K3	4123 Conrad Road Alexandria, Virginia. 22312	A. ☐ Fully Sprinklered (All required areas are sprinklered) B. ☐ Partially Sprinklered (Not all required areas are sprinklered) C. ☑ None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER:
☑ MEDICARE ☐ MEDICAID	11-17-21 K4	4-20-1989 K6	5. ☑ 2012 EXISITING 6. ☐ 2012 NEW K7

E-SCORE: .8 K5

USE FOR EXISTING FACILITIES ONLY	
E-Score	Level of Evacuation Difficulty
≤ 1.5	Prompt
> 1.5 ≤ 5.0	Slow
> 5.0	Impractical

5. SURVEY FOR CERTIFICATION OF: SMALL FACILITY - LEVEL OF EVACUATON DIFFICULTY (*Check one*)
USE FOR EXISTING FACILITIES ONLY
1. ☑ Prompt 2. ☐ Slow 3. ☐ Impractical
K8

6. BED COMPOSITION	e. NUMBER OF ICF/IID BEDS CERTIFIED FOR MEDICAID
a. TOTAL NO. OF BEDS IN THE FACILITY 3	3

6. A. ☑ THE FACILITY MEETS, BASED UPON *(check all appropriate boxes)*:
1. ☑ COMPLIANCE WITH ALL PROVISIONS 2. ☐ ACCEPTANCE OF A PLAN OF CORRECTION 4. ☐ FSES 5. ☐ PERFORMANCE BASED DESIGN

B. ☐ THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Signature)	TITLE	OFFICE	DATE
David W. Holland SURVEYOR ID K10 44279	Life Safety Inspector	Office of Licensure and Compliance	11-17-21
FIRE AUTHORITY OFFICIAL (Signature) Ron Reynolds	TITLE LSC Medical Facilities Inspector	OFFICE Office of Licensure and Certification	DATE 11-22-21

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

PART VI - FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS 2786 FORMS)

Provider Number	Facility Name	Survey Date
49G022	Conrad House	11-17-21
K1		*K4

K6 DATE OF PLAN APPROVAL

4-20-1989

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING _____

[A]
A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 [14] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 [1]
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 [ ]
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 [ ]
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: [ ] K351: [ ]

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: [ ] e.g. 2.5

*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

A1. [X]	A2. [ ]	A3. [ ]	A4. [ ]	A5. [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A. [ ]	B. [ ]	C. [X]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G022	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**11/17/2021**

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
K 000	INITIAL COMMENTS The facility is a one-story structure with an attic of Type V(000) construction type. The facility does not have a fire sprinkler system. An unannounced recertification Life Safety Code survey was conducted on 11/17/2021 in accordance with 42 Code of federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Persons with Intellectual Disability (ICF/ID). The facility was surveyed for compliance using the 2012 Life Safety Code existing regulations. The Facility was n compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		

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.

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

11/19/2021

Genna Bunney
GBunney@CLA-Va.org

Ref: Conrad House
Provider Number 49G022

Dear Ms. Bunny,

This concerns the off-site recertification Life Safety Code survey of the referenced facility conducted on 11/17/2021 in accordance with 42 Code of Federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The facility was surveyed for compliance using the Life Safety Code 2012 Existing regulations. No deficiencies were found.

All institutional buildings must meet all applicable Life Safety Code (NFPA 101) requirements in accordance with 42 Code of Federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities certification requirements issued by the Centers for Medicare and Medicaid Services (CMS), in order to participate in the Medicare/Medicaid programs.

If you have any questions or if we may be of assistance to you, please contact me at david.holland@vdh.virginia.gov call (804) 638-0077.

Sincerely,

David W. Holland

David W. Holland
LSC Medical Facilities Inspector

Commonwealth of Virginia

Tillman, Bryanna <bryanna.tillman@vdh.virginia.gov>

Fwd: Conrad 49G022 EID #9U5B21 Request for RECERTIFICATION SURVEY

1 message

Walker, Joyce <joycea.walker@vdh.virginia.gov> Mon, Nov 22, 2021 at 8:52 PM
To: Bryanna Tillman <bryanna.tillman@vdh.virginia.gov>
Cc: Angela Conner <angela.conner@vdh.virginia.gov>, Walker Joyce gif68453 <joycea.walker@vdh.virginia.gov>

Attached are the LSC recertification survey reports to print for the supervisor. **Note: Close certification kit after health data entry is complete.**

If you have any questions, please let me know.

Thanks!☺

Joyce A. Walker, Aspen Coordinator
Office of Licensure & Certification
Virginia Department of Health
9960 Mayland Drive - Suite 401
Henrico, Virginia 23233-1463
Telephone: (804) 367-2129
Work Cell: (804) 662-0079
Fax: (804) 527-4502
Email: joycea.walker@vdh.virginia.gov

---------- Forwarded message ---------
From: **Reynolds, Ronald** <ron.reynolds@vdh.virginia.gov>
Date: Mon, Nov 22, 2021 at 10:21 AM
Subject: Fwd: Conrad House
To: Joyce Walker <joycea.walker@vdh.virginia.gov>
Cc: David Holland <david.holland@vdh.virginia.gov>

Hi Joyce,

Attached is the paperwork for Conrad House, no deficiencies.

Thanks,

Ron

Type of Facility: ICF/IID
Facility Name: Conrad
Location (city): Alexandria
Provider#: 49G022
Event ID#: 9U5B21
Supervisor: Wietske Weigel Delano

LSC inspector to complete:

Highest Scope/Severity: N/A

Date of Survey: 11/17/21
Total Hours: 8

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Ron Reynolds, MPH, MPA
Life Safety Code, Medical Facilities Inspector
Ron.reynolds@vdh.virginia.gov
Mobile: 804-718-8038
Office: 804-367-2133

Office of Licensure & Certification
Virginia Department of Health
9960 Mayland Drive - Suite 401
Henrico, Virginia 23233-1463
Telephone: (804) 367-2102
Fax: (804) 527-4502

5 attachments

- **670 Conrad House11-17-21.pdf**
  86K
- **2567 Conrad House 11-17-21 no deficiencies.pdf**
  47K
- **Booklet Ron and David signed Conrad House 11-17-21.pdf**
  1947K
- **Cover Letter Conrad House 11-17-21.pdf**
  691K
- **11-22-2021 MEMO 49G022.pdf**
  31K