PRINTED: 03/20/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		49G022	B. WNG			10/2023
CONRAD	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4123 CONRAD STREET ALEXANDRIA, VA 22312	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
E 000	survey was conducted through 03/10/2023. compliance with 42 Condition of Participal Facilities for Individue		E 00			
E 039	Disabilities. No emer complaints were invested to test the emergence must do all of the following th	gency preparedness estigated during the survey lents (2) (13(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), 1.102(d)(2), §485.68(d)(2), 6.625(d)(2), §485.727(d)(2), 1.12(d)(2), §494.62(d)(2). (54, CORFs at §485.68, REHs Organizations" under t §485.920, RHCs/FQHCs at Facilities at §494.62]: (1ity] must conduct exercises by plan annually. The [facility] dowing:	E 03	E 039: Emergency Preparedn Requirements: #1: The Compliance and Trainiconduct full scale exercise for a staff. An After-Action Report withe Compliance and Training M the completion of the drill. #2: All Individuals would be at evacuate their home. #3: The Compliance/Training M scale exercise and the After Actionsure compliance with the timensure any areas identified for incorporated into the polices an healthcare operations. The Committen will maintain copies of all of Action Reports, including any cafterwards. #4: The Project Director and the Committee will review the After will monitor the dates to ensure attempt will be completed every accordance with regulations.	ing Manger will Ill Individuals and Ill be completed by anger directly after risk if they had to Igr. will track all full- tion Reports to the frames, and to improvement are d procedures and inpliance/Training trills and After- hanges made a Quality Assurance Action Report and a full evacuation or	
	accessible, conduct exercise every 2 yea (B) If the [facility natural or man-made activation of the eme exempt from engagin community-based or	a facility-based functional irs; or] experiences an actual e emergency that requires ergency plan, the [facility] is		#5: AOC: April 24, 2023		

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	COMPLETED
		49G022	B. WNG		03/10/2023
NAME OF PE	ROVIDER OR SUPPLIER		41	REET ADDRESS, CITY, STATE, ZIP CODE 123 CONRAD STREET LEXANDRIA, VA 22312	ir
(X4) ID PREFIX TAG	(EACH DEFICIENT	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
E 039	actual event. (ii) Conduct an addityears, opposite the functional exercise this section is condunot limited to the fol (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercises, and a set directed messages, designed to challen (iii) Analyze the [facility's] emergence at (2) Testing for hospatient's home. The exercises to test the annually. The hospicity is participate in a community based (A) When a community based (B) If the hospice eman-made emergency plaengaging in its nex community-based (Community-based)	tional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is flowing: ale exercise that is ir individual, facility-based or drill; or cise or workshop that is led by udes a group discussion using y-relevant emergency of problem statements, or prepared questions age an emergency plan. cility's] response to and ation of all drills, tabletop argency events, and revise the cy plan, as needed. 18.113(d):) pices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not at an individual facility based every 2 years; or experiences a natural or ency that requires activation of in, the hospital is exempt from at required full scale exercise or individual iconal exercise following the	E 039		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION -		COMPLETED	
		49G022	B. WING			03/10/2023	
NAME OF PE	F PROVIDER OR SUPPLIER AD ICF		412	ET ADDRESS, CITY, STATE, ZIP CODE CONRAD STREET XANDRIA, 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 O (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETION	
E 039	opposite the year the exercise under paragis conducted, that may to the following: (A) A second full-scarcommunity-based or exercise; or (B) A mock disaster (C) A tabletop exercing a facilitator and incluing a narrated, clinically-scenario, and a set of directed messages, designed to challeng (3) Testing for hospic care directly. The hospic endirectly. The hospic endirectly in an analysis community-based	ional exercise every 2 years, in full-scale or functional graph (d)(2)(i) of this section and include, but is not limited alle exercise that is a facility based functional drill; or ise or workshop that is led by des a group discussion using prelevant emergency of problem statements, or prepared questions an emergency plan. Ces that provide inpatient ospice must conduct emergency plan twice per nust do the following: annual full-scale exercise that	E 039				
	man-made emergen the emergency plan engaging in its next based or facility-base following the onset (ii) Conduct an addi may include, but is r (A) A second full-so community-based or exercise; or (B) A mock disaster	periences a natural or periences a natural or periences a natural or periences activation of the hospice is exempt from required full-scale community ed functional exercise of the emergency event. It ional annual exercise that not limited to the following: cale exercise that is ra facility based functional					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING	E CONSTRUCTION	COMPLETED
		49G022	B. WNG		03/10/2023
NAME OF PR	ROVIDER OR SUPPLIER	15		STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
E 039	narrated, clinically-rand a set of probler messages, or prepachallenge an emergiii) Analyze the homaintain document exercises, and emergeness	des a group discussion using a relevant emergency scenario, in statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	E 039		
	§482.15(d), CAHs at (2) Testing. The [P] conduct exercises twice per year. The do the following: (i) Participate in an is community-base (A) When a community-based function (B) If the [PRTF, H] actual natural or m	RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must an annual full-scale exercise that ed; or unity-based exercise is not ect an annual individual, tional exercise; or lospital, CAH] experiences an ean-made emergency that			88
	requires activation [facility] is exempt required full-scale facility-based funct onset of the emerg (ii) Conduct a and that may inclu following: (A) A second full- community-based functional exercise (B) A mo (C) A tabletop	of the emergency plan, the from engaging in its next community based or individual, tional exercise following the gency event. In [additional] annual exercise or ide, but is not limited to the scale exercise that is or individual, a facility-based			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE:	
		49G022	B. WING		03/	10/2023
NAME OF PI	ROVIDER OR SUPPLIER		4	STREET 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	emergency scenario, statements, directed questions designed to plan. (iii) Analyze the maintain documental exercises, and emerg [facility's] emergency *[For PACE at §460.8 (2) Testing. The PAC exercises to test the annually. The PACE following: (i) Participate in an a is community-based; (A) When a community accessible, conduct as	arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and ion of all drills, tabletop gency events and revise the plan, as needed. A4(d):] E organization must conduct emergency plan at least organization must do the nnual full-scale exercise that or ty-based exercise is not an annual individual,	E 039			
	man-made emergency the emergency plan, engaging in its next rebased or individual, fexercise following the event. (ii) Conduct an a years opposite the years opposite the years conducted that mate to the following: (A) A second full-sca community-based or functional exercise; (B) A mock disaster (C) A tabletop exercise.	riences an actual natural or cy that requires activation of the PACE is exempt from equired full-scale community acility-based functional conset of the emergency dditional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section y include, but is not limited ale exercise that is individual, a facility based or				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		79 34	(X3) DATE SURVEY COMPLETED	
4		49G022					10/2023
NAME OF PE	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CIT 123 CONRAD STREE LEXANDRIA, VA	ET .		333
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTI PRRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
E 039	using a narrated, scenario, and a sidirected message designed to chall (iii) Analyze the maintain docume exercises, and et PACE's emerger *[For LTC Faciliti (2) The [LTC factest the emerger including unannum emergency procedured in the community-based (i) Participate in is community-based full (B) If the [LTC factual natural or requires activative LTC facility is expendividual, facility following the on (ii) Conduct an may include, but (A) A second full community-based functional exercity (B) A mock discipled a facilitator including and a set of processing designed and a set of processi	clinically-relevant emergency set of problem statements, es, or prepared questions lenge an emergency plan. PACE's response to and entation of all drills, tabletop mergency events and revise the ncy plan, as needed. les at §483.73(d):] lility] must conduct exercises to ncy plan at least twice per year, punced staff drills using the ledures. The [LTC facility, the following: an annual full-scale exercise that listed; or munity-based exercise is not fuct an annual individual, inctional exercise. acility] facility experiences an man-made emergency plan, the tempt from engaging its next cale community-based or ly-based functional exercise set of the emergency event. additional annual exercise that t is not limited to the following: ull-scale exercise that is ed or an individual, facility based lise; or	E 039				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	NSTRUCTION	COMPLETED
		49G022	B. WING		03/10/2023
NAME OF P	ROVIDER OR SUPPLIER		4123	ET ADDRESS, CITY, STATE, ZIP CODE CONRAD STREET XANDRIA, VA 22312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
E 039	challenge an emergi (iii) Analyze the [LT and maintain docume exercises, and emerging the following procession of the following and a sedirected messages designed to challer (iii) Analyze the IC and many include the second of the following an arrated, of the following and a sedirected messages designed to challer (iii) Analyze the IC maintain documen exercises, and emergency and a sedirected messages designed to challer (iii) Analyze the IC maintain documen exercises, and emergency and emergency exercises, and emergency exercises and emergency exercises, and emergency exercises and exercises and emergency exercises and emergency exercises a	ency plan. "C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the semergency plan, as needed. 83.475(d)]: F/IID must conduct exercises cy plan at least twice per nust do the following: annual full-scale exercise that d; or nity-based exercise is not than annual individual, conal exercise; or. Iperiences an actual natural or not that requires activation of the ICF/IID is exempt from the ICF/IID is exe	E 039		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	COMPI	
		49G022	B. WNG _		03/	10/2023
NAME OF PE	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CO 4123 CONRAD STREET ALEXANDRIA, VA 22312	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE BE APPROPRIATE	(X5) COMPLETION DATE
E 039	Continued From pag	e 7	E 0	39		
	to test the emergence least annually. The least annually. The lip in a further community-based; (A) When a consaccessible, conduct facility-based function. (B) If the HHA or man-made emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an addition opposite the year the exercise under parais conducted, the limited to the follow (A) A second frommunity-based of functional exercise; (B) A mock dis (C) A tabletop.	at HA must conduct exercises by plan at HHA must do the following: Ill-scale exercise that is or an annual individual, anal exercise every 2 years; experiences an actual natural gency that requires activation an, the HHA is exempt from required full-scale or individual, facility based following the onset of the dional exercise every 2 years, are full-scale or functional agraph (d)(2)(i) of this section hat may include, but is not sing: all-scale exercise that is or an individual, facility-based or				
	emergency scenari statements, directe questions designed plan. (iii) Analyze the HH documentation of a	narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency IA's response to and maintain Il drills, tabletop exercises, and and revise the HHA's	od (**	Fa

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY	
		49G022	B. WING_		03/	10/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 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 CORR ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
E 039	Continued From pa	ge 8	E	039			
	to test the emergenthe following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenaristatements, directe questions designed plan. If the OPO exman-made emerge the emergency planengaging in its nex following the onset (ii) Analyze the OP documentation of a	oPO must conduct exercises acy plan. The OPO must do r-based, tabletop exercise or annually. A tabletop exercise is and includes a group a narrated, clinically relevant to, and a set of problem at messages, or prepared at to challenge an emergency experiences an actual natural or ency that requires activation of an, the OPO is exempt from the required testing exercise of the emergency event. O's response to and maintain all tabletop exercises, and and revise the [RNHCI's and					
	exercises to test th must do the followi (i) Conduct a pape least annually. A ta discussion led by a clinically-relevant e of problem stateme prepared questions emergency plan. (ii) Analyze the RN maintain documentand emergency evemergency plan, a This STANDARD	RNHCI must conduct e emergency plan. The RNHCI ng: r-based, tabletop exercise at abletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set ents, directed messages, or a designed to challenge an alHCI's response to and tation of all tabletop exercises, ents, and revise the RNHCI's	9				

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G022	B. WING		03/10/2023
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1123 CONRAD STREET ALEXANDRIA, VA 22312	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES HENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
E 039	failed to ensure preparedness place preparedness place. The findings included the facility staff faile attempt at full so full-scale exercise. On 03/08/2023 a facility's emerge reviewed with O training and comfacility's emerge evidence an attention of the factor of th	testing of the emergency an. ude: de to provide evidence of an ale exercise or evidence that a se was conducted. at approximately 2:40 p.m., the ncy preparedness plan was SM (other staff member) #1, apliance manager. Review of the ency preparedness plan failed to empt at full scale exercise or full-scale exercise was M#1 stated that they were not a that a full scale exercise was tempted during 2022. at approximately 3:00 p.m. ASM staff member) #1, project DSM (other staff member) #1, pliance manager, were made ove findings.	E 039		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G022	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION		SURVEY LETED
NAME OF PR	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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 000	Continued From pag	e 10	W 000		1	
	time of the survey. T	our bed facility was four at the The survey sample consisted lual reviews, Individuals #1				
W 125	PROTECTION OF C CFR(s): 483.420(a)(W 129	W 125: - Client Rights. #1: All staff will receive training on c specifically with respect to mealtime regard to Individual #1. In addition,	s, specifically in	
2	Therefore, the facility individual clients to e of the facility, and as States, including the the right to due proc This STANDARD is Based on observation document review, it facility staff failed to exercise their right of	not met as evidenced by: on, staff interview and facility was determined that the allow an individual to of dignity during a meal for ls in the survey sample,	**	mealtime dignity issues for all Indivireviewed by resident. #2: All Individuals in the home have be affected by non-compliance of the mealtimes. #3: All staff (home and day program mandatory refresher training on right the Individuals, by the Compliance/Manger. #4: The QIDP and/or the Program observe at least one mealtime a we observations of staff interactions. The Project Director will review the with the Quality Assurance Commit quarterly basis. #5:AOC: April 24, 2023	the potential to be dignity during by will receive hits and dignity of Training Manager will tek and record the QIDP and above results	
	the Individual as the	e facility staff stood next to y ate their lunch.				
	diagnoses that inclusevere intellectual d On 03/08/2023 at application in the second i	ded but were not limited to: isability (1). pproximately 12:20 p.m., pserved seated at the facility's ating lunch independently, revealed DSP (direct support nding next to Individual #1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		49G022	B. WING		03	10/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312	XII	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 125	interview was cone asked to describe or staying with an #1 stated they wo sit across from the to eat slowly, take don't choke and chowas dignified to staindividual while the When informed of #1 stated that they to Individual #1 who The facility policy part "Dignity. (Nar its programs in such the dignity of each will be respected a his/her need for second of the control of the co	approximately 4:00 p.m., an ducted with DSP #1. When the procedure when assisting Individual while they ate DSP ald sit next to the Individual or on to cue them during the meal small bites, make sure they new properly. When asked if it and next to or over an ey ate, DSP #1 stated no. It he above observation DSP is should have been sitting next aile they ate their lunch. Human Rights" documented in the of Corporation) will operate that a manner as to ensure that individual as a human being at all times, regardless of ervices."	W 12			
	References: (1) Refers to a groby a limited mental adaptive behaviors schedules and rountellectual disability and may result autism or cerebral causes, such as la	up of disorders characterized a capacity and difficulty with a such as managing money, tines, or social interactions. It originates before the age of from physical causes, such as palsy, or from nonphysical ack of stimulation and adult of the such as palsy.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		49G022	B. WING		03/1	0/2023
NAME OF PE	ROVIDER OR SUPPLIER		4123	ET ADDRESS, CITY, STATE, ZIP CODE CONRAD STREET XANDRIA, VA 22312	AS	6
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 125	from the website: https://www.report ctSheet.aspx?csic	i.nih.gov/NIHfactsheets/ViewFa	W 125			
W 159	Each client's activintegrated, coordinated intellecture. This STANDARD Based on staff intrecord reviews, a was determined to Intellectual Disab coordinate and morograms for one sample, Individual The findings inclusivity. The QIDP failed (individual services skills Individual # evidence quantity progress outcom community activities. 1a. The QIDP failed (individualized services services skills Individualized services specific skills Individualized services specific skills Individualized services specific skills Individualized services. Individual # 2 was activities.	re treatment program must be mated and monitored by a sald disability professional who- is not met as evidenced by: terview, day program program and facility document review, it hat the QIDP (Qualified lilties Professional) failed to conitor active treatment of two individuals in the survey als #2.	#1 (IS) (C) Direction de Incoco an state #2 Cc the ob co #3 tra da to fai ch #4 Di re er	Is and Comprehensive Functional FA) will be reviewed by the QIDP of rector or Compliance/Training Man velop quantifiable objectives for all cluding but not limited to: communimentity activities, safety and well alysis, data recording tools will be aff utilization, to match the ISP objective quarterly analysis. The QIDP/Project Director and/opmpliance/Training Manager will resorted the Association of the Compliance/Training Manager will be advised and/or participances to the ISPs. The Compliance/Training Manager will be advised and/or participances to the ISPs. The Compliance/Training Manager will be advised and/or participances to the ISPs. The Compliance/Training Manager will be advised and/or participances to the ISPs. The Compliance/Training Manager will be advised and/or participances to the ISPs. The Compliance/Training Manager will be advised and/or participance of the Compliance with the ICF/IID paximize outcomes for all Individual 5: AOC: April 24, 2023	Assessment or Project ager, to areas, ication, being. Task developed for actives for review 100% of equantitative ion tools will receive alysis, and be submitted by dates. All pate in the er, the Project committee will views to process and to areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		49G022	B. WING _	37	0	3/10/2023
NAME OF PROVIDER OR SUPPLIER CONRAD ICF			STREET ADDRESS, CITY, STATE, ZIP 4123 CONRAD STREET ALEXANDRIA, VA 22312	CODE		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES ENCY MUST 8E PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TTON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 159	dated 09/01/2022 documented, "Ou enhance his com Yes. Support Insencouraged to us communicate, (In through his prefeusing vocalization enhance his comeffective request will not be told "yhe is saying, (Inchis attempts. How "Outcome 3. (Incommunity and is Skill-building: Yes (Individual #2) woutings will inchifor recreation, les (Individual #2's) (Indiv	P for (Name of Day Program) 2 through 08/31/2023 atcome 1. (Individual #2) will amunication skills. Skill-building: atructions: (Individual #2) will be see his functional language to adividual #2) will communicate arred methods of communication ans, gestures, and pec symbols to amunication, (Individual #2's) as will be honored, (Individual #2) ares" unless it is understood what dividual #2) will be praised for all	W 1	59		
	with others, (Ind his attempts. He "Outcome 5. (In and safety. Skil	ividual #2) will be praised for all ow often? Weekly." dividual #2) will maintain health I-building: Yes. Support dividual #2) will be monitored at		2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING _	CONSTRUCTION		E SURVEY IPLETED
	49G022	B. WING		0:	3/10/2023
NAME OF PROVIDER OR SUPPLIER CONRAD ICF		4	TREET ADDRESS, CITY, STATE, ZIP COI 123 CONRAD STREET LEXANDRIA, VA 22312	DE	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
remain with his given remain with his given reeds a breat others, (Individual prevent falls, (Individual preferences will develop his interest opportunities, (Individual preferen	page 14 lual #2)will be encouraged to group and request a walk when k or wants to socialize with al #2) will use the elevator to dividual #2) will be reminded to with his head up to ensure his insitions, When exploring his fill be reminded to provide others ace as needed and actively entifying when it is safe to cross transportation/etc., (Individual and for all his attempts. How dividual #2) will engage in choosing to develop his lls. Skill-building: Yes. Support dividual #2) will engage in choice, (Individual #2) will have to increase his leisure, social, ities of daily living, and functional ividual #2) will be encouraged to ities from start to finish his be noted, (Individual #2) will rest in music and explore new individual #2) will be praised for all ow often? Daily." Tomes stated above failed to cific skills Individual #2 was led to evidence quantitative stermine progress. at approximately 2:10 p.m., an onducted with ASM staff member) #1, project director raining and compliance manager. Interview the staff member who	W 159			

EPARTMENT OF HEALTH A	ND HUMAN SERVICES				PRINTED: 03/20/20/ FORMAPPROVE DMB NO. 0938-039
ENTERS FOR MEDICARE &	QIDP, ASM #1 stated that they	T			
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98					
	8				1
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			17		
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0%					
			==		
		w			
					8
	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	IDENTIFICATION NUMBER:		VG		COMPLETED
	400000	B WING			03/10/2023
AME OF PROVIDER OR SUPPLIER	49G022	5	STREET ADDRESS, CITY, STATE,	ZIP CODE	00,10,2020
IAME OF PROVIDER OR SUPPLIER			4123 CONRAD STREET		
CONRAD ICF			ALEXANDRIA, VA 22312		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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 15	W 159		
	had been without a designated QIDP for			
	approximately nine months and that they had			
	hired someone to take the position as the QIDP			
	within the past couple of weeks. ASM #1 further			
	stated that the program manager, the nurse and			
	themselves were qualified as a QIDP and had			
	been filling in. When asked how often the QIDP			
	visits the day program ASM #1 sated that visits	2		
	were done quarterly and the last visit to Individual			
	#2's day program was approximately two months			
	ago. When asked who reviews the ISP from the			
	day program when it is developed ASM #1 stated			
	that the ISP is reviewed with the facility's QIDP			
	(Qualified Intellectual Disabilities Professional).			
	After reviewing Individual #2's outcomes #1, #3,			
	#5 and #6 as stated above ASM #1 and OSM #1			
	were asked to identify the specific skills Individual			
	#2 was learning and to evidence quantitative			
	measures to determine progress Individual #2's			
	progress. ASM #1 and OSM #1 stated that they			
	were unable to identify the specific skills Individual #2 was learning and the quantitative			
	measures to determine progress. ASM #1 further	3.04		
	stated that it was the responsibility of the QIDP to			
	ensure the outcomes were written in measurable			
	terms.			
	terms.			
	The facility's QIDP "Job Description" documented			
	in part, "Provides input for the development of the			
	annual Individual Service Plan (ISP) for each			
	individual supported, writing, typing or			
	proof-reading documents as needed, Assists			
	Home Manager in implementing or ensuring the			
	implementation of the particular requirements of			
	the ISP on a daily basis. In the ICF, ensures			
	compliance with all pertinent federal regulations			
	applicable to community ICFs"	0.0		
	03	10 m		
311	On 03/09/2023 at approximately 3:00 p.m. ASM			1.81

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	49G022	B. WING	03/10/2023

NAME OF PROVIDER OR SUPPLIER CONRAD ICF			. 4123 CONRAD STREET			DE	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE CO BE APPROPRIATE	(X5) MPLETION DATE		
144450	40	W 15					
W 159	Continued From page 16	AA 19	3				
	(administrative staff member) # 1, project			¥.			
	manager, and OSM (other staff member) #1,						
	trainer and compliance manager, were 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.	i .					
	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			187			
	responsiveness. This information was obtained						
	from the website:			82			
	https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100						
	CtSneet.aspx?csid=100	10.					
	1b. The QIDP failed to ensure data collection for			70			
	Individual #2's outcomes for communication,						
	community activities, safety and wellbeing and		52				
	activities.	1					
				#8			
	Review of the data collection dated 02/01/0223]					
	through 03/06/2023 failed to evidence quantitative						
	measures for determining Individual #2's	6	AS				
	progress outcomes of communication,	8					
	community activities, safety and wellbeing and						
	activities.						
	On 02/00/2022 at approximately 2:10 a.m. an						
	On 03/09/2023 at approximately 2:10 p.m., an interview was conducted with ASM			10			
	(administrative staff member) #1, project director			A 19	100		
	and OSM # 1, training and compliance manager.						
	After reviewing Individual #2's data collection for						
	the outcomes #1, #3, #5 and #6 as stated above						

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		49G022	B. WING	<u> </u>	03/1	10/2023
NAME OF PE	ROVIDER OR SUPPLIER		41	REET ADDRESS, CITY, STATE, ZIP CODE 123 CONRAD STREET LEXANDRIA, VA 22312		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 196	included quantitat percent accuracy stated that the dat quantitative meas On 03/09/2023 at (administrative stamanager, and OS trainer and complaware of the above No further informated ACTIVE TREATM CFR(s): 483.440(a). Each client must treatment prograr consistent impler specialized and g services and relaisubpart, that is di (i) The acquisition the client to funct determination and (ii) The prevention loss of current. This STANDARD Based on staff in review it was detailed to develop for the developm	I #1 were asked if the data ive measures, such as 'With 80 for two months.' OSM #1 ta collection did not include any ures. approximately 3:00 p.m. ASM aff member) # 1, project the staff member) # 1, project the staff member) # 1, iance manager, were made the findings. ation was provided prior to exit. MENT (a)(1) receive a continuous active (m), which includes aggressive, mentation of a program of the eneric training, treatment, health the services described in this rected toward: (m) of the behaviors necessary for ion with as much self the independence as possible; and on or deceleration of regression optimal functional status. It is not met as evidenced by: terview and clinical record termined that the facility staff an ISP (Individual Service Plan) ent of independent daily living the wo individuals in the survey all #2.		W 196: Active Treatment #1: The QIDP/Project Director or the Compliance/Training manager will I of the ISP for Individual #2, to includimited to: the inclusion of dining skindividual #2's independence with foreakfast, table set up and after breand filling dishwasher, based on the Individual #2. Individual #2's ISP with to include quantitative #2: All Individuals who reside in the risk for non-compliance. The QIDP or the Compliance/Training Manage ISPs for all other Individuals for sim #3: All home and day program staft training on revisions, by the QIDP/I or the Compliance/Training Manage #4. The Compliance and Training Manage #4. The Compliance and Training Manage #4. The Compliance compliance with process and to maximize outcomes Individuals in the home. #5: AOC: April 24, 2023	ead the revision de but not be ills to enhance ixing a cold eakfast clean up, e CFA for vill be reviewed to the home are at the review the lilar issues. If will receive Project Director r. Manager, the surance r the quarterly the ICF/IID	2:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G022	B. WING _		03/10/2023
NAME OF PROVIDER OR SUPPLIER CONRAD ICF			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
W 196	Continued From	page 18	W 1	196	
	an outcome to el independent leve assessment. Individual # 2 wa included but wer disability (1). On 03/09/2023 a observation duri (direct support p #2 their breakfar plate with bagel, DSP #4 then ca eat. Individual # independently u cup. When Individual # the table. Furth removed Individual the table, took if	the facility staff failed to develop inhance dining skills to an all based on the comprehensive as admitted with diagnoses that the not limited to: intellectual at approximately 7:30 a.m., an an approximately 7:30 a.m., an an approximately 7:30 a.m., an approximately 7:30 a.m., an an approximately 7:30 a.m.,			
	Individual #2's of 08/29/2022 door - Some physical assists by tugging perform task; Toneeded, but verequired." Und "Two" for clears #2 was coded dishwasher. Individual #2's dated 03/2023	comprehensive assessment dated cumented in part, "Scoring: Two (2) of intervention required -resident ing and pulling, can partially hree (3) - No physical intervention robal and gestural prompts are er "Eating" Individual #2 was code is table, "Housekeeping" Individual "Three" for fills and empties ISP for (Name of Day Program) failed to evidence an outcome to dual #2's ability to set a table with a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		49G022	B. WING			3/10/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4123 CONRAD STREET ALEXANDRIA, VA 22312	ODE	19
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(25) COMPLETION DATE
W 196	setting at the end kitchen, rinse the dishwasher. On 03/09/2023 at interview was constaff member) #1 training and compinformed of the olderwiew of Individue #1 and OSM #1 vaddress daily living meal, removing pland filling the dish should be included the skill. On 03/09/2023 at (administrative st manager, and OS trainer and complaware of the about the skill was trainer and complaware of the a	and utensils, remove their place of a meal, take the items to the m and place them in a approximately 2:30 p.m., an ducted with ASM (administrative, project director and OSM # 1, pliance manager. When observation stated above and all #2's ISP dated 03/2023, ASM over easked if the ISP shoulding skills for setting a table for a lace setting following a meal physical consistency with the director of the ispection	W 15	96		
40	https://www.reportsheet.aspx?csi	rt.nih.gov/NIHfactsheets/ViewFa d=100		F 45		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		49G022	B. WING _		03/10/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312	žV.	
(X4) ID PREFIX TAG	/FACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
W 231	must be express provide measura This STANDARI Based on staff in and facility docu that the facility si in measurable term survey sample. The findings included the day program being addressed Plan) outcomes activities, safety Individual #2 we should be supposed to the safety of the safety and safety safety and safety safety and safety sa	f the individual program plan ed in behavioral terms that able indices of performance. It is not met as evidenced by: atterview, clinical record review ment review it was determined thaff failed to develop outcomes as for one of two individuals in the individual #2.	W2	#231: IPP #1: The QIDP, Project Director and Compliance/Training Manger will re Individual #2's day program ISP to quantifiable objectives, in entirety. communication, community activition well being will be the focus to ensure treatment is included. #2: All Individuals who attend day risk. Any other Individuals who attorograms, will have their ISPs revice QIDP, Project Director and/or Community and trained on the revisions to the ISP attending day programs, by the QID Director and/or Compliance/Trainiff #4: The Compliance and Training Project Director and the Quality Accommittee will review all ISPs, after reviews to ensure compliance with process in the day programs any if #5: AOC: April 24, 2023	eview and revise include The areas of es, safety and are active programs are at end any day ewed by the apliance/Training s. al staff will be for all Individuals DP, Project ang Manger. Manager, the ssurance er the quarterly of the ICF/IID	
	Individual #2's I dated 09/01/20/documented, "Cenhance his convers. Support II encouraged to communicate, through his presuing vocalization enhance his coeffective reques will not be told he is saying, (II	SP for (Name of Day Program) 22 through 08/31/2023 Dutcome 1. (Individual #2) will mmunication skills. Skill-building: nstructions: (Individual #2) will be use his functional language to (Individual #2) will communicate ferred methods of communication ions, gestures, and pec symbols to mmunication, (Individual #2's) sts will be honored, (Individual #2) "yes" unless it is understood what ndividual #2) will be praised for all flow often? Daily."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY
		49G022	B. WNG		03/	10/2023
NAME OF PROVIDER OR SUPPLIER CONRAD ICF		STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 231	"Outcome 3. (Indicommunity and in Skill-building: Yes (Individual #2) will Outings will inclured recreation, lead (Individual #2's) p (Individual #2's) p (Individual #2) will activities to learn how he will get to review safety professions while in will be reminded to space as needed with others, (Individual times,	ividual #2) will explore his icrease his safety awareness. Support Instructions: I explore his community weekly. de but not be limited to outings iming, and building social skills, irreferences will be noted, I complete travel training about the purpose of his outing, and from the destination, and tocol, (Individual #2) will be mes, encouraged to remain with sisted with making safe in his community, (Individual #2) to provide others with personal when engaging in conversation vidual #2) will be praised for all	W 231			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G022	B. WING		03/10/2023
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 231	activities of his class the opportunity to vocational, activition of the opportunity to vocational, activition of the opportunities, (Indicomplete activities preferences will develop his intercopportunities, (In his attempts. However, and opportunities, (In his attempts. However, and opportunities, (In his attempts. However, (In his attempts.	lividual #2)will engage in hoice, (Individual #2) will have to increase his leisure, social, ties of daily living, and functional vidual #2) will be encouraged to es from start to finish his be noted, (Individual #2) will est in music and explore new idividual #2) will be praised for all	W 23		

PARTMENT OF HEALTH A			PRINTED: 03/20/2 FORM APPROV
NTERS FOR MEDICARE & that the ISP is	MEDICAID SERVICES		OMB NO. 0938-0
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		1 N N N N N N N N N N N N N N N N N N N	
TEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED
	49G022	B. WING	03/10/2023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
141.004	2	W 231		
W 231	Continued From page 23	VV 231		
	reviewed with the facility's QIDP (Qualified			
	Intellectual Disabilities Professional). After			
	reviewing Individual #2's outcomes #1, #3, #5 and #6 as stated above ASM #1 and OSM #1			
	were asked to identify the specific skills Individual	1		
	#2 was learning and to evidence quantitative			
	measures to determine progress Individual #2's			
	progress. ASM #1 and OSM #1 stated that they			
	were unable to identify the specific skills			
	Individual #2 was learning and the quantitative			
	measures to determine progress.			
	The facility's policy "Instructions for the Part V			
	Plan for Supports Template" documented in part,			100
	"For each Support Activity, the measure by which			
	progress will be assessed is defined in the			
	completion of this statement. Use one of the			
	formulas below determined by the type of support			
	activity to complete the "I no longer want or need			
	supports when" statement to make the Support	W.		
	Activity measurable. By when: Anticipated end			
	date of the support activity. May be long term (several years), short term (several months), or			
	end of the plan year, depending on the person's			
100	desires and preferences."			
	desiles and preferences.			
	On 03/09/2023 at approximately 3:00 p.m. ASM			
	(administrative staff member) # 1, project			
	manager, and OSM (other staff member) #1,			
	trainer and compliance manager, were made			
	aware of the above findings.			X
	No further information was provided prior to exit.			
	.0			
	References:			
	(1) Refers to a group of disorders characterized			
	by a limited mental capacity and difficulty with		V9	
	adaptive behaviors such as managing money,			
	schedules and routines, or social interactions.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	COMPLETED
	49G022	B. WING	03/10/2023

ONRAD I	CF		STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (XS) (EACH CORRECTIVE ACTION SHOULD BE COMPLET	
W 231	Continued From page 24 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	W 23		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to document the data collection in measurable terms for one of two individuals in the survey sample, Individual #2.	W 25	#1: Individual #2's ISP will be revised to ensure a data collection tool and task analysis to match the quantitative objective and revision noted in above areas. #2: All Individuals who attend day programs have the potential to be affected, therefore all day program documentation for Individuals who attend day programs will be reviewed and revised, to ensure quantitative data collection. #3: All day program staffs, who work with the Individuals who reside at Conrad will be trained on quantitative data, the tools and any revisions. #4. The Compliance/Training Manager, the Project Director and the Quality Assurance committee will review all ISPs, after the quarterly reviews to ensure compliance with the ICF/IID process and to maximize outcomes for all Individuals in the home #5: AOC: April 24, 2023	
	The findings include: For Individual #2, the facility staff failed to ensure the day program staff collected the data in measurable terms for the ISP (Individual Service Plan) outcomes of communication, community activities, safety and wellbeing and activities. Individual # 2 was admitted with diagnoses that included but were not limited to: profound intellectual disability (1). Individual #2's ISP for (Name of Day Program)			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		49G022	B. WNG _		03/10/2023
NAME OF PR	COVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4123 CONRAD STREET ALEXANDRIA, VA 22312	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
W 252	documented, "Ou enhance his comyes. Support Insencouraged to us communicate, (In through his prefeusing vocalization enhance his comeffective requests will not be told "yhe is saying, (Indhis attempts. How the sattempts of the saying was a saying to the saying was a say	through 08/31/2023 Introduction 1. (Individual #2) will munication skills. Skill-building: tructions: (Individual #2) will be see his functional language to adividual #2) will communicate rred methods of communication ns, gestures, and pec symbols to imunication, (Individual #2's) s will be honored, (Individual #2) wes" unless it is understood what lividual #2) will be praised for all	W 2	52	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		TE SURVEY MPLETED
		49G022	B. WING _			3/10/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 4123 CONRAD STREET ALEXANDRIA, VA 22312	DE	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 252	others, (Individua prevent falls, (Ind walk slowly and w safety during tran community he will with personal spa participate in ider the street/board t #2) will be praise often? Daily." "Outcome 6. (Indactivities of his chindependent skill Instructions. (Indactivities of his chindependent skill Instructions, (Indicomplete activities preferences will I develop his interespondents, (In his attempts. However, Indactivities, (In his attempts, Indactivity of the datter of the da	#2) will use the elevator to ividual #2) will be reminded to vith his head up to ensure his sitions, When exploring his be reminded to provide others are as needed and actively stifying when it is safe to cross ransportation/etc., (Individual dornall his attempts. How lividual #2) will engage in moosing to develop his s. Skill-building: Yes. Support ividual #2)will engage in moice, (Individual #2) will have o increase his leisure, social, ties of daily living, and functional ridual #2) will be encouraged to se from start to finish his one noted, (Individual #2) will est in music and explore new dividual #2) will be praised for all	Wa	252		
72	interview was comember) #2, pro Program). After collection for the stated above OS included quantita percent accurace	at approximately 11:20 a.m., an inducted with OSM (other staff agram director for (Name of Day reviewing Individual #2's data outcomes #1, #3, #5 and #6 as SM #2 was asked if the data ative measures, such as "with 80 by for two months." OSM #2 ata collection did not include any				Si

TATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		49G022	B. WNG		03/10/2023
NAME OF PRO	OVIDER OR SUPPLIER		412	REET ADDRESS, CITY, STATE, ZIP CODE 23 CONRAD STREET EXANDRIA, VA 22312	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
	interview was con (administrative st	approximately 2:10 p.m., an ducted with ASM aff member) #1, project director	W 252		3
16	After reviewing I the outcomes #1, ASM #1 and OSM included quantita percent accuracy	ining and compliance manager. Individual #2's data collection for #3, #5 and #6 as stated above If #1 were asked if the data Itive measures, such as 'VVith 80 If for two months.' OSM #1 Ita collection did not include any Issures.			
	(administrative st manager, and Os trainer and comp aware of the abo				
	References: (1) Refers to a giby a limited men adaptive behavious schedules and relimited limited limi	roup of disorders characterized tal capacity and difficulty with ors such as managing money, butines, or social interactions. Solity originates before the age of alt from physical causes, such as all palsy, or from nonphysical lack of stimulation and adult			
a.	responsiveness.	This information was obtained e: ort.nih.gov/NIHfactsheets/ViewFa			3
W 382		SE AND RECORDKEEPING	W 382	W382: Drug Storage and Recordkee #1: The nurse will retrain the DSP #5, will receive verbal counseling from the Director and/or Program Manager, whi	Project

documented in the personnel file and training record. #2. All staff have the potential for leaving medications unsecured. The Nurse and Project Director will review the polices and procedures, for any areas which need improvement, specifically how to accomplish hand washing the fourthing or carrying the Individuals' medication box, for proper infection prevention. Medications will be given in a private area. #3. All staff will receive a medication training specific to this deficient practice by the nurse, and the training will be documented in the training records for Conrad staff. #4. The Project Director, consultant Pharmacist and/or Nurse will conduct periodic medication pass observations, at least monthly. All staff who assist with Medication administrations'ell-administration will be observed at least quarterly. The observations will be documented and maintained in the compliancedratining area. The Project Manager will assure the OA committee reviews the observations and makes any areas for improvement on an ongoing basis. ACC: April 24, 2023 #490022 #490022 ## WING ## QUARTERUPPLERICLIA ## QUAR	NAME OF PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE	
documented in the personnel file and training record. #2. All staff have the potential for leaving medications unsacured. The Nurse and Project Director will review the polices and procedures, for any areas which need improvement, specifically how to accomplish hand washing after touching or carrying the Individuals "meant on box, for proper infection prevention. Medications will be given in a private area. #3. All staff will receive a medication training specific to this deficient practice by the nurse, and the training will be documented in the training records for Conrad staff. #4. The Project Director, consultant Pharmacist and/or Nurse will conduct periodic medication pass observations, at least monthly. All staff who assist with Medication administrations-fadministration will be observed at least quarterly. The observations will be documented and maintained in the compliance/training area. The Project Manager will ensure the QA committee reviews the observations and makes any areas for improvement on an ongoing basis. ACC: April 24, 2023		IDENTIFICATION NUMBER:	A. BUILDING	The state of the s	
documented in the personnel file and training record. #2: All staff have the potential for leaving medications unsecured. The Nurse and Project Director will review the polices and procedures, for any areas which need improvement, specifically how to accomplish hand washing after touching or carrying the Individuals' medication box, for proper			(X2) MULTIPLE (rivate area. 3: All staff will receive a medication training pecific to this deficient practice by the nurse, are training will be documented in the training ecords for Conrad staff. 4: The Project Director, consultant Pharmaciand/or Nurse will conduct periodic medication poservations, at least monthly. All staff who as with Medication administration/self-administrativill be observed at least quarterly. The beservations will be documented and maintain the compliance/training area. The Project Manifill ensure the QA committee reviews the beservations and makes any areas for improvement on an ongoing basis. OC: April 24, 2023	and ist pass ssist tion ned in nager
			re # m D a h	ocumented in the personnel file and training ecord. 2: All staff have the potential for leaving nedications unsecured. The Nurse and Projectivector will review the polices and procedures ny areas which need improvement, specificallow to accomplish hand washing after touching arrying the Individuals' medication box, for programs.	ct s, for lly g or oper

(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 382	Continued From page 28	W 382		
	The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to secure medications during the medication administration observation.			
	The findings include:			
	The facility staff left four medication bubble packs containing medications on a table unattended and within reach of two individuals.			H-7.
	On 03/09/2023 at approximately 7:20 a.m., an observation was made of DSP (direct support professional) #5 administering medications to the facility's Individuals. During the medication administration DSP #5 was observed removing four medication bubble packs from an Individual's			0 - 82
	medication box and placing them on the table, which was located in the facility's foyer, adjacent to the facility's kitchen, next to the medication box. DSP #5 left the medications, proceeded to			
	the kitchen to wash their hands. Observations revealed one Individual sitting at the table with the medication in front of them and another Individual standing at the table across from the Individual who was sitting at the table. Observations of the position of the medications revealed that they			
	were within less than an arm's reach. The medications that were left unattended on the table were: risperidone (used to treat schizophrenia, bipolar disorder and irritability caused by autism), lithium (used to treat mood disorders), clonazepam (used to treat anxiety) and tamsulosin (used to treat an enlarged prostate).	<i>b</i>		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		COMPLETED
	49G022	B. WING	03/10/2023

ME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>8-03</u>
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(VA) ID	SUMMARY STATEMENT OF DEFICIENCIES	10		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM	(X5) PLETIC NATE
W 382	Continued From page 29	W 3	32	
#	On 03/09/2023 at approximately 8:20 a.m., an interview was conducted with DSP #5. When asked how they ensure medication are not left available for Individual to access independently DSP #5 stated that the medications are double locked in a closet and are not left unattended when they are being administered. After being informed of the above observation, DSP #5 stated that the medications should not have been unattended and that they should have put them back into the medication box when they went to the kitchen to wash their hands.			
	On 03/09/2023 at approximately 9:30 a.m., an interview was conducted with RN (registered nurse) #1. After informed of the above observation RN #1 was asked if the medications should have been left unattended. RN #1 stated that it was not a good idea because someone could get ahold of them. On 03/09/2023 at approximately 3:00 p.m. ASM (administrative staff member) #1, project manager, and OSM (other staff member) #1, trainer and compliance manager, were made			
W 420	aware of the above findings. No further information was provided prior to exit. CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv)	W 48	20 W 420: CLIENT #1: a) This was taken care of immediately it was	
	The facility must provide each client with functional furniture, appropriate to the clients needs. This STANDARD is not met as evidenced by: Based on observations, staff interview and facility document review, it was determined that the	50	pointed out. b) Per the facility's "Maintenance Protocol", The Program Manager/designee will complete a weekly survey of the property, inside and outside for any areas which need repair on the structure or household furniture. This will include but not be limited to: all light switches and electrical outlets. If such areas are found, they will be documented on a maintenance request and forward to the Compliance/Training Manger and Project Director within 24 hours. Safety barriers will be utilized to either block or advise or hazards. c) The Program Manager will complete a weekly	

		harm, o	d, the item will be removed, p or replaced immediately. The e cited in the 2567 will be repl	ndividual's
		and fun All docu	e cited in the 2567 will be repl ctional furniture. Imentation of surveys will be i gram Manager's House folder	naintained in
		Project #2: All all have as they #3: The survey, repair o Compli Project for any All staf Manag	the Compliance/Training Man Director w/in 24 hours of comindividual's have bedroom funder a potential for breakage or nage. Program Manger will complet on all areas, and submit any or replacement to the Project Pance/Training Manger within 2 Director will review the Facilit revisions needed. If will be trained to report to the er (Project Director/Compliances which are broken or need when identified. Any immediate	pletion. niture therefore seeding repair te a weekly areas needing Anager and A hours. The y's Protocol's Program ce/Training) removal or
		areas, will be reporte #4: Th will rev actions reporti	to health and safety or Individed correct at time of notice by an and to Program Manger and Progress of the Project Director, and the Quiew the maintenance reports, on a quarterly basis, to ensuing and correction of any issue appropriate actions as need C: April 24, 2023	uals or staff, y staff, and oject Director. Committee corrective re prompt s noted, and
		\$1 St.		
,a				
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST		(X3) DATE SURVEY COMPLETED
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	49G022	B. WING		03/10/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/20/2023 **FORM APPROVED**

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

W 420 Continued From page 30 W 420 facility staff failed to maintain two of four Individual's bedrooms in good repair. The facility staff failed to secure the light switch cover plate to the switch box and failed to maintain a dresser in good repair. The findings include: On 03/08/2023 at approximately 10:20 a.m. and on 03/09/2023 at approximately 8:30 a.m., an observation of an Individual's bedroom, located on the left going from the fover down the hallway. revealed a light switch located on the wall on right hand side when entering the bedroom. Observation of the switch plate cover revealed that it was loose and not attached to the switch box. On 03/08/2023 at approximately 10:25 a.m. and on 03/09/2023 at approximately 8:20 a.m., an observation of an Individual's bedroom, located at the end of the hallway, across from the bathroom, revealed a dresser with a broken and missing drawer. Further observation of the dresser revealed that inside opening for the drawer had a partial/broken drawer bottom. Further observation of the bedroom revealed a broken dresser drawer with a missing bottom, next to the bedroom window across from the bedroom door. On 03/09/2023 at approximately 12:35 p.m., an observation of the Individual's rooms described above was conducted with OSM (other staff member) #1, training and compliance manager. After reviewing the switch plate cover and the dresser OSM #1 stated that they were not aware

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	49G022	B, WING	03/10/2023

of the repairs needed. When asked to describe the procedure for maintaining items in good

	NTERS FOR MEDICARE & MEDICAID SERVICES ME OF PROVIDER OR SUPPLIER		OMB NO. 0938-03 STREET ADDRESS, CITY, STATE, ZIP CODE		
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ONRAD ICF		8			
(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) COMPLETK DATE	
W 420	Continued From page 31	W 43	20		
	repair OSM #1 stated that the house manager				
	does a walk-through each to identify items that				
	are in need of repair, and they send an email to				
	the maintenance staff describing what needs to				
	be repaired. OSM #5 further stated that the				
0.5	house manager was away and unavailable.				
	The facility's "Maintenance Protocol" documented				
	in part, "Each home manager is responsible for				
	ensuring at each home in kept in clean condition.				
	Regular walk throughs (at least weekly) are	W.			
	expected to inspect that items are in working				
	order and no obvious maintenance issues exist."				
00	On 03/09/2023 at approximately 3:00 p.m. ASM (administrative staff member) # 1, project manager, and OSM (other staff member) #1, trainer and compliance manager, were made aware of the above findings.				
	No further information was provided prior to exit.				
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