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 _____	03/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted onsite on 03/08/2023 through 03/10/2023. Corrections are required for compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the	E 039	**E 039: Emergency Preparedness Testing Requirements:** #1: The Compliance and Training Manger will conduct full scale exercise for all Individuals and staff. An After-Action Report will be completed by the Compliance and Training Manger directly after the completion of the drill. #2: All Individuals would be at risk if they had to evacuate their home. #3: The Compliance/Training Mgr. will track all full-scale exercise and the After Action Reports to ensure compliance with the time frames, and to ensure any areas identified for improvement are incorporated into the polices and procedures and healthcare operations. The Compliance/Training Mgr. will maintain copies of all drills and After-Action Reports, including any changes made afterwards. #4: The Project Director and the Quality Assurance Committee will review the After Action Report and will monitor the dates to ensure a full evacuation or attempt will be completed every 2 years or in accordance with regulations. #5: AOC: April 24, 2023	

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

Gena Burney Project Director 4/5/2023

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E 039	Continued From page 1 actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 2 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a	E 039		

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E 039	Continued From page 3 facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		

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E 039	Continued From page 4 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion,	E 039		

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E 039	Continued From page 5 using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039		

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E 039	Continued From page 6 challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 7 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 8 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on staff interview and facility document	E 039		

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E 039	Continued From page 9 review it was determined that the facility staff failed to ensure testing of the emergency preparedness plan. The findings include: Facility staff failed to provide evidence of an attempt at full scale exercise or evidence that a full-scale exercise was conducted. On 03/08/2023 at approximately 2:40 p.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #1, training and compliance manager. Review of the facility's emergency preparedness plan failed to evidence an attempt at full scale exercise or evidence that a full-scale exercise was conducted. OSM #1 stated that they were not able to evidence that a full scale exercise was conducted or attempted during 2022. 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.	E 039		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 03/08/2023 through 03/10/2023. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey report will follow. No complaints were investigated during the survey.	W 000		

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W 000	Continued From page 10 The census in this four bed facility was four at the time of the survey. The survey sample consisted of two current individual reviews, Individuals #1 and #2.	W 000		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to allow an individual to exercise their right of dignity during a meal for one of two individuals in the survey sample, Individual #1. The findings include: For Individual #1, the facility staff stood next to the Individual as they ate their lunch. Individual #1 was admitted to the facility with diagnoses that included but were not limited to: severe intellectual disability (1). On 03/08/2023 at approximately 12:20 p.m., Individual #1 was observed seated at the facility's dining room table eating lunch independently. Further observation revealed DSP (direct support professional) #1 standing next to Individual #1 while they were eating their lunch.	W 125	**W 125: - Client Rights.** #1: All staff will receive training on dignity, specifically with respect to mealtimes, specifically in regard to Individual #1. In addition, specific mealtime dignity issues for all Individuals will be reviewed by resident. #2: All Individuals in the home have the potential to be affected by non-compliance of the dignity during mealtimes. #3: All staff (home and day program) will receive mandatory refresher training on rights and dignity of the Individuals, by the Compliance/Training Manger. #4: The QIDP and/or the Program Manager will observe at least one mealtime a week and record observations of staff interactions. The QIDP and the Project Director will review the above results with the Quality Assurance Committee on a quarterly basis. #5:AOC: April 24, 2023	

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W 125	Continued From page 11 On 03/08/2023 at approximately 4:00 p.m., an interview was conducted with DSP #1. When asked to describe the procedure when assisting or staying with an Individual while they ate DSP #1 stated they would sit next to the Individual or sit across from them to cue them during the meal to eat slowly, take small bites, make sure they don't choke and chew properly. When asked if it was dignified to stand next to or over an individual while they ate, DSP #1 stated no. When informed of the above observation DSP #1 stated that they should have been sitting next to Individual #1 while they ate their lunch. The facility policy "Human Rights" documented in part "Dignity. (Name of Corporation) will operate its programs in such a manner as to ensure that the dignity of each individual as a human being will be respected at all times, regardless of his/her need for services." 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. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained	W 125		

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W 125	Continued From page 12 from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100	W 125		
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 staff interview, day program program record reviews, and facility document review, it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate and monitor active treatment programs for one of two individuals in the survey sample, Individuals #2. The findings include: The QIDP failed to ensure Individual #2's ISP (individual service plan) identified the specific skills Individual #2 was learning and failed to evidence quantitative measures to determine progress outcomes for communication, community activities, safety and wellbeing and activities. 1a. The QIDP failed to ensure Individual #2's ISP (individualized service plan) had identified the specific skills Individual #2 was learning and failed to evidence quantitative measures to determine progress for communication, community activities, safety and wellbeing and activities. Individual # 2 was admitted with diagnoses that included but were not limited to: intellectual	W 159	**W159: QIDP** #1: Individuals #2's Individualized Service Plan (ISP) and Comprehensive Functional Assessment (CFA) will be reviewed by the QIDP or Project Director or Compliance/Training Manager, to develop quantifiable objectives for all areas. Including but not limited to: communication, community activities, safety and wellbeing. Task analysis, data recording tools will be developed for staff utilization, to match the ISP objectives for future quarterly analysis. #2: The QIDP/Project Director and/or Compliance/Training Manager will review 100% of the other 3 Individuals ISPs to ensure quantitative objectives, task analysis, data collection tools comply. #3. All home and day program staff will receive training on the new ISPs, the task analysis, and data collection tools, including date to be submitted to the QIDP before the quarterly review dates. All families will be advised and/or participate in the changes to the ISPs. #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	

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

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W 159	Continued From page 13 disability (1). Individual #2's ISP for (Name of Day Program) dated 09/01/2022 through 08/31/2023 documented, "Outcome 1. (Individual #2) will enhance his communication skills. Skill-building: Yes. Support Instructions: (Individual #2) will be encouraged to use his functional language to communicate, (Individual #2) will communicate through his preferred methods of communication using vocalizations, gestures, and pec symbols to enhance his communication, (Individual #2's) effective requests will be honored, (Individual #2) will not be told "yes" unless it is understood what he is saying, (Individual #2) will be praised for all his attempts. How often? Daily." "Outcome 3. (Individual #2) will explore his community and increase his safety awareness. Skill-building: Yes. Support Instructions: (Individual #2) will explore his community weekly. Outings will include but not be limited to outings for recreation, learning, and building social skills, (Individual #2's) preferences will be noted, (Individual #2) will complete travel training activities to learn about the purpose of his outing, how he will get to and from the destination, and review safety protocol, (Individual #2) will be monitored at all times, encouraged to remain with his group, and assisted with making safe decisions while in his community, (Individual #2) will be reminded to provide others with personal space as needed when engaging in conversation with others, (Individual #2) will be praised for all his attempts. How often? Weekly." "Outcome 5. (Individual #2) will maintain health and safety. Skill-building: Yes. Support Instructions. (Individual #2) will be monitored at	W 159		

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W 159	Continued From page 14 all times, (Individual #2)will be encouraged to remain with his group and request a walk when he needs a break or wants to socialize with others, (Individual #2) will use the elevator to prevent falls, (Individual #2) will be reminded to walk slowly and with his head up to ensure his safety during transitions, When exploring his community he will be reminded to provide others with personal space as needed and actively participate in identifying when it is safe to cross the street/board transportation/etc., (Individual #2) will be praised for all his attempts. How often? Daily." "Outcome 6. (Individual #2) will engage in activities of his choosing to develop his independent skills. Skill-building: Yes. Support Instructions. (Individual #2)will engage in activities of his choice, (Individual #2) will have the opportunity to increase his leisure, social, vocational, activities of daily living, and functional living skills, (Individual #2) will be encouraged to complete activities from start to finish his preferences will be noted, (Individual #2) will develop his interest in music and explore new opportunities, (Individual #2) will be praised for all his attempts. How often? Daily." Review of outcomes stated above failed to identify the specific skills Individual #2 was learning and failed to evidence quantitative measures to determine progress. On 03/09/2023 at approximately 2:10 p.m., an interview was conducted with ASM (administrative staff member) #1, project director and OSM # 1, training and compliance manager. When asked to interview the staff member who was	W 159		

	designated as the QIDP, ASM #1 stated that they			

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W 159	Continued From page 15 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 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 stated that it was the responsibility of the QIDP to ensure the outcomes were written in measurable 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" On 03/09/2023 at approximately 3:00 p.m. ASM	W 159		

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W 159	Continued From page 16 (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. 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 1b. The QIDP failed to ensure data collection for Individual #2's outcomes for communication, community activities, safety and wellbeing and activities. Review of the data collection dated 02/01/0223 through 03/06/2023 failed to evidence quantitative measures for determining Individual #2's progress outcomes of communication, community activities, safety and wellbeing and activities. On 03/09/2023 at approximately 2:10 p.m., an interview was conducted with ASM (administrative staff member) #1, project director 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	W 159		

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W 159	Continued From page 17 ASM #1 and OSM #1 were asked if the data included quantitative measures, such as 'With 80 percent accuracy for two months.' OSM #1 stated that the data collection did not include any quantitative measures. 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.	W 159		
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. 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 develop an ISP (Individual Service Plan) for the development of independent daily living skills for one of two individuals in the survey sample, Individual #2. The findings include:	W 196	**W 196: Active Treatment** #1: The QIDP/Project Director or the Compliance/Training manager will lead the revision of the ISP for Individual #2, to include but not be limited to: the inclusion of dining skills to enhance Individual #2's independence with fixing a cold breakfast, table set up and after breakfast clean up, and filling dishwasher, based on the CFA for Individual #2. Individual #2's ISP will be reviewed to include quantitative #2: All Individuals who reside in the home are at risk for non-compliance. The QIDP/Project Director or the Compliance/Training Manager will review the ISPs for all other Individuals for similar issues. #3: All home and day program staff will receive training on revisions, by the QIDP/Project Director or the Compliance/Training Manger. #4. The Compliance and 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	

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W 196	Continued From page 18 For Individual #2, the facility staff failed to develop an outcome to enhance dining skills to an independent level based on the comprehensive assessment. Individual # 2 was admitted with diagnoses that included but were not limited to: intellectual disability (1). On 03/09/2023 at approximately 7:30 a.m., an observation during breakfast revealed staff DSP (direct support professional) #4 served Individual #2 their breakfast by taking the bowl of cereal, plate with bagel, and cup to the dining room table. DSP #4 then called Individual #2 to the table to eat. Individual #2 was observed eating independently using regular utensils, spoon and cup. When Individual #2 finished eating they left the table. Further observations revealed DSP #4 removed Individual #2's bowl, plate, and cup from the table, took it to the kitchen, placed them in the sink, rinsed them and placed them in the dishwasher. Individual #2's comprehensive assessment dated 08/29/2022 documented in part, "Scoring: Two (2) - Some physical intervention required -resident assists by tugging and pulling, can partially perform task; Three (3) - No physical intervention needed, but verbal and gestural prompts are required." Under "Eating" Individual #2 was code "Two" for clears table, "Housekeeping" Individual #2 was coded "Three" for fills and empties dishwasher. Individual #2's ISP for (Name of Day Program) dated 03/2023 failed to evidence an outcome to address Individual #2's ability to set a table with a	W 196		

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W 196	Continued From page 19 plate, bowl, cup and utensils, remove their place setting at the end of a meal, take the items to the kitchen, rinse them and place them in a dishwasher. On 03/09/2023 at approximately 2:30 p.m., an interview was conducted with ASM (administrative staff member) #1, project director and OSM # 1, training and compliance manager. When informed of the observation stated above and review of Individual #2's ISP dated 03/2023, ASM #1 and OSM #1 were asked if the ISP should address daily living skills for setting a table for a meal, removing place setting following a meal and filling the dishwasher OSM #1 stated that it should be included to establish consistency with the skill. 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. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100	W 196		

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W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to develop outcomes in measurable terms for one of two individuals in the survey sample, Individual #2. The findings include: For Individual #2, the facility staff failed to ensure the day program staff define the specific skills being addressed 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: intellectual disability (1). Individual #2's ISP for (Name of Day Program) dated 09/01/2022 through 08/31/2023 documented, "Outcome 1. (Individual #2) will enhance his communication skills. Skill-building: Yes. Support Instructions: (Individual #2) will be encouraged to use his functional language to communicate, (Individual #2) will communicate through his preferred methods of communication using vocalizations, gestures, and pec symbols to enhance his communication, (Individual #2's) effective requests will be honored, (Individual #2) will not be told "yes" unless it is understood what he is saying, (Individual #2) will be praised for all his attempts. How often? Daily."	W 231	**W 231: IPP** #1: The QIDP, Project Director and/or Compliance/Training Manger will review and revise Individual #2's day program ISP to include quantifiable objectives, in entirety. The areas of communication, community activities, safety and well being will be the focus to ensure active treatment is included. #2: All Individuals who attend day programs are at risk. Any other Individuals who attend any day programs, will have their ISPs reviewed by the QIDP, Project Director and/or Compliance/Training Manger to ensure the ISP complies. #3: All day program and residential staff will be trained on the revisions to the ISP for all Individuals attending day programs, by the QIDP, Project Director and/or Compliance/Training Manger. #4: The Compliance and 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 in the day programs any Individual attends. #5: AOC: April 24, 2023	

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W 231	Continued From page 21 "Outcome 3. (Individual #2) will explore his community and increase his safety awareness. Skill-building: Yes. Support Instructions: (Individual #2) will explore his community weekly. Outings will include but not be limited to outings for recreation, learning, and building social skills, (Individual #2's) preferences will be noted, (Individual #2) will complete travel training activities to learn about the purpose of his outing, how he will get to and from the destination, and review safety protocol, (Individual #2) will be monitored at all times, encouraged to remain with his group, and assisted with making safe decisions while in his community, (Individual #2) will be reminded to provide others with personal space as needed when engaging in conversation with others, (Individual #2) will be praised for all his attempts. How often? Weekly." "Outcome 5. (Individual #2) will maintain health and safety. Skill-building: Yes. Support Instructions. (Individual #2) will be monitored at all times, (Individual #2)will be encouraged to remain with his group and request a walk when he needs a break or wants to socialize with others, (Individual #2) will use the elevator to prevent falls, (Individual #2) will be reminded to walk slowly and with his head up to ensure his safety during transitions, When exploring his community he will be reminded to provide others with personal space as needed and actively participate in identifying when it is safe to cross the street/board transportation/etc., (Individual #2) will be praised for all his attempts. How often? Daily." "Outcome 6. (Individual #2) will engage in activities of his choosing to develop his independent skills. Skill-building: Yes. Support	W 231		

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W 231	Continued From page 22 Instructions. (Individual #2)will engage in activities of his choice, (Individual #2) will have the opportunity to increase his leisure, social, vocational, activities of daily living, and functional living skills, (Individual #2) will be encouraged to complete activities from start to finish his preferences will be noted, (Individual #2) will develop his interest in music and explore new opportunities, (Individual #2) will be praised for all his attempts. How often? Daily." Review of outcomes stated above failed to evidence identify the specific skills Individual #2 was learning and failed to evidence quantitative measures to determine progress. On 03/09/2023 at approximately 11:20 a.m., an interview was conducted with OSM (other staff member) #2, program director for (Name of Day Program). After reviewing Individual #2's outcomes #1, #3, #5 and #6 as stated above OSM #2 was asked to identify the specific skills Individual #2 was learning and to evidence quantitative measures to determine progress Individual #2's progress. OSM #2 stated that they were unable to identify the specific skills Individual #2 was learning and the quantitative measures to determine progress. When asked who reviews the ISP from the day program when it is developed OSM #2 stated that it is reviewed with Individual #2's team at the day program, the responsible party and staff from the facility. On 03/09/2023 at approximately 2:10 p.m., an interview was conducted with ASM (administrative staff member) #1, project director and OSM # 1, training and compliance manager. When asked who reviews the ISP from the day program when it is developed ASM #1 stated	W 231		

	that the ISP is			

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W 231	Continued From page 23 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. The facility's policy "Instructions for the Part V Plan for Supports Template" documented in part, "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 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 desires 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. 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.	W 231		

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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 231		
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. 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)	W 252	**W252: Program Documentation** #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	

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W 252	Continued From page 25 dated 09/01/2022 through 08/31/2023 documented, "Outcome 1. (Individual #2) will enhance his communication skills. Skill-building: Yes. Support Instructions: (Individual #2) will be encouraged to use his functional language to communicate, (Individual #2) will communicate through his preferred methods of communication using vocalizations, gestures, and pec symbols to enhance his communication, (Individual #2's) effective requests will be honored, (Individual #2) will not be told "yes" unless it is understood what he is saying, (Individual #2) will be praised for all his attempts. How often? Daily." "Outcome 3. (Individual #2) will explore his community and increase his safety awareness. Skill-building: Yes. Support Instructions: (Individual #2) will explore his community weekly. Outings will include but not be limited to outings for recreation, learning, and building social skills, (Individual #2's) preferences will be noted, (Individual #2) will complete travel training activities to learn about the purpose of his outing, how he will get to and from the destination, and review safety protocol, (Individual #2) will be monitored at all times, encouraged to remain with his group, and assisted with making safe decisions while in his community, (Individual #2) will be reminded to provide others with personal space as needed when engaging in conversation with others, (Individual #2) will be praised for all his attempts. How often? Weekly." "Outcome 5. (Individual #2) will maintain health and safety. Skill-building: Yes. Support Instructions. (Individual #2) will be monitored at all times, (Individual #2)will be encouraged to remain with his group and request a walk when he needs a break or wants to socialize with	W 252		

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W 252	Continued From page 26 others, (Individual #2) will use the elevator to prevent falls, (Individual #2) will be reminded to walk slowly and with his head up to ensure his safety during transitions, When exploring his community he will be reminded to provide others with personal space as needed and actively participate in identifying when it is safe to cross the street/board transportation/etc., (Individual #2) will be praised for all his attempts. How often? Daily." "Outcome 6. (Individual #2) will engage in activities of his choosing to develop his independent skills. Skill-building: Yes. Support Instructions. (Individual #2)will engage in activities of his choice, (Individual #2) will have the opportunity to increase his leisure, social, vocational, activities of daily living, and functional living skills, (Individual #2) will be encouraged to complete activities from start to finish his preferences will be noted, (Individual #2) will develop his interest in music and explore new opportunities, (Individual #2) will be praised for all his attempts. How often? Daily." Review of the data collection dated 02/01/0223 through 03/06/2023 failed to evidence quantitative measures for determining Individual #2's progress. On 03/09/2023 at approximately 11:20 a.m., an interview was conducted with OSM (other staff member) #2, program director for (Name of Day Program). After reviewing Individual #2's data collection for the outcomes #1, #3, #5 and #6 as stated above OSM #2 was asked if the data included quantitative measures, such as "with 80 percent accuracy for two months." OSM #2 stated that the data collection did not include any	W 252		

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W 252	Continued From page 27 quantitative measures. On 03/09/2023 at approximately 2:10 p.m., an interview was conducted with ASM (administrative staff member) #1, project director 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 ASM #1 and OSM #1 were asked if the data included quantitative measures, such as 'With 80 percent accuracy for two months.' OSM #1 stated that the data collection did not include any quantitative measures. 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. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100	W 252		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2)	W 382	**W382: Drug Storage and Recordkeeping** #1: The nurse will retrain the DSP #5, and the DSP will receive verbal counseling from the Project Director and/or Program Manager, which will be	

			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 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 administration/self-administration 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. AOC: April 24, 2023	

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W 382	Continued From page 28 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. 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 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).	W 382		

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W 382	Continued From page 29 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 aware of the above findings. No further information was provided prior to exit.	W 382		
W 420	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv) 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	W 420	**W 420: CLIENT** #1: a) This was taken care of immediately it was 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 survey each Individual's bedroom furniture and personal items, to ensure all are in safe working	

			order. If any areas with bedroom furniture are identified, the item will be removed, protected from harm, or replaced immediately. The Individual's furniture cited in the 2567 will be replaced with safe and functional furniture. All documentation of surveys will be maintained in the Program Manager's House folder and a copy sent to the Compliance/Training Manger and the Project Director w/in 24 hours of completion. #2: All Individual's have bedroom furniture therefore all have a potential for breakage or needing repair as they age. #3: The Program Manger will complete a weekly survey, on all areas, and submit any areas needing repair or replacement to the Project Manager and Compliance/Training Manger within 24 hours. The Project Director will review the Facility's Protocol's for any revisions needed. All staff will be trained to report to the Program Manager (Project Director/Compliance/Training) any areas which are broken or need removal or repair when identified. Any immediate hazard areas, to health and safety or Individuals or staff, will be correct at time of notice by any staff, and reported to Program Manger and Project Director. #4: The Project Director, and the QA Committee will review the maintenance reports, corrective actions on a quarterly basis, to ensure prompt reporting and correction of any issues noted, and will take appropriate actions as needed. #5: AOC: April 24, 2023	

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W 420	Continued From page 30 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 foyer 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 of the repairs needed. When asked to describe the procedure for maintaining items in good	W 420		

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W 420	Continued From page 31 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 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 expected to inspect that items are in working order and no obvious maintenance issues exist." 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.	W 420		