

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2010
NAME OF PROVIDER OR SUPPLIER WARD & WARD		STREET ADDRESS, CITY, STATE, ZIP CODE 7011 9TH ST, NW WASHINGTON, DC 20012		
(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) COMPLETE DATE
1090	Continued From page 1 porch floor had chipping and peeling paint. 2. The 1st floor bathroom, next to the office, had broken floor tiles and broken tiles around the shower door, posing as a potential safety hazard. 3. The bathroom tub located in Resident #4's room, had evidence of chipping and peeling paint in the bottom of the tub. 4. The common bathroom door on the second floor, was not secured tightly to the floor. In addition the door hinges were loose causing the door not to close properly. 5. Resident #3's bathroom toilet seat was worn/damaged.	1090	Cont. 4 2 ND floor common bathroom door secured. 5. Replaced residents #3 toilet seat.	3/19/10
1206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review. The GHMRP failed to have on file a current health screening for one (1) of six (6) house direct care staff. (Staff #6). The finding includes: On March 2, 2010, at approximately 2:00 p.m., a review of personnel files was conducted and	1206	Personnel Dept. (HR) will generate notices 30 days in advance of any certification expiration to ensure current certifications. Please find attached current health screening on Staff #6.	3/15/10

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I 206	Continued From page 2 revealed that the GHMRP failed to have evidence of a current health certificate for one of the six house staff. The House Manager confirmed this at the time of the record review.	I 206		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the Group Homes for Persons with Mental Retardation (GHMRP) failed to ensure that all persons making entries into the clients' records were dated and signed, for two of the two residents (Residents #1 and #2) included in the sample. The findings include: Review of Resident #1 and #2's medical records on February 25, 2010, beginning 12:14 p.m., revealed "Annual & Quarterly Nursing Assessments" dated September 30, 2009. Continued review of the assessments revealed that the GHMRP's nurse had not signed the documents. Interview with the Licensed Practical Nurse on the aforementioned date revealed that the Registered Nurse (RN) conducted the assessments. At the time of the survey, there was no documented evidence of the signature of the RN that conducted the "Annual & Quarterly Nursing Assessment for Residents #1 and #2.	I 291	Ward & Ward is transitioning from paper to an electronic system and from 3/2010 onward all RN assessments will contain an electronic signature. Additionally the clinical Director will review records quarterly to ensure that assessments are in the record.	3/15/10

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I 379	Continued From page 3	I 379		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours of the next work day. This Statute is not met as evidenced by: Based on interview and review of the incident reports, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH), Health Regulation Administration, for one of the two residents (Resident #1) included in the sample. The finding includes: Review of the facility's incident reports on February 25, 2010, beginning at 10:55 a.m. revealed the following: On August 19, 2009, at approximately 5:45 p.m., the GHMRP evening supervisor staff received a phone call from the Qualified Mental Retardation Professional (QMRP) reporting that Resident #1 had not returned from her day program. Continued review of the incident report revealed that the supervisor was requested to go to the resident's day program to pick her up, however prior to leaving was advised to check the van	I 379	All QMRP's and Apartment Supervisors are required to follow the District of Columbia Serious Reportable written reporting requirements. (attached) Additionally all incidents will be reviewed by Incident Management Coordinator or Investigator before submission to MCIS to ensure proper reporting.	3/15/10

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I 379	Continued From page 4 that resident usually rides. Resident #1 was discovered on the locked van, still strapped in her seat belt, and sweating profusely. Interview with the GHMRP's Facility Manager (FM) was conducted on February 24, 2010, at 2:55 p.m., to ascertain information regarding the facility's Incident Management protocol. According to the FM, she/and or the QMRP would take the responsibility to first contact 911/nurse in the event of an emergency, contact the family, the Department of Disabilities Administration, the Incident Management Coordinator (IMC) and the Department of Health (DOH). At the time of the survey, there was no documented evidence that the GHMRP notified the Department of Health (DOH) of all unusual incidents that substantially interfered with Resident #1's welfare and at risk.	I 379		
I 401	3520.3 PRDFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to evaluate the residents' decision making skills (competency) for one of the two residents (Resident #1) included in the sample. The finding includes: Interview with the Qualified Mental Retardation	I 401		

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I 401	Continued From page 5 Professional (QMRP) on February 25, 2010, at approximately 1:29 p.m., revealed Resident #1's sister was her legal guardian. Review of the resident's habilitation record on the aforementioned date revealed that the resident had an Individual Support Plan (ISP) dated April 13, 2009. Continued review of the ISP revealed a section entitled "Essential Planning Considerations." According to this document, Resident #1's sister was making medical decisions on her behalf. The resident's record also revealed a "Diagnostic Assessment" dated April 6, 2009. According to the assessment, Resident #1 "was diagnosed with moderate intellectual disabilities, however, the assessment did not evidence the resident's decision making abilities. At the time of the survey, professional services failed to identify Resident #1's capacity for decision making regarding habilitation, medical and financial decisions.	I 401	Ward & Ward is a CRF provider and assessments done for our individuals are done by vendors who contract with DDS or Medicaid. However I did notify the DDS Service Coordinator of this deficiency to prevent this moving forward. (Attached)	3/15/10
I 500	3523.1 RESIDENTS RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and	I 500		

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I 500	<p>Continued From page 6</p> <p>protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with [Title 7, Chapter 13, § 7-1305.10. Mistreatment, neglect or abuse prohibited ... [Formerly § 6-1970(e)] that governs the care and rights of persons with mental retardation for one of the two residents (Resident #1) included in the sample.</p> <p>The finding includes:</p> <p>Interview and record review of the facility's incident reports on February 25, 2010, beginning at 10:55 a.m. revealed the following:</p> <p>On August 19, 2009, at approximately 5:45 p.m., the GHMRP evening supervisor staff received a phone call from the Qualified Mental Retardation Professional (QMRP) reporting that Resident #1 had not returned from her day program. Continued review of the incident report revealed that the supervisor was requested to go to the resident's day program to pick her up, however prior to leaving was advised to check the van that resident usually rides. Resident #1 was discovered on the locked van, still strapped in her seat belt, and sweating profusely.</p> <p>Interview with the GHMRP's Facility Manager (FM) was conducted on February 24, 2010, at 2:55 p.m., to ascertain information regarding the facility's Incident Management protocol. According to the FM, she/and or the QMRP would</p>	I 500	See Tag # 1379	3/15/10

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I 500	<p>Continued From page 7</p> <p>take the responsibility to first contact 911/nurse in the event of an emergency, contact the family, the Department of Disabilities Administration, the Incident Management Coordinator (IMC) and the Department of Health (DOH).</p> <p>Review of the incident management policy on February 25, 2009, revealed a section entitled "Identification of An Incident/Offense." Further review of the policy revealed reportable and serious reportable incidents. The policy listed examples of serious reportable incidents that included "Missing Person." Continued review of the policy revealed another section entitled "Verbal Reporting of Deaths and all Other Serious Reportable Incidents." This section of the policy included several governmental agencies that should be notified. Two of the agencies included for the staff to immediately call were:</p> <p>a. Emergency personnel, as needed, via 911; and e. The Department of Health/Health Regulations Administration....</p> <p>It should be noted that neither of the aforementioned agencies were contacted. On February 25, 2010, review of the GHMRP's investigation dated August 21, 2009 at approximately 10:55 a.m. revealed that the QMRP instructed the staff to "slowly remove Resident #1 from the van and be given cool water. She also requested that the resident be transported to the nurse's station immediately for evaluation and possible treatment."</p> <p>At the time of the survey, the GHMRP failed to ensure their policy and procedures on Incident Management was implemented as written to</p>	I 500		

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I 500	Continued From page 8 ensure the rights of resident #1 was protected.	I 500			