Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2009
NAME OF PROVIDER OR SUPPLIER WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 815 FLORAL PL, NW WASHINGTON, DC 20012		

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I 000	INITIAL COMMENTS A licensure survey was conducted from July 9, 2009 through July 10, 2009. A random sample of two residents was selected from a resident population of four women with various degrees of disabilities. The findings of this survey were based on observations at the group home, interviews with residents and residential staff as well as the review of clinical and administrative records, including incident reports.	I 000	Revised 8/18/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that modified diets were served as prescribed, for one of the two residents included in the sample. (Resident #2) The finding includes: Observations of the evening medication administration on July 9, 2009, at 5:53 PM, revealed Resident #1 was administered Amlodipine Besylate (Norvasc) 5 mg for hypertension. Interview with the Registered Nurse (RN) revealed that Resident #1 was also prescribed Diovan in the morning for hypertension. Observations of the dinner meal at 6:07 PM, revealed Resident #1 was served five pieces of ham approximately 1/2 inch thick in place of roasted turkey breast according to the	I 042	Ward & Ward individuals are able to request changes ~~to~~ the daily menu additionally if what on the menu is not available staff are to notify the nursing dept. to get instructions on menu substitutions or individual request to ensure meals are served in accordance with the nutritionist prescribed diet.	8/19/09

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Ward — TITLE: Program Director — (X6) DATE: 8-19-09

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I 042	Continued From page 1 menu. Further observation revealed the resident was also served cream of corn, spinach, apples and wheat bread. At 6:13 PM, additional interview with the RN who observed the ham on Resident #1's dinner plate, acknowledged that ham wasn't a good choice for the resident. The RN stated that the ham was very high in sodium and that she would address this concern with the nutritionist. Review of Resident #2's July 2009 Physician's Orders (POS) on July 10, 2009, at 11:59 AM and current Health Passport dated February 5, 2009, revealed the resident was prescribed an 1800 low cholesterol, low fat, low sodium, and high fiber diet. Further record review revealed a current Health Management Care Plan (HMCP) dated and signed March 20, 2009. The HMCP confirmed that Resident #1 was prescribed Norvasc and Diovan for hypertension. There was no evidence that Resident #1 was provided her dinner in accordance with the documented menu and as ordered.	I 042		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that the modified diet for one out of two residents included in the sample had been reviewed at least quarterly by the consulting dietitian. (Resident #1) The finding includes:	I 043	To ensure inclusion of quarterly nutritional assessments in the medical chart the nursing monthly notes and RN quarterly assessment will include reference to nutrition and notification to nutritionist.	8/19/09

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I 043	Continued From page 2	I 043		
	On July 10, 2009, at 12:23 PM, review of Resident #1's medical records revealed a Nutritional Quarterly (NQ) report dated January 2, 2009. The NQ recommended follow up of a minimum of one hour every three (3) months. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 2:00 PM revealed that she would address this concern with the GHRMP nutritionist. There was no evidence that the nutritionist had reviewed Resident #1's diet on a quarterly basis as recommended.			
I 090	3504.1 HOUSEKEEPING	I 090	Staff are required to complete a facility checklist weekly to identify any maintenance needs. The checklist is monitored weekly by the QMRP. Additionally, the following identified maintenance needs have been completed as follows: (over)	
	The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.			
	This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner for four of four residents included residing in the facility. (Residents #1, #2, #3, and #4)			
	The findings include:			
	On July 10, 2009, beginning at 4:09 PM, a walk through of the facility that was conducted with the Qualified Mental Retardation Professional revealed the following:			
	Exterior			

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I 090	Continued From page 3 1. Mold and Mildew was observed on the entire deck which was attached to the dining room area leading to the backyard. 2. The sliding screen door leading to the deck was observed to be off track. Interview with the direct staff who assisted the surveyor in putting the sliding door back on track, revealed that it needed to be replaced. 3. The gutter outside of the basement door was observed with mold and mildew on the brick siding. There were also leaves, twigs, and a large plastic bag blocking the drain. 4. The entire top ceiling of the car porch was observed with peeling paint. 5. The water drain located on the side of the home near the car porch was observed to be covered with tall weeds and twigs. 6. The siding located above the front door was observed to be separated from its foundation. 7. There were holes located in Residents #1 and #2 window screens outside of their bedrooms. 8. The top left of the home located near the roof siding was observed to be separated from its foundation. Rooted wood was observed underneath the siding. The QMRP acknowledged that all of the aforementioned maintenance issues listed above needed to be addressed.	I 090	1. Deck attached to dining room area cleaned to remove mold and mildew. 2. Sliding Screen door repaired. 3. Gutter outside basement door was cleaned to remove mold and mildew and cleared of all debris. 4. Car porch ceiling painted. 5. Water drain cleared of all debris. 6. Siding above front door repaired. 7. Replaced Screens in Resident #1 and #2 bedroom. 8. Siding repaired Located top left near roof.	8/21/09 8/21/09 8/21/09 8/21/09 8/21/09 8/21/09 8/21/09 8/21/09
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in	I 135		

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I 135	Continued From page 4 order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for four of four residents residing in the GHMRP. (Residents #1, #2, #3, and #4) The finding includes: Interview with the House Manager (HM) on July 10, 2009, at 10:02 AM revealed the GHMRP had five shifts of direct care personnel. The shifts were weekdays 8 AM - 4 PM, 4 PM - 12 AM, 12 AM - 8 AM and on weekends 8 AM - 8 PM and 8 PM - 8 AM. There was no evidence that the facility conducted simulated fire drills at least four times (4) a year for each shift from June 2008 to June 2009. Review of the fire drill log book on June 10, 2009, at approximately 10:05 AM, revealed there were no fire drills conducted from June 2008 to June 2009 for the 8 AM - 4 PM morning weekday shift. At approximately 5:15 PM, interview with the Qualified Mental Retardation Professional (QMRP) acknowledged that fire drills were not conducted quarterly on each shift.	I 135	Review of the fire drills reveal that drills were conducted quarterly for each shift. Ward & Ward ~~Cano~~ can provide documentation for 8-4p, 4p-12 and 12-8am.	8/19/09
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident ' s Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel.	I 188		

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I 188	Continued From page 5 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have on file for review, current contracts for licensed consultants. The findings include: On July 10, 2009, at approximately 3:20 PM, review of personnel records and interview with the Qualified Mental Retardation Professional (QMRP) revealed that the following consultants' records were without current contracts at the time of the survey. (Primary Care Physician, Dietician, and Social Worker)	I 188	Ward & Ward is a community residential facility (CRF) and our individuals access the identified consultants PCP, Dietician and social worker through medicaid. They do not contract with Ward & Ward.	8/19/09
I 206	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 ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for 1 of 7 direct care staff, 2 of 3 consultants, and 4 of 4 nurses. The findings include:	I 206		

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I 206	Continued From page 6 Interview with the Qualified Mental Retardation Professional (QMRP) and review of the personnel records on July 10, 2009, beginning at 3:09 PM revealed the following: 1. The GHMRP failed to provide evidence that current health certificates were on file for 1 of 7 direct care staff. (Staff#5) 2. The GHMRP failed to provide evidence that current health certificates were on file for 2 of 3 consultants. (Consultants #1 and #2) 3. The GHMRP failed to provide evidence that current health certificates were on file for 4 of 4 nurses. (Nurse #1, #2, #3 and #5) The nurse's files were requested on July 10, 2009, at 9:30 AM; however, there were not available for review.	I 206	1. QMRP will provide quarterly monitoring of staff records to ensure timely recertification. 2. Personnel will monitor consultants records quarterly to ensure timely recertification. 3. Clinical Staff (nursing) records are maintained at the main office and nurses station for review.	8/19/09 8/19/09 8/19/09
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that agendas for training were included in the in service training records for four of four residents' residing in the GHRMP. (Residents #1, #2, #3, and #4) The findings include: On July 10, 2009, at 11:27 AM, review of the staff in-service records and interview with the House Manager (HM) revealed there were no agendas on file. (i.e. nutrition, rights, behavior management, sexuality, making choices, ethnic	I 223	Please find attached the schedule of monthly in-service training completed by the QMRP's. Additionally, the QA. provides a syllabus that is followed and hand out given to staff for reference.	8/19/09.

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I 223	Continued From page 7 training, etc.)	I 223		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure three of three nurses were certified to provide cardiopulmonary (CPR) and First Aid to four of four residents residing in the GHMRP. (Residents #1, #2, #3, and #4) The findings include: The GHMRP failed to ensure current CPR and First Aid certifications were on file for 4 of 4 nurses. (Nurse #1, #2, #3 and #4) On July 10, 2009, at 9:30 AM, the nursing files were requested by the House Manager (HM) along with the direct care staff and consultants file. At approximately 2:55 PM, the personnel files were requested again by the surveyor. The Qualified Mental Retardation Professional (QMRP) returned from the agency's office at approximately 3:05 PM with the requested personnel files. However, the nurses files were not included with the direct care staff and the consultant files.	I 227	See Tag # 1206 #3.	8/19/09

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I 379	Continued From page 8	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 or the next work day. This Statute is not met as evidenced by: Based on interview and review of the incident reports, the 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 two of two residents included in the sample. (Residents #1 and #2) The findings include: 1. On July 10, 2009, beginning at 8:55 AM, review of the GHMRP unusual incident report log book and interview with the House Manager (HM) revealed an incident report dated November 27, 2008. The incident report revealed that after Resident #1 finished her PM care, she stepped out of the bath tub (located in her bedroom) with staff by her side and missed her step. The resident fell and bruised her head on the foot board of the bed. The resident sustained bruises to her head and was transported to the hospital emergency room via the GHMRP van for precautionary measures. Review of the hospital emergency room discharged reported dated	I 379	All incidents were reported to IMEU and entered into the MCIS system within the required time frame. Additionally Ward & Ward will require the incident management coordinator oversight to ensure DOH is notified of all incidents serious and reportable.	8-19-09

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I 379	Continued From page 9 November 27, 2009 revealed that Resident #1 was diagnosed with a closed head injury. Interview with the Qualified Mental Retardation Professional (QMRP) on the July 10, 2009, at approximately 5:10 PM revealed that the aforementioned incident was not forwarded to the Department of Health (DOH) as required. 2. An incident report dated February 6, 2009 reviewed at 9:46 AM, revealed Resident #2 was discovered with a red nose after returning home from her day program. According to the incident, the resident stated that someone hit her when asked by the group home staff. On July 10, 2009, at approximately 5:15 PM interview with the QMRP revealed that a called was made to the day program regarding the incident, but no formal investigation was conducted and/or completed to determine how the injury had occurred. Review of the nursing note dated February 6, 2009 revealed that Resident #2's nose appeared to bruised and reddened upon assessment. Further review of the nurse's notes revealed measurements of 10 millimeter left to right, and 9 millimeter up/down Resident #2's nose. There was no evidence that the incident was forwarded to the Department of Health as required. 3. On June 7, 2009, Resident #2 was asked by staff to finish up her bathing to take her medications. As staff approached the resident with a towel, she yelled out "I hit myself". Staff informed the resident not to hit herself. Resident #2 then yelled out "I wanna die". After staff moved a little closer to her and asked her to repeat herself, the resident yelled out again, "I wanna die". As the resident was putting on her clothes, she stated that she wanted to go to	I 379		

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I 379	Continued From page 10 heaven. The director on nursing was called and was informed of Resident #2's outburst. The nurse instructed that staff to call 911. Resident #2 was taken by EMS to a local hospital and admitted. On July 10, 2009, at approximately 9:50 PM, interview with the HM revealed confirmed that the resident was transported to local hospital for suicidal threats. Later that day at approximately 5:20 PM, interview with the QMRP acknowledged that the incident was not forwarded to DOH as required.	I 379		

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R 000	INITIAL COMMENTS A licensure survey was conducted from July 9, 2009 through July 10, 2009. A random sample of two residents was selected from a resident population of four women with various degrees of disabilities. The findings of this survey were based on observations at the group home, interviews with residents and residential staff as well as the review of clinical and administrative records, including incident reports.	R 000		

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