

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER WARD & WARD		STREET ADDRESS, CITY, STATE, ZIP CODE 823 FERN PL, NW WASHINGTON, DC 20012		
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I 000	INITIAL COMMENTS A licensure survey was conducted on August 26, 2009 through August 27, 2009. A random sample of two residents was selected from a resident population of four women with various disabilities. The findings of the survey were based on observations, interviews with staff in the home, as well as a review of resident and administrative records, including incident reports.	I 000	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 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the GHMRP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner for four of four residents residing in the facility. (Residents #1, #2, #3, and #4) The findings include: Observation and interview with the lead counselor (LC) during the environmental walk through on August 26, 2009, at approximately 1:30 p.m. reveal the following: The bath tub in resident #2's bedroom, the bathtub's surface was chipping and peeling.	I 091	The bath tub in resident #2's bedroom, bath has been repaired. Additionally, the lead counselor completes a weekly checklist, and the QMRP monitors the checklist weekly to ensure that all facilities are in good repair.	10/2/09
I 203	3509.3 PERSONNEL POLICIES	I 203		

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Michael Warren

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Program Director

(X6) DATE

10/2/09

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I 203	Continued From page 1 Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to have on file for review, current job descriptions, for two out of seven employees, and two of two Trained Medication Employee's (TME). (Staff #2 and #3; TME #1 and #2) The finding includes: Interview with the Lead Counselor and review of the GHMRP's personnel files conducted on August 26, 2009, at approximately 1:50 p.m., revealed the GHMRP failed to provide evidence of current job descriptions for Staff #1 and #2 and for TME #1 and #2. This was verified by the lead Counselor.	I 203	<i>Clinical Dir. (RN)</i> QMRP's are required quarterly to review staff's personnel records and ensure all required certifications are current. Additionally, Personnel Dept. (HR) will generate notices 30 days in advance of any certification expiration to ensure current certifications. The Clinical Director is required to review all medical personnel's records quarterly. i.e. TME's LPN's and RN's.	10/2/09
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 interviews and record review, the facility failed to achieve compliance with state regulations pertaining to health (22DCMR 35, section 3509.6) for one of seven employees(I 206		

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I 206	Continued From page 2 Staff #6) and for two Licensed Practical Nurse's (LPN) (LPN #1 and #2) and one of two TME's (TME #1) The finding includes: The State regulatory agency conducted a review of personnel records on August 26, 2009, at approximately 1:50 p.m. at which that time, there was no evidence of current health certificates on file for Staff #6. This was verified by Staff #6. In addition there was no current health certificates on file for LPN #1 and #2 and for TME #1. This was verified by the lead counselor.	I 206	See tag # 1203.	10/2/09
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 record review and staff interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure that first aide, cardiopulmonary resuscitation (CPR) had been completed for 1 of 7 direct care staff and three of three Licensed Practical Nurses' (LPN). (Staff #2 and LPN #1, #2 and #3) The findings include:	I 227	See tag # 1203.	10/2/09

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I 227	Continued From page 3 Interview with the Lead Counselor and review of the GHMRP's personnel files conducted on August 26, 2009, at approximately 1:50 p.m., revealed the GHMRP failed to provide evidence of CPR training for Staff #2 and LPN's #1, #2, and #3. This was verified by the lead Counselor.	I 227		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to maintain each residents' record, for one of the two residents (Resident #1) included in the sample. The finding includes: Interview with the GHMRP's residential director on August 27, 2009 at 2:55 p.m., revealed Resident #1 was employed and received a paycheck every two weeks and Social Security Income (SSI). Review of the resident's financial records on the aforementioned date revealed that the resident was employed in the year of 2008. Interview with the residential director and review of the Bank Statements revealed two checks had been deposited for February 6, 2009 in the amount of \$181.18 and on February 20, 2009, \$113.96 was deposited. According to the residential director, Resident #1 works Monday through Friday and earns \$7.00 per hour.	I 260	<i>Lead Counselors weekly 10/5/09 will verify that individuals financial records are complete and in the facility. QMRP's will monitor the financial records monthly and QA will provide quarterly oversight.</i>	

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I 260	Continued From page 4 Further review of the resident's financial record revealed that there was no documented evidence of SSI deposits from September 2008 through March 2009. At the time of the survey, the GHMRP failed to provide documented evidence of consistent deposits for Resident #1's earned income and SSI payments.	I 260		
I 412	3520.13 PROFESSION SERVICES: GENERAL PROVISIONS If a resident evidences the need for a professional service for which arrangements do not exist, the GHMRP shall have fourteen (14) days to show evidence of arrangements for provision of the professional service, except that in life threatening situations, arrangements must be made immediately. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Person (GHMRP) failed to ensure professional services were arranged for two of two residents (Residents #1 and #2) included in the sample. The finding includes: 1. During the entrance interview on August 26, 2009, at approximately 11:25 AM revealed that Resident #1 received medicaid waiver services. Review of the resident's medicaid waiver authorization on the aforementioned date revealed that an initial "Speech, Hearing and Language Therapy" assessment had been approved. Interview with the qualified mental retardation professional (QMRP) on August 27,	I 412	1. QMRP has made the contact with [redacted] (Speech Therapist) and monthly [redacted] will submit therapy progress notes. QMRP will notify DDS service Coordinator if documentation is not forwarded.	10/2/09



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1412	<p>Continued From page 5</p> <p>2009 revealed that the resident was seen by speech therapist twice a week. Review of Resident #1's habilitation record on August 27, 2009, at 9:41 a.m. revealed no documented evidence of a Speech-Language Evaluation. At the time of the survey, the GHMRP failed to make an arrangement for Resident #1 to obtain a speech-language assessment.</p> <p>2. Interview with the GHMRP's qualified mental retardation professional (QMRP) on August 27, 2009, at approximately 10:50 a.m. revealed that Resident #2 received psychotropic medication in conjunction with a behavior support plan (BSP) to manage his behaviors.</p> <p>Review of Resident #2's medical record on the aforementioned date revealed a physician's order dated August 2009. Continued review of the physicians's order revealed the resident was prescribed Mellaril 100 mg for Impulse Control disorder. The resident also had a physician's order for a EKG to be conducted every three months.</p> <p>Review of the resident's nursing quarterly dated December 31, 2008, revealed Resident #2 received an EKG on October 10, 2008.</p> <p>Interview with the designated nurse and review of the resident's medical record on August 27, 2009 at 1:19 p.m., revealed no documented evidence that the resident had another EKG since October 2008, and was not scheduled to have one.</p> <p>At the time of the survey, the GHMRP failed to ensure Resident #2 received an EKG every three months as recommended.</p> <p>3. Interview with the GHMRP's qualified mental retardation professional (QMRP) on August 27,</p>	1412	<p>2. The assigned LPN is required to review records monthly and responsible for scheduling all follow up appointments. Additionally the Supervising RN is required to review records quarterly to ensure all follow-ups are scheduled and completed. Clinical Director will provide oversight of RN and provide plan of correction for any deficiency noted.</p>	10/2/09

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1412	Continued From page 6 2009 at approximately 10:50 a.m. revealed that Resident #2 received psychotropic medication in conjunction with a behavior support plan (BSP) to manage his behaviors. Review of the resident's medical record on August 27, 2009, revealed that the resident was monitored by a psychiatrist through monthly medication reviews, however there was no documented evidence that the resident had a psychiatric evaluation. Continued review of the psychotropic medication reviews revealed no reviews for October 2008 through December 2008. At 12:35 PM, the surveyor was escorted to the nurse's station for an interview with the LPN. Interview with the LPN revealed they purged the medical records and she proceeded to look for a psychiatric evaluation and the missing aforementioned psychotropic medication reviews. At the time of the survey, the LPN was unable to find a psychiatric evaluation and the aforementioned psychotropic medication reviews for Resident #2. 4. Review of Resident #2's medical record on August 27, 2009, at 11:29 a.m. revealed an audiology appointment on March 24, 2009. Interview with the staff on August 27, 2009 at approximately 11:32 a.m., revealed that although the resident was transported for the appointment, when they arrived, the receptionist indicated that the resident was not on their schedule for audiology. At 1:23 PM, an interview was conducted with the LPN to ascertain information regarding a rescheduled appointment. According to the LPN, the audiology appointments was only scheduled annually. It should be noted that the resident was last seen by the audiologist in 2008.	1412	3. Medical record more than a year old are typically purged from the medical record and kept for 5 years, in compliance GHRMP regulations. The psychotropic medication review and psychiatric evaluation are at the nurses station and are available for review. 4. As per recommendation by the PCP resident #2 does not require annual audio eval because he is legally deaf.	10/2/09. 10/2/09.

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1412	Continued From page 7 At the time of the survey, the GHMRP failed to ensure Resident #2 was seen annually as recommended. Review of Resident #2's medical record on August 27, 2009, at 11:36 a.m. revealed the resident was seen by the dentist on November 11, 2008. The resident was diagnosed with multiple missing teeth and periodontals disease. Continued review of the consult revealed that the resident was scheduled to return on November 25, 2008. Further review of the medical record revealed that the resident returned to the dentist on August 5, 2009, nine months later. At the time of the survey, the GHMRP failed to ensure that Resident #2 was transported for his follow-up dental appointment scheduled for November 25, 2009.	1412	5. see tag # 1412 #2.	10/2/09
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with D.C. Law 2-137 (now Title 7, Chapter 13), and this chapter for two of the residents (Resident #1 and #2) included in the sample. The findings include:	1500		

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I 500	Continued From page 8 Section 7-1305.05 (g). [Formerly 6-1965] The facility failed to ensure the resident's right to receive prompt and adequate medical attention, as evidenced below: 1. Review of Resident #1's medical record on August 26, 2009 at 12:38 p.m. revealed a physician's order dated May 19, 2009. Continued review of the physician's order revealed the resident was prescribed Motrin 400 mg 1 tab three times day pm (as needed). Interview with the GHMRP's staff on August 26, 2009 revealed the resident was seen by his primary care physician (PCP) on May 19, 2009. Further interview with the staff revealed the PCP examined the resident and diagnosed him with a swollen shoulder. According to the staff, Resident #1's PCP ordered an x-ray for the resident on the same day, but was unable to get one, because the x-ray department was closed. Interview with the residential nurse was conducted on August 27, 2009 at 1:10 p.m. to ascertain information regarding if the resident had been rescheduled for the x-ray of his shoulder. Initially, the residential nurse reported that she had no knowledge about the x-ray, but that it should have been rescheduled. At the time of the survey, the facility failed to ensure Resident #1 received adequate medical attention. 2. Review of Resident #1's medical record on August 26, 2009 at 2:44 p.m., revealed the resident had a dental appointment on March 9, 2009. Interview with the staff revealed that although the resident was transported for the appointment he would not allow the dentist to	I 500	1. See 1412 #2. 2. See 1412 #2.	10/5/09 10/5/09

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1500	<p>Continued From page 9</p> <p>examine him. Continued review of the dental consult revealed that the resident was last seen by the dentist on January 24, 2008. According to the consult, the dentist recommended Debridement (full mouth) and Subgingival Scale of four quadrants. The dentist also indicated that "in order for the aforementioned treatment to be carried out, the patient will require additional sedation."</p> <p>Review of the the resident's habilitation record on August 26, 2009, revealed Resident #1 had a psychological assessment dated March 4, 2008. The psychological assessment indicated that the resident did not evidence the capacity to make informed decisions on his behalf regarding his ongoing medical treatment or the capacity to choose someone to make these decisions.</p> <p>Interview with the residential nurse and revealed that Resident #1 had a guardian but the GHMRP had difficulty getting in touch with her. Further review of the psychological assessment verified that the resident had a limited guardian to provide consent for any invasive or ongoing medical treatment.</p> <p>At the time of the survey, the facility failed to ensure Resident #1 received adequate medical attention.</p> <p>3. Review of the GHMRP's incident reports on August 26, 2009 beginning at 11:30 a.m., revealed Resident #2 had been involved in an incident on July 27, 2009. Continued review of the incident revealed one of the GHMRP's trained medication employees (TME) discovered the resident's left ring finger was injured. The resident's injury was brought to the staff's attention and reported to the nurse's station via</p>	1500			3. See 1412 #2. 10/5/09

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I 500	<p>Continued From page 10</p> <p>telephone. According to the incident report, the GHMRP's LPN and RN examined Resident #2's finger and determined that he should be seen by a physician. The report stated that the resident was taken to the hospital.</p> <p>Interview with GHMRP's direct care staff on August 26, 2009 at 11:45 a.m. was conducted to ascertain information regarding the emergency room visit and the resident's diagnosis. Further interview with the direct care staff revealed the resident's finger appeared to be smashed, however, the direct staff informed the surveyor that the resident was not taken to the emergency room. At 12:53 p.m. the GHMRP's LPN was interviewed regarding the aforementioned incident. The LPN reported that she was not the residential nurse for this facility, but would review Resident #2's medical record for detailed information. The LPN reviewed the resident's medical record which revealed a nursing note that indicated Resident #2's finger was swollen and the finger nail was missing. Additionally, the LPN indicated that the note had a recommendation for the resident to be seen by his primary care physician (PCP).</p> <p>Interview with the residential nurse on August 27, 2009 revealed that she did recall the incident and remembered that the resident was not seen by the PCP. Additionally, the residential nurse revealed that Resident #2 stayed home and did not attend his day program the next day (July 28, 2009).</p> <p>At the time of the survey, the GHMRP failed to ensure Resident #2 received prompt and adequate medical attention.</p>	I 500		

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R 000	INITIAL COMMENTS A licensure survey was conducted from August 26, 2009 through August 27, 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		
R 120	4701.1(a) BACKGROUND CHECK REQUIREMENT No facility shall employ or use the contract services of an unlicensed person if: (a) The person has been convicted of a criminal offense listed in section 4705.1 of these rules within the seven (7) years prior to a criminal background check conducted pursuant to these rules; or... This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have background checks completed for 2 of 2 Trained Medication Employees (TME). (TME #1 and #2) The finding includes: Interview with the lead counselor on August 26, 2009 at 1:55 p.m. and review of the staff personnel records, revealed that two TME 's assigned to this facility failed to have criminal background checks in their records. This was verified by the lead counselor.	R 120	See Tag # 1203.	10/2/09

Health Regulation Administration

Michael Hansen

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Program Director

(X6) DATE

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