Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/22/2012
NAME OF PROVIDER OR SUPPLIER WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 302 'S' ST, NE WASHINGTON, DC 20002		

(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
I 000	INITIAL COMMENTS	I 000		
	A licensure survey was conducted from June 20, 2012 through June 22, 2012. A sample of three residents was selected from a population of five men with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home, interviews with direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]			
I 206	3509.6 PERSONNEL POLICIES	I 206	Ward & Ward's H.R. Dept. weekly reviews the staff's certification data base that contains all the dates of staff's certifications, including health. Those certifications that will expire in 30 days or less are highlighted. This prompts HR to generate a form letter (enclosed) to staff as a reminder to renew certification. The identified direct care staff's physician recommended follow up in 2	
	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 group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for one of the six direct care staff and two of seven consultants. The findings include: On June 20, 2012, beginning 3:00 p.m., review of			

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I 206	Continued From page 1 the personnel records failed to show evidence of a current physician's health inventory/certificate for one direct care staff and two consultants. At approximately 3:20 p.m., on the same day, interview with the qualified intellectual disabilities professional (QIDP) confirmed that there was no evidence of health inventories performed by a physician for the aforementioned personnel.	I 206	years and that date was mistakenly entered into the data base. Additionally, all consultant's certification dates will be entered into the data base to ensure compliance. 7-10-12	
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on interview and record review the Group Home for Person's with Intellectual Disabilities' (GHPID) nursing staff failed to maintain the Medication Administration Record (MAR) for one of one resident in the sample. (Resident #3) The findings include: Review of the facility's incident reports on June 20, 2012, beginning at approximately 10:04 a.m. revealed Resident #1 was involved in an incident dated December 14, 2011. According to the report, the resident complained of stomach pain, experienced vomiting and a loose stool. Further review of the report revealed that the resident was taken to the emergency room and admitted with a diagnosis of acute chronic small bowel obstruction. The resident was discharged on December 22, 2011. Review of the discharge summary revealed the resident experienced diarrhea and mild gastroenteritis on top of his partial small bowel obstruction during his hospitalization.	I 474	Ward & Wards Nursing Dept. each month receives new MAR's for each individuals and LPN's transcribe from the previous month any missing medications onto the new MAR. RN's provide oversight in monitoring MAR's to ensure accuracy month to month. Upon review the new medication was not written on the January 2012 MAR. The Assigned LPN, [redacted] was terminated and the assigned RN, [redacted] received ~~two~~ written reprimand and placed on	

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I 474	Continued From page 2 Review of Resident #1's medical record on June 20, 2012, at approximately 2:13 p.m. revealed the resident was seen by his gastroenterologist on December 27, 2011. The gastroenterologist recommended Probiotic #30 one tab, once a day and to monitor for possible reoccurrence of bowel obstruction. Review of the medication administration records (MAR) revealed the resident was administered the Probiotic on December 28, 2011 through December 31, 2011. Although the medication was started on December 28, 2011, there was no documented evidence that Resident #1 received the aforementioned medication again until February 2012. At the time of the survey, the facility failed to provide evidence that a medication administration record MAR) had been maintained for Resident #1 for January 2012.	I 474	90 day probation (enclosed) to be monitored by the D.O.N. 7-10-12	