

Health Regulation & Licensing 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 08/24/2011
NAME OF PROVIDER OR SUPPLIER WARD & WARD		STREET ADDRESS, CITY, STATE, ZIP CODE 7011 9TH ST, NW WASHINGTON, DC 20012	

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1 000 INITIAL COMMENTS

1 000

On August 3, 2011, the Department of Health (DOH) received notification of a complaint from an anonymous individual via US mail. The complainant identified the following concerns:

Allegation #1: Theft and misuse of resident monies.

Findings: Interview with management staff and the review of the resident's financial records failed to reveal mismanagement of resident funds.

Conclusion: This allegation could not be substantiated.

Allegation #2: Resident abuse and neglect.

Findings: Interview with the facility's administrator and the review of the facility's incident management system failed to show evidence of abuse/neglect. Deficiencies, however, were cited for failure to report significant incidents to DOH timely.

Conclusion: This allegation could not be substantiated.

Allegation #3: Falsification of documentation.

Conclusion: This allegation could not be substantiated.

Allegation #4: Unsanitary living conditions.

Findings: Deficiencies were cited in the area of housekeeping.

Conclusion: This allegation could not be

Received 10/28/11

**Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002**

Health Regulation & Licensing Administration

Michael Warren

TITLE *Program Director* (X6) DATE *10/24/11*

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

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1000	<p>Continued From page 1</p> <p>substantiated.</p> <p>Allegation #5: Individuals given wrong medication and reported medication errors.</p> <p>Findings: Review of the facility's medical records failed to evidence any incidents of individuals receiving the wrong medication. Deficiencies, however, were cited for the facility's failure to coordinate health care services and maintaining medication administration records.</p> <p>Conclusion: This allegation could not be substantiated.</p> <p>Allegation #6: Hostile work environment.</p> <p>Findings: Interviews conducted with facility employees failed to evidence a hostile work environment.</p> <p>Conclusion: This allegation could not be substantiated.</p> <p>An onsite investigation was conducted from August 12, 2011 thru August 24, 2011.</p> <p>The findings of this investigation were based on observations, interviews with direct care staff, the agency's management staff, and a review of the clinical, financial and administrative records. Additionally, this investigation included a review of the facility's incident management system. The report includes incidental findings discovered during the investigative process.</p> <p>[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within</p>	1000	

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1000	Continued From page 2 this report].	1000		
1379	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 interfere\$ 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 staff interview and record review, the facility failed to ensure that all incidents were reported immediately to the other officials in accordance with State Law as required by DC Regulation (22 DCMR Chapter 35 Section 3519.10) for one of the four residents in this investigation. (Resident #4) The finding includes: The facility failed to ensure timely reporting of significant incidents to the regulatory agency as evidenced below: On April 5, 2011, the Facility Manager (FC) failed to report that Resident #4 allegation that he was slapped. In addition, there was no evidence that a medical assessment or an investigation had been completed.	1379	1379: Please find attached the incident report dated 4-5-10, that indicated that the incident was investigated and closed. Further find attached our reporting requirements that include Dept of Health notification that was revised on 8/2/11.	

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I 401	Continued From page 3	I 401	1401. Please find attached a prescription dated 8/24/11 from Dr. Richard Wilson (PCP). Further attached is the August 2011 P.O. which is signed by PCP. On that order revisions have been made to include the recommendations made by the January 2011 GYN consult. Additionally the assigned LPN is responsible for reviewing the record weekly and providing a monthly report. The assigned RN provides oversight monthly and submits a quarterly report to ensure that	
I 401	<p>3520.3 PROFESSIONAL SERVICES: GENERAL PROVISIONS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included treatment services, and services designed to prevent deterioration or further loss of function by the resident for one of four residents in the facility. (Resident #3)</p> <p>➔ The finding includes:</p> <p>The group home for persons with intellectual disabilities (GHPID) GHPID's nursing service failed to ensure Resident #3's primary care physician (PCP) was made aware of the gynecologist's recommendations on January 5, 2011, as evidenced below:</p> <p>On August 22, 2011, at approximately 8:05 a.m., observation of the morning medication administration pass revealed Resident #3 was administered Multivitamin one (1) tablet and Calcium Citrate 1000 plus Vitamin D 80 IU by mouth. Interview with Trained Medication Employee (TME) revealed the medications were prescribed as nutritional supplements.</p> <p>Review of Resident #3's August Medication Administration Records (MAR's) on August 22,</p>	I 401		

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I 401	Continued From page 4 2011, at approximately 8:25 a.m., revealed Multivitamin one (1) tablet and Calcium Citrate 1000 plus Vitamin D 80 IU by mouth every day was transcribed and initialed on the MAR. Review of Resident #3's available physician's order (PO's) dated June, July and August 2011, on August 23, 2011, at approximately 11:45 a.m., revealed no PO's for Multivitamin one (1) tablet and Calcium Citrate 1000 plus Vitamin D 80 IU by mouth every day. Review of Resident #3's gynecologist consult dated January 5, 2011, on August 23, 2011, at approximately 1:35 p.m., revealed a recommendation for Multivitamin one (1) tablet and Calcium Citrate 1000 plus Vitamin D 80 IU by mouth every day. Interview with the facility's Director of Nursing (DON) and Licensed Practical Nurse (LPN) on August 24, 2011, at approximately 2:00 p.m., revealed the facility nursing staff did not inform Resident #3's PCP of the aforementioned consultant's recommendations dated January 5, 2011. There is no evidence coordination of care was provided between the Resident #3's PCP and gynecologist.	I 401	<i>there is coordination between the physicians and the individuals are receiving all medical supports that are needed.</i>	
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 observation, interview and record review, the GHMRP failed to ensure nursing staff	I 474		

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I 474	Continued From page 5 maintained Medication Administration Records (MAR) for one of the four residents included in the investigation. (Resident #4) The finding includes: During administration of the medication on August 22, 2011, at approximately 7:30 a.m., Resident #4 received one Multi-vitamin tablet, Ferrous Sulfate 325 mg and Enpresse 6- 5-10 by mouth. Review of the Medication Administration Record (MAR) on August 22, 2011, at approximately 8:05 a.m. revealed no documented evidence of a MAR for the month of August 2011. Interview with the Trained Medication Employee (TME) on August 22, 2011, at approximately 8:10 a.m. revealed Resident #4's August MAR was not available in the facility. Interview with the facility's Director of Nursing (DON) and Licensed Practical Nurse (LPN) on August 24, 2011, at approximately 2:00 p.m., confirmed the August MAR was not in the facility at the time of the investigation. The GHPID failed to provide evidence that a MAR had been maintained for Resident #4 for the month of August 2011.	I 474	<i>Please find attached the September 2011 MAR's for individual # 4. Additionally the LPN will monitor MAR's at least weekly and the RN will provide monthly oversight to ensure accuracy when medications are administered.</i>	