Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0017	A. BUILDING _____ B. WING _____	08/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARD & WARD	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 A licensure survey was conducted from August 13, 2009 through August 14, 2009. A random sample of two residents was selected from a resident population of three men 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	Recewel 10/9/09 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 090	3504.1 HOUSEKEEPING 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 five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The findings include: On August 14, 2009, beginning at 10:28 a.m., a walk through of the GHMRP with the house manager (HM) revealed the following: Interior 1. The inside door frame located in the kitchen was observed with peeling paint. 2. The basement wall was covered with brown	I 090	Lead Counselor's are required to complete a facility checklist weekly to identify any maintenance concerns. Depending on the nature of the repair maintenance has 72 business hours to respond. QMRP's are to provide monthly oversight of the check list to ensure all repairs are completed. Additionally maintenance has done the following: 1. Painted the inside door frame in kitchen 2. Basement walls have	10/5/09 10/5/09

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TITLE (X6) DATE

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

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I 090	Continued From page 1 substance that the HM could not identify. 3. There was cob webs observed around the window located near the wall with the brown substance. 4. The window blinds located in the kitchen near the cabinets was observed with a build up a dust. Exterior 1. The steps leading into the front of the GHMRP was observed to be in need of treatment. 2. The wood including the poles, side of the steps, and the porch was observed with faded and peeling paint located in the front of the GHRMP. The HM and direct care staff acknowledged that all of the aforementioned maintenance issues listed above needed to be addressed.	I 090	Cont. #2. been painted 3. Removed cob webs and cleaned window. 4. Replaced blinds in kitchen. Exteriors: 1. Steps were treated and painted with stain. 2. Entire porch was repainted with stain.	10/5/09 10/5/09 10/5/09 10/5/09
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 five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The findings include:	I 091		

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I 091	Continued From page 2 Observation and interview with the house manager (HM) during the environmental walk through on August 14, 2009, beginning at 10:28 a.m., revealed the following: Interior 1. The vent cover located underneath the stove toward the back was observed to be ripped. 2. The blinds located over the window air condition unit were observed to be torn. 3. The majority of the windows throughout the GHMRP including all residents' bedrooms, kitchen, basement, and living room was observed without window screens. 4. Torn blinds were observed in Resident #5's bedroom located near the inoperable fire place. 5. There was a large whole located in the residents' bathroom located on the second level. 6. There was cable wire that exposed sharp nails detached from the wall leading into residents #3 and #4 bedroom. The cable wire also presented a safety hazard. Exterior 1. The screen door located in the kitchen was observed with several holes and tears. 2. There was an approximate two (2) inch nail sticking out of the pole located on the front porch. There was a half inch nail sticking out of the same pole located on the front porch.	I 091	1. Replaced hood range. 2. Replaced blinds. 3. Replaced and installed Screens. 4. Replaced blinds. 5. Repaired hole in wall and painted. 6. Repaired the cable wire installation. Exterior: 1. Installed new screen door. 2. Repaired exposed nails.	10/5/09 10/5/09 10/5/09 10/5/09 10/5/09 10/5/09 10/5/09 10/5/09

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I 091	Continued From page 3 The HM and direct care staff acknowledged that all of the aforementioned maintenance issues listed above needed to be addressed.	I 091		
I 092	3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents and vermin. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure it was maintained free of insects for five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The finding includes: On August 13 and 14, 2009, there were several ants observed inside the door located in the kitchen. Interview with the house manager (HM) on August 14, 2009, at approximately 12:15 PM revealed that the GHMRP had a contract with a pest control company. However, when asked, the HM was unable to locate any receipts and/or a service contract upon request.	I 092	Ward & Ward has a Contract @ American Pest to provide monthly service for our facilities. Receipts for service are now maintained at the facility instead of our main office and are available for review.	10/5/09.
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to store poisons and caustic agents in a locked cabinet and/or out of direct reach of each	I 095	Lead Counselors complete a weekly checklist that includes proper storage of caustic agents. Additionally, the QMRP reviews checklist to monitor and correct any deficiencies. (See attached)	10/5/09

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I 095	Continued From page 4 resident. The finding includes: During the environmental walk-thru on August 14, 2009, beginning at 10:28 a.m., caustic agents (i.e. fabulous all purpose cleaner, bleach, and lemon cleaning agent) were observed being stored openly underneath the residents' bathroom. The residents were observed to use the bathroom several times prior to the environmental walk-thru. Continued environmental walk-thru of the basement revealed clorox, washing powders, and oven cleaner was being stored openly. Residents were observed in the basement with direct care staff retrieving their laundry. This was confirmed with interview with the direct care staff on the same day at approximately 11:30 a.m.	I 095		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in 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 interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for five of five residents residing in the GHMRP. (Residents #1, #2, #3, #4, and #5) The finding includes: Interview with the house manager (HM) on August 13, 2009, at 11:13 a.m., revealed the GHMRP had five shifts of direct care personnel. The shifts were weekdays 8 AM - 4 PM, 4 PM -	I 135	Ward & Ward will provide facility with file cabinet to maintain purged records to ~~nt~~ Comply with regulation to maintain records for 5 years. Lead Counselor and QMRP will oversee the storage of purged records to ensure availability.	10/5/09

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I 135	Continued From page 5 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 July 2008 to July 2009. Review of the fire drill log book on August 13, 2009, at approximately 11:15 AM, revealed there were no fire drills conducted from August 2008 to December 2008 on each shift. Interview with the HM revealed that the August 2008 to December 2008 fire drills were filed away. On August 14, 2009, at approximately 12:45 p.m., the surveyor requested the aforementioned fire drills from the HM again. The HM was not able to produce the fire drills.	I 135		
I 136	3505.6 FIRE SAFETY Each GHMRP shall maintain records of each simulated fire drill. This Statute is not met as evidenced by: Based on interview and record review revealed that the GHMRP failed to ensure fire drills records were monitored and accurately completed. The finding includes: The GHMRP failed to ensure the accurate documentation and record keeping of all fire drills conducted. [See citation 3505.5]	I 136	See I135.	10/5/09
I 161	3507.2 POLICIES AND PROCEDURES	I 161		

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I 161	Continued From page 6 The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP governing body failed to review its policies and procedures annually. The finding includes: On August 13, 2009, at approximately 11:38 a.m., review of the policy and procedure manual failed to provide evidence that the agency's policy manual had not been reviewed and approved annually by the governing body as required. The last noted date for review was on March 5, 2008. Interview with the house manager (HM) on the same day at approximately 11:43 a.m., revealed that she would contact the main office to see if there was an updated copy the signature sheet. At approximately 11:50 a.m., the HM stated that the main office did not have a current signature for the policy and procedures manual.	I 161	The Governing body reviewed and signed Policy and Procedures manual on 3-5-09. a copy of the signature Page has been sent to all facilities. (See attached)	10/5/09.
I 164	3507.4(b) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (b) Physical environment, which covers housekeeping, maintenance, household items and furnishings; This Statute is not met as evidenced by: Based on interview and review of records the GHMRP failed to ensure that a policy to address physical environment was include in its policy and procedure manual for five of five residents	I 164	The policy and Procedure manual that was approved by the Governing Body on 3-5-09 on page 27 the Policy: Preventive Maintenance for Facilities addresses the physical environment. (See attached)	10/5/09

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I 164	Continued From page 7 residing in the facility. (Residents #1, #2, #3, #4, and #5) The finding includes: On August 13, 2009, at approximately 12:05 p.m., interview with the house manager (HM) and review of the personnel policies and procedures manual failed to have a policy on physical environment which covered cleaning the kitchen, and housekeeping.	I 164		
I 166	3507.4(d) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (d) Record keeping, which covers resident records, administrative records, and confidentiality of records; This Statute is not met as evidenced by: Based on interview and record review, the facility failed to have a policy on record keeping for five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The finding includes: On August 13, 2009,at approximately 12:10 p.m., interview with the house manager (HM) and review of the personnel policies and procedures manual revealed, the GHMRP failed to have a policy on recording keeping at the time of the survey.	I 166	The Policy & Procedure Manual that was approved by the Governing Body on 3/5/09 has a policy on Page 157 Confidentiality/ Privacy. In section '3' of that policy it addresses residents records, admin. records and confidentiality of records. (See attached)	10/5/09
I 184	3508.5(a) ADMINISTRATIVE SUPPORT	I 184		

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I 184	Continued From page 8 Each GHMRP shall have an organization chart that shows the following: (a) All major components of the administering agency or the roles of individuals when the licensee is not an agency; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide an organizational chart reflecting the changes in the components of the agency's staffing structure. The finding includes: Review of the agency's policy and procedure manual on August 13, 2009, at approximately 12:20 p.m. failed to evidence an organization chart reflecting the changes in the components of the agency's staffing structure and lines of authority. Interview with the HM on the same day at approximately 12:30 p.m., revealed that she was recently placed as the HM for this GHMRP location. Further interview with the HM revealed that the GHMRP had a new qualified mental retardation professional for this group home.	I 184	The Policy & Procedure Manual that was approved by the Governing Body on 3/5/09 contains an Organizational chart that reflects agencies staffing structure. Change of assignments within the same job description does not indicate a structure change. (See attached)	10/5/09
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and review of records, the GHMRP failed to establish and maintain a system that ensures a complete and accurate accounting of residents' funds that are entrusted to the facility for three of three residents included in the sample. (Residents #1, #2, and #3)	I 189	Lead Counselors weekly will verify that the financial records are in the facility. QA will provide oversight to ensure records are in facility.	10/5/09.

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I 189	Continued From page 9 The finding includes: On August 13, 2009, at approximately 10:20 a.m., a request for the residents' financial records was requested from the house manager (HM) by August 14, 2009 no later than 10:00 AM. Interview with the HM on August 14, 2009, approximately 12:50 PM revealed that all the residents' records could not be retrieved and that she did not have all the documents to justify the residents' expenditures/receipts. The GHMRP failed to have files detailing funds accounting for Resident #1's, #2 and #3 monies received and disbursed at the time of the survey.	I 189		
I 203	3509.3 PERSONNEL POLICIES 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 GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter for six of seven employees. (Staffs #1, #2, #3, #4, #6, and #7) The finding includes: Interview with the house manager and review of the GHMRP's personnel files on August 13, 2009, beginning at 12:40 a.m., revealed the GHMRP failed to provide evidence that six direct care staff had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter.	I 203	QMRP's and Clinical Dir. are required quarterly to review staff's personnel records and ensure all required certifications are current. Additionally, Personnel Dept. will generate notices 30 days in advance of any certifications expiration to ensure current certifications.	10/5/09

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I 206	Continued From page 10	I 206		
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 four of seven direct care staff, five of five consultants, two of two nurses, and two of two trained medication employees (TME). The findings include: Interview with the house manager (HM) and review of the personnel records on August 13, 2009, beginning at 12:40 p.m., revealed the following: 1. The GHMRP failed to provide evidence that current health certificates were on file for four of seven direct care staff. (Staffs #1, #2, #4, and #7) 2. The GHMRP failed to provide evidence that current health certificates were on file for five of five consultants. The consultants' files were requested on August 13, 2009, at approximately 10:20 a.m.; however, there were not available for	I 206	1. See 1203. 2. See 1203.	10/5/09 10/5/09

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I 206	Continued From page 11 review. 3. The GHMRP failed to provide evidence that current health certificates were on file for two of two nurses. The nurse's files were requested on August 13, 2009, at approximately 10:20 a.m.; however, there were not available for review. 4. The GHMRP failed to provide evidence that current health certificates were on file for two of two TMEs. The TMEs files were requested on August 13, 2009, at approximately 10:20 a.m.; however, there were not available for review.	I 206	3. See 1203. 4. See 1203.	10/5/09 10/5/09
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 interview and record review, the GHMRP failed to ensure two of two 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 two of two nurses (Nurse #1 and #2) and two of two trained medication employees (TME). (TME #3 and #4) On August 13, 2009, beginning at approximately	I 227	See 1203.	10/5/09

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I 227	Continued From page 12 12:40 p.m., the nursing files were requested by the HM along with the TMEs files. On August 14, 2009, at approximately 12:00 p.m., the personnel files were requested again by the surveyor. The HM returned from the agency's office and stated that she was not authorized to transport the nurses and TMEs files to the facility.	I 227		
I 240	3511.1(a) DIRECT CARE STAFF RATIOS The minimum daily ratio of on-duty, direct care staff to residents in each GHMRP that serves severely physically handicapped residents, residents who are aggressive, assaultive or security risks, residents who manifest severely hyperactive or psychotic-like behavior, and other residents who require considerable adult guidance and supervision shall be not less than the following: (a) 1:4 during the waking hours of the day, approximately 6:00 a.m. to 10:00 p.m., when residents remain in the GHMRP during the day; and... This Statute is not met as evidenced by: Based on observations, interview, and record review the GHMRP failed to have direct care on duty to meet the needs of five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The finding includes: Upon my arrival to the group home on August 14, 2009, at approximately 8:25 a.m., Resident #3 was observed to run off the front porch in an attempt to hug a female that was walking by. The female pushed Resident #3 away gently and continued on walking. At 8:27 a.m., Staff #2 was	I 240	The posted staff schedule does comply with the government staffing ratio's at all times. However on 8/14/09 the individual's did not attend their day programs in order to attend funeral services. The HM (M) ~~did not~~ only had one additional staff instead of two. HM and QMRP have been made aware of staffing ratio requirements and ensure Compliance at all times.	10/5/09

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	HFD12-0017	A. BUILDING _____ B. WING _____	08/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARD & WARD	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 240	Continued From page 13 observed coming from the side of the group home. At no time was any staff observed in sight to redirect and/or prevent Resident #3 from leaving the front porch to hug the female. Continued observation at 8:47 a.m., revealed Resident #5 in the kitchen alone while Staff #2 was outside with other residents. At 8:53 a.m., Residents #1 and #2 was outside sitting on the front porch alone while Staff #2 was inside assisting the other residents with laundry. Interview with Staff #2 on the same day at approxiamtly 8:40 a.m., revealed that he was the only staff on duty with all five residents. Staff #2 further revealed that all residents' remained home from day program in order to attend a viewing from the passing of one of their administrators. At 11:30 a.m., the house manager (HM) and the qualified mental retardation professional (QMRP) arrived to the group home from grocery shopping. Shortly after Staff #2 and the residents assisted with bringing the groceries inside the facility, Staff #2 and the QMRP left the facility. When asked by the surveyor, the HM stated that she was the only staff on duty working with all five residents. The HM further stated that there should be at least two staff on duty when all five residents are home during the day. The HM indicated that they were short staff. On August 14, 2009, at 3:00 p.m., review of Resident #1's medical book revealed a diagnosis of intermittent explosive disorder and was prescribed Zyprexa 2.5 mg for his maladaptive behaviors (aggression toward peers) which was incorporated into his behavior support plan (BSP). This was confirmed with the director of nursing who administered the medication during the medication administration on August 13, 2009	I 240		

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I 240	Continued From page 14 at 5:42 p.m. On August 14, 2009, at 3:38 p.m., review of Resident #3's medical book reveald a diagnosis of intermittent explosive disorder, psychotic disorder and was prescribed Risperdal 2 mg for his maladaptive behaviors (stealing, hoarding, inappropriate touching/body boundary violation) which was incorporated into his behavior support plan BSP. This was confirmed with the director of nursing who administered the medication during the medication administration on August 13, 2009 at 5:40 p.m. It should be noted that Residents #4 and #5 were prescribed psychotropic medications and had BSPs to address their maladaptive behaviors. At the time of the survey, there was no evidence the GHMRP had adequate staff to effectively supervise and address eadh resident's behavioral needs.	I 240		
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure records were available for inspection at all times by personnel of authorized regulator agencies for five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The finding includes:	I 261	Records that are kept at the main office that are requested for review will be brought to the facility at the time of the survey.	10/5/09

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I 261	Continued From page 15 On August 13, 2009, at approximately 10:20 a.m., during the entrance conference a request was made for various documents including the Human Rights Committee (HRC) minutes, contracts, nurses, and consultant files to be provided on August 14, 2009, by 10:00 a.m. Interview with the house manager (HM) on August 13, 2009 revealed that the aforementioned documents were in the main office. On August 14, 2009, interview with HM by telephone at approximately 11:00 a.m. revealed that she was at the main office requesting the documents. The HM stated that she was not authorized to transport the aforementioned documents from the main office to the group home. The HM further stated that I (surveyor) would have to drive up to the main office to look at the requested documents. At the time of the survey, the GHMRP failed to ensure the availability of documents for review during inspection.	I 261		
I 272	3513.1(c) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (c) Weekly staff schedules, including substitutions; This Statute is not met as evidenced by: Based on interview and record review, the facility failed to maintain a weekly staff schedule, to reflect current employees and substitutions. The finding includes: The facility failed to have a staff schedule in the	I 272	Staffing schedules are posted monthly in each facility. Additionally a copy of each facilities schedule is kept by the Programs Director. (see attached)	10/5/09

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I 272	Continued From page 16 facility. On August 13 and 14, 2009, a request was made to the house manager (HM) regarding the weekly staffing schedule. At the time of the survey, the HM stated that she could not retrieve a staff schedule.	I 272		
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 one of three residents included in the sample. (Residents #2) The finding includes: On August 13, 2009, beginning at 10:45 a.m., review of the GHMRP unusual incident report log book revealed an incident report dated October 10, 2008. The incident report revealed that on the morning of October 10, 2008, at 6 a.m., Resident #2 complained that he was not feeling well and was not acting like himself. The nurse arrived at the group home at 7:15 a.m. to assess	I 379	In compliance with incident management reporting procedures and government regulations, the QMRP's are responsible for reporting incidents to all required agencies, (see attached.), in addition to the incident management reporting on the MCIS system.	10/5/09

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I 379	Continued From page 17 Resident #2. After the assessment, the nurse transported Resident #2 to the hospital emergency room where he was admitted. Interview with the licensed practical nurse (LPN) on August 13, 2009, at approximately 3:20 p.m., revealed that she transported Resident #2 to the hospital on October 10, 2008. The LPN further revealed that Resident #2 remained hospitalized for six (6) days due to abdominal pain and a small bowel obstruction. This was confirmed through review of Resident #2's medical records on August 13, 2009, 4:06 p.m. Resident #2 medical records revealed a "Transfer Summary" from the hospital dated October 16, 2008. The summary indicated that Resident #2 was admitted on October 10, 2008 with complaints of abdominal pain and small bowel partial obstruction. Interview withe the director of nursing (DON) on August 13, 2009, at approximately 5:50 p.m. acknowledged that this unusual incident report should have forward to the Department of Health. There was no evidence that the incident was forwarded to the Department of Health as required.	I 379		