

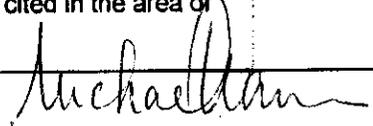
Health Regulation & Licensing Administration

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 08/16/2011
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NAME OF PROVIDER OR SUPPLIER WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 302 'S' ST, NE WASHINGTON, DC 20002
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(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
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<p>1 000 INITIAL COMMENTS</p> <p>On August 3, 2011, the Department of Health (DOH) received notification of a complaint from an anonymous individual via US Mail. The letter identified the following concerns:</p> <p>Allegation #1: Theft and misuse of resident monies.</p> <p>Findings: Interview with management staff and the review of the resident's financial records failed to reveal mismanagement of resident funds. Deficiencies, however, were cited for failure to have an effective system for financial record keeping.</p> <p>Conclusion: This allegation could not be substantiated.</p> <p>Allegation #2: Resident abuse and neglect.</p> <p>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.</p> <p>Conclusion: This allegation could not be substantiated.</p> <p>Allegation #3: Falsification of documentation.</p> <p>Conclusion: This allegation could not be substantiated.</p> <p>Allegation #4: Unsanitary living conditions.</p> <p>Findings: Deficiencies were cited in the area of housekeeping.</p>	1 000	<p><i>Received 10/28/11</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
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Health Regulation & Licensing Administration  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Program Director</i> (X6) DATE <i>10/24/11</i>
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I 000	Continued From page 1 Conclusion: This allegation could not be substantiated. Allegation #5: Individuals given wrong medication and unreported medication errors. Findings: Review of the facility's medical records failed to evidence any incidents of individuals receiving the wrong medication. Conclusion: This allegation could not be substantiated. Allegation #6: Hostile work environment. Findings: Interviews conducted with facility employees failed to evidence a hostile work environment. Conclusion: This allegation could not be substantiated. Due to the nature of the complaint allegations an onsite investigation was initiated on August 16, 2011. The 4 male residents residing in this home habitation information was inspected in order to verify the compliant allegations. The findings of this investigation were based on environmental observations/inspection, interviews with direct care staff and 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. [Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within	I 000		

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I 000	Continued From page 2 this report].	I 000		
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 inspection, the group home for persons with intellectual disabilities (GHPID) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner. The findings include: Observations during the environmental walk-through and interview with the Direct Care Staff (DCS) on August 16, 2011, beginning at approximately 3:00 p.m., revealed the following: 1. In resident #1's bedroom the dresser drawer was broken. 2. In resident #4's bedroom, the dresser had two broken dresser drawers. In Resident #5's bedroom, the third and fourth dresser drawers were missing. 3. In the second floor bathroom, the caulking around the bottom of the bathtub was cracked in certain areas.	I 090	1090 1. Replaced dresser in individual # 1 bedroom. 2. Replaced dresser in individual # 4 bedroom. 3. Repaired second floor bathroom caulking around bathtub. 4. All repairs and replacements were completed by 10-21-11. Additionally the Facility Manager will complete facility checklist weekly. The QDDP will monitor checklist weekly and Program Director will review checklist monthly.	
I 189	3508.7 ADMINISTRATIVE SUPPORT	I 189		

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I 189	<p>Continued From page 3</p> <p>Each GHMRP shall maintain records of residents' funds received and disbursed.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to maintain a complete accounting of residents' personal funds, for five of five residents residing in this facility. (Residents #1, #2, #3, #4 and #5)</p> <p>The findings include:</p> <p>The GHPID failed to provide evidence that funds received and disbursed on the behalf of Resident #1, #3 and #4's personal accounts, as evidenced below:</p> <p>1. On August 9, 2011 at 10:00 a.m. interview with the Financial Analyst and the Financial Administrator revealed that Resident #1 has a personal bank account. Further interview with the Financial Analyst on August 11, 2011 at approximately 11:00 a.m., failed to reveal that Resident #1 personal funds were being accounted as evidenced below:</p> <p>a. Review of a June 2011 bank statement revealed that on June 30, 2011 check #191 was disbursed in the amount of \$350.00 with no corresponding receipts available.</p> <p>b. Interview and review of the Resident #1's September 2010 bank statement revealed Check #80 in the amount of \$1,164 on September 30, 2010. Further interview failed to provide corresponding receipts to account for the purpose the check was written.</p>	I 189	<p>1189 1. Please find attached revised policies on:</p> <ul style="list-style-type: none"> * Individuals Personal Finances, * Record Keeping for Individuals Personal Funds - Deposits, * Record Keeping for Individuals Personal Funds - Expenses, * Request For Funds, * Submission of Receipts, * Individuals Community Account - unapproved expenses, * Disbursement & Reimbursement of Personal Allowance Funds. <p>These policies are being implemented to ensure that documentation is able to support habilitation vendor agreements, receipts and paid bills in accordance to regulations 3508.6 and 3508.7.</p> <p>1a. see attached receipts for the 6/30/11 withdrawal.</p> <p>1b. see attached invoice for Vegas vacation for the 9/30/10 withdrawal.</p>

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I 189	Continued From page 4 2. Interview on August 9, 2011 at 12:00 noon with the Financial Analyst and the Financial Administrator revealed that Resident #2 has a personal bank account. Further interview with the Financial Analyst on August 11, 2011 at approximately 11:00 a.m., failed to reveal that Resident #2 personal funds were being maintained as evidenced below: a. On December 15, 2010, Resident #2 was disbursed \$100.00 for weekend activities. Review of the corresponding receipts failed to account for \$87.00 of the \$100.00 disbursed. b. On September 30, 2010, Resident #2 was disbursed \$1,164 for a vacation trip. Interview and review of the financial records failed to provide evidence as to what the funds were used for. Additionally, the financial representatives were unable to provide documentation and failed to evidence of any corresponding receipts for the trip. c. On November 15, 2011 Resident #2 was disbursed \$225.00, however no corresponding receipts were available in the residents financial records to account for the personal funds withdrawal. 3. Interviews conducted on August 9, 2011 at 1:00 p.m. with the Financial Analyst and the Financial Administrator revealed that Resident #3 has a personal bank account. Further interview with the Financial Analyst on August 11, 2011 at approximately 11:00 a.m., failed to reveal that Resident #3 personal funds were maintained as evidenced below: a. Review of the November 2010 bank statement revealed that two disbursement of one check	I 189	2. see TAG # 1189 I and attached policies. 2a. unapproved expenses will be reimbursed to the individuals. 2b. see attached invoice for Las Vegas vacation for \$1164 withdrawal on 9/30/10. 2c. see memo attached. 3. see TAG # 1189 I and attached policies. 3a. unapproved expenses will be reimbursed to the individuals.	

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I 189	<p>Continued From page 5</p> <p>#233 for \$100.00 on November 12, 2011 and second check #231 was written for \$225.00 were withdrawn on 11/12/10. Review of the receipts failed to evidence the purpose these checks were written and no accounting documentation existed for Resident #3's records.</p> <p>b. Review of the records revealed that on September 3, 2010, a metro flash pass was purchased from CVS in the amount of \$10.00 and two additional metro pass were purchased for two direct care staff out of the Resident #3's personal funds.</p> <p>4. Interviews conducted on August 9, 2011 at 2:00 p.m. with the Financial Analyst and the Financial Administrator revealed that Resident #4 has a personal bank account. Further interview with the Financial Analyst on August 11, 2011 at approximately 11:00 a.m., failed to reveal that Resident #4 personal funds were maintained as evidenced below.</p> <p>a. On June 30, 2011, a disbursement of \$350.00 was withdrawn from Resident #4's personal bank account. No corresponding receipt was available to determine the purpose of this disbursement.</p> <p>b. On May 6, 2011, Resident #4 was disbursed \$100.00 for weekend recreation activities. Review of the available receipts failed to account for \$51.41 of the \$100.00 disbursement.</p> <p>c. On March 7, 2011, Resident #4 was disbursed \$100.00 for weekend recreation activities. Review of the available receipts failed to account for \$58.44 of the \$100.00 disbursement.</p> <p>d. On February 5, 2011, Resident #4 was disbursed \$100.00 for weekend recreation</p>	I 189	<p>3b. unapproved expenses will be reimbursed to the individuals.</p> <p>4. see TAG # 1189 I and attached policies.</p> <p>4a. see attached receipts for the \$350 withdrawal on 6-30-11.</p> <p>4b. unapproved expenses will be reimbursed to the individual.</p> <p>4c. see TAG # 1189 4b.</p> <p>4d. see TAG # 1189 4b.</p> <p>4e. see TAG # 1189 4b.</p>

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I 189	Continued From page 6 activities. Review of the available receipts failed to account for \$31.29 of the \$100.00 disbursement. e. On January 15, 2011, Resident #4 was disbursed \$100.00 for weekend recreation activities. Review of the available receipts failed to account for \$71.45 of the \$100.00 disbursement. 5 Interviews conducted on August 9, 2011 at 3:15 p.m. with the Financial Analyst and the Financial Administrator revealed that Resident #5 has a personal bank account. Further interview with the Financial Analyst on August 11, 2011 at approximately 11:00 a.m., failed to reveal that Resident #5 personal funds were being maintained as evidenced below: a. Interview and review of the April 2011 bank statement revealed a check #312 in the amount of \$4,528.17 withdrawn on April 5, 2011. Review of the financial records failed to reveal corresponding receipt or a copy of the check to account for the resident personal funds.	I 189	<i>5a Please see attached Vinner Trust report to show that the \$4,528.17 was deposited on 3/30/11.</i>
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.	I 379	

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I 379	<p>Continued From page 7</p> <p>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 incidents that present a risk to residents' health and well-being were reported immediately and in writing to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for four of the five residents of the GHPID. (Resident #1, #2, #3 and #4)</p> <p>The finding includes:</p> <ol style="list-style-type: none"> On 12/2/10, Resident #2 was experiencing abdominal pain, diarrhea, and vomiting and was transported to the emergency room for treatment. It was later reported that he had a bowel obstruction. On 12/15/10, Resident #3 reported that his stomach was hurting and was admitted into the emergency room for evaluation and treatment. On 2/16/11, Resident #3 communicated to the direct care staff that his stomach was hurting. The nurse was contacted and he was taken to the emergency room for evaluation and treatment. On 2/24/11, Resident #3 was complaining of stomach pain and the nurse was contacted. After the nurses examination, he was transported to the emergency room. On 3/5/11, Resident #1, #2 and Resident #4 were observed in the group home with not enough staff on duty during a visit to provide adequate supervision. On 3/15/11, on two separate incident reports 	I 379	<p>1379.</p> <ol style="list-style-type: none"> Incident was completed and entered into the MCIS System and was accepted. Additionally see attached Ward & Ward's Incident reporting requirements that were revised on 8/2/11 to include Dept of Health notification on all incidents. See 1379 #1.

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1379	Continued From page 8 for Resident #1, it was discovered that the home lack adequate staffing to cover the shift and to provide supervision for the resident safety in the group home. 9. On 6/7/11, it was discovered that resident #3 had not had a bowel movement in two days and staff were instructed to take him to the emergency room.	1379	1390 1a. Please find attached the staff sign in sheet dated 6-14-11 which indicates nurses training on HMCPS. Also attached are the HMCPS of C.C. and J.H. with the Tenia Pedis concern indicated and the treatment Plan. Additionally the LPN assigned to this facility is required to see each individual weekly and provide a monthly report. The RN assigned to this facility will is required monitor each individual monthly and provide a quarterly report which will be reviewed by the Program Director.
1390	3520.1 PROFESSIONAL SERVICES: GENERAL PROVISIONS Each resident of a GHMRP, regardless of his or her age or degree of disability, shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan in accordance with the current "Outcome Performance Measures" from the "Council on Quality and Leadership in Support for People With Disabilities" (Council) and to the extent of funds appropriated for purposes of D.C. Law 2-137, as amended. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Person's with Intellectual Disabilities (GHPID) failed to provide nursing services required to meet the needs of two of five residents in the home. (#1 and #5) The findings include: → 1. The GHPID's nursing staff failed to provide training on preventive measures for tenia pedis as evidenced below: a. Review of Resident #1's medical record on August 9, 2011 at approximately 12:17 p.m. revealed that the client was evaluated by the	1390	

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I 390	<p>Continued From page 9</p> <p>podiatrist on September 9, 2010, March 17, 2011 and June 20, 2011. On each occasion, the Resident was noted to have tenia pedis. Interview with the nurse on the same day to inquire about the training the staff received regarding the prevention of the recurrence of the tenia pedis, the nurse acknowledged that there had been no specific training regarding this condition, i.e. making sure the space between his toes was dry after bathing etc.</p> <p>b. Review of Client #5's record on August 9, 2011 at approximately 1:23 p.m. revealed the podiatrist evaluated the resident on June 20, 2010, December 13, 2010, and June 1, 2011. On June 20, 2010 and June 13, 2011, the resident was diagnosed with tenia pedis. Interview with the nurse on the same day to inquire about the training the staff received regarding the prevention of the recurrence of the tenia pedis, the nurse acknowledged that there had been no specific training regarding this condition, i.e. making sure the space between his toes was dry after bathing etc.</p> <p>At the time of the investigation, there was no evidence that the nursing staff provided the direct care staff with training on preventive measures in order to reduce/prevent incidents of tenia pedis.</p> <p>2. The GHPID's nursing staff failed to have evidence that residents with tenia pedis was assessed to determine the effectiveness of the treatments as evidenced below:</p> <p>a. Review of Resident #1's medical record on August 9, 2011 at approximately 12:17 p.m. revealed that the client was evaluated by the podiatrist on September 9, 2010, March 17, 2011 and June 20, 2011. On each occasion, the</p>	I 390	<p>1b. see 1390 1a.</p> <p>2a. see 1390 1a.</p> <p>2b. see 1390 1a.</p>	

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I 390	Continued From page 10 Resident was noted to have tenia pedis. Review of the nursing notes for the resident, however, failed to have evidence of a nursing assessment noting the tenia pedis and weather the condition was resolving with the treatments. Interview with the nurse on the same day, she acknowledged the lack of documentation of the foot assessments. b. Review of Client #5's record on August 9, 2011 at approximately 1:23 p.m. revealed the podiatrist evaluated the resident on June 20, 2010, December 13, 2010, and June 1, 2011. On June 20, 2010 and June 13, 2011, the resident was diagnosed with tenia pedis. Interview with the nurse on the same day, she acknowledged the lack of documentation of the foot assessments.	I 390	