

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 FLORAL PL, NW WASHINGTON, DC 20012</b>	

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1 000 INITIAL COMMENTS

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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. Deficiencies, however, were cited for failure to have an effective system for financial record keeping.

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.

*Received 10/28/11*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
800 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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I 000	Continued From page 1  Conclusion: This allegation could not be substantiated.  Allegation #5: Individuals given wrong medication and reported 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 allegations, an onsite investigation was initiated on August 4, 2011 through August 5, 2011. All residents files from a population of four females with varying degrees of intellectual disabilities were reviewed.  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.  [Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report].	I 000	

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1 090 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 group home for persons with intellectual disabilities (GHPID) failed to ensure the interior and exterior of the facility were maintained in a safe and sanitary manner.

The findings include:

1. On August 5, 2011, beginning at 3:40 p.m., the surveyor conducted observation of the external environment. The following concerns were identified:
  - a. The right hand rail on the steps leading from the back porch to the back yard, was splintered on the top, near the middle of the rail. Both rails were weather worn and had splinters.
  - b. One of the risers was missing from the steps leading from the back yard porch to the porch.
  - c. One of the balusters in the metal railing on the front porch was observed to be rusted and broken off near the bottom, causing it to have a jagged edge.
2. Observations of the interior environment were initiated on August 4, 2011.
  - a. On August 4, 2011, at 3:30 p.m., the seat of the toilet in the basement bathroom was noted to

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1090: EXTERIOR

- A. Replaced handrails on steps leading from back porch.
- B. Replaced missing riser.
- C. Repaired metal railing on front porch.

~~D.~~ INTERIOR

- A. Replaced toilet seat in basement bathroom.
- B. Removed broken piece of plastic from wall.
- C. Secured area rug to floor.

All repairs and replacements were completed by 10-28-11. Additionally the facility Managers and QDDP will complete weekly facility checklist which will be monitored by Program Director monthly.

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I 090 Continued From page 3

be disconnected from the commode. On August 5, 2011 at 3:50 p.m., the toilet seat was noted to have been reconnected to the commode.

b. On August 5, 2011, at 3:52 p.m., the bathroom on the second floor had a piece of broken plastic attached to the left side of the wall (above the left side of the hand sink). Staff indicated that it was where the paper towel holder was previously attached to the wall.

c. Area rugs in the hall way of the facility were observed to move on the floor when pressure was applied.

The above cited deficiencies were acknowledged by the facility's qualified intellectual disabilities professional (QIDP) on August 5, 2011 at approximately 4:45 p.m.

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1189 1. Please find attached revised Policies on:

- \* Individuals Personal Finance,
- \* Record Keeping for Individuals Personal Funds - Deposits,
- \* Record Keeping for Individuals Personal Funds - Expenses,
- \* Request for Funds,
- \* Submission of Receipts,
- \* Individual community account - unapproved expenses,
- \* Disbursement & Reimbursement of personal allowance funds.

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 staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to maintain records of residents' personal funds, for three of three residents included in the sample. (Residents #2, #3 and #4)

The findings include:

1. Review of the financial records for Residents #2, #3, and #4 on August 4, 2011, beginning at 2:19 p.m., revealed that on December 10, 2010, a withdrawal of \$100.00 was made from each individual's account. Further review of each

I 189

These policies are being implemented to ensure that documentation is able to support habitation, vendor agreements, receipts and paid bill in accordance to regulation 3508.6 and 3508.7. also find attached receipts for each of the individuals' 12/10 \$100 withdrawals that indicate they shopped at the same store but the totals are different and account for the \$100 total.

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1189	<p>Continued From page 4</p> <p>resident's financial records revealed that a copy of the same receipt (same receipt number, date, time, and place) was used to justify each \$100.00 withdrawal. Review of the copied receipt (located in each residents file) indicated there was a purchase for \$92.49 at a local discount department chain on December 11, 2010, at 11:54 a.m.</p> <p>On August 10, 2011, at approximately 4:00 p.m., interview with the financial assistance revealed that the house manager was responsible for maintaining the residents' funds. Interview with the financial administrator revealed that the provider was "making changes and fixing their financial management process".</p> <p>2. Review of the financial records for Residents #2, #3 and #4 on August 4, 2011, beginning at 2:19 p.m., revealed that on August 6, 2010, a withdrawal of \$81.00 was made from each individual's account. Further review of each resident's financial records revealed that a copy of the same receipts (same invoice number, date, time, and place) was used to justify the purchase of \$16.15. Review of the copied receipt (located in each residents file) revealed the following:</p> <p>a. A purchase for \$3.29 at a local fast food chain on August 1, 2010, at 1:08 p.m.;</p> <p>b. A purchase for \$4.23 at a local cosmetics store on August 6, 2010, at 2:42 p.m.;</p> <p>c. A purchase for \$4.23 at a local beauty supply store on August 7, 2010, at 6:39 p.m.;</p> <p>d. A purchase for \$4.40 at a local fast food chain on August 29, 2010, at 12:07 p.m.;</p>	1189	<p>2. see TAG # 1189 1 and attached Policies.</p> <p>2a. unapproved expenses will be reimbursed to the individuals.</p> <p>2b. see TAG # 1189 2a.</p> <p>2c. see TAG # 1189 2a.</p> <p>2d. see TAG # 1189 2a.</p>

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I 189	<p>Continued From page 5</p> <p>On August 10, 2011, at approximately 4:00 p.m., interview with the financial assistance revealed that the house manager was responsible for maintaining the residents' funds. Interview with the financial administrator revealed that they were "making changes and fixing their financial management process".</p> <p>3. Review of the financial records for Residents #2 and #3, on August 4, 2011, beginning at 2:19 p.m., revealed that on September 10, 2010, a withdrawal of \$20.00 was made from each individual's account. Also on September 17, 2010, a withdrawal of \$70.00 was made from each individual's account. Further review of each resident's financial records revealed that a copy of the same receipt (same receipt number, date, time, and place) was used to justify the difference of \$12.69. Review of the copied receipt (located in each residents file) indicated the purchase was made at a local beauty supply store on September 20, 2010, at 4:31 p.m.</p> <p>On August 10, 2011, at approximately 4:00 p.m., interview with the financial assistance revealed that the house manager was responsible for maintaining the residents' funds. Interview with the financial administrator revealed that they were "making changes and fixing their process".</p>	I 189	<p>3. See TAG# 1189 1, and attached policies. Also find attached receipts for \$70 and \$20 withdrawals for individuals #2 and #3.</p>
I 379	<p>3519.10 EMERGENCIES</p> <p>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</p>	I 379	

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1379	<p>Continued From page 6</p> <p>followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all incidents that present a risk to resident's health and well-being were reported immediately to the Department of Health (DOH), Health Regulation and Licensing Administration (HRLA), for one of the four residents residing in the facility. (Resident #2)</p> <p>The findings include:</p> <p>On July 21, 2011 staff noticed that Resident #2's upper lip was swollen. In addition, scratches were observed on her upper lip, around her neck and her right eye looked swollen. Resident #2 was unable to explain how the injuries occurred.</p> <p>Interview conducted with the QIDP on August 4, 2011 at 2:30 p.m. revealed their incident policy only required all serious reportable incidents are forwarded to the Department of Health (DOH). At the time of the incident this was not considered as a serious reportable. Reportedly, effective the week prior to this investigation, the agency's new policy requires that all incidents be reported to DOH.</p>	1379	<p>1379:</p> <p>Please find attached the incident report that was submitted within the 24 hour guidelines and copy of the revise reporting requirements for Ward &amp; Ward. Revised 8/2/11.</p>