

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2010
NAME OF PROVIDER OR SUPPLIER WARD & WARD		STREET ADDRESS, CITY, STATE, ZIP CODE 806 FLORAL PL, NW WASHINGTON, DC 20012		
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1 000	INITIAL COMMENTS An licensure survey was conducted on July 9, 2010. A random sample of two residents was selected from a population of four females with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home, interviews with staff, and the review of clinical and administrative records including incident reports.	1 000	Received 8/9/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
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 Mentally Retarded Person (GHMR P) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for four of the four residents residing in the facility. (Residents #1, #2, #3, and #4) The findings include: Observation and interview with the facility's House Manager (HM) on July 9, 2010, beginning at 12:30 p.m. revealed the following: Exterior: 1. The sidewalk to the entrance of the facility is elevated, a possible trip hazard.	1 090	Exterior: 1. Sidewalk to entrance was repaired.	8/5/10

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

STATE FORM

Michael W...

TITLE Program Director

(X5) DATE 8/5/10

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1090	Continued From page 1 Interior: 1. In the basement the patio door is off the track therefore, the door will not close properly. 2. In the living room ceiling there were water stains and blistering. 3. Resident #4's bedroom window is stuck open thereby not allowing the air-condition to work properly. The temperature reading in the bedroom was 78 degrees. 4. Resident #3's bathroom had several floor tiles missing. These deficiencies were acknowledged by the HM at the conclusion of the environmental inspection.	1090	Interior: 1. Basement patio door replaced. 2. Repaired living room ceiling 3. Resident's #4 bed - room window was repaired. 4. Resident #3 bathroom floor tiles replaced.	8/5/10 8/5/10 8/5/10 8/5/10
1401	3520.3 PROFESSIONAL SERVICES: GENERAL PROVISIONS 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. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with mental retardation (GHMRP) failed to ensure professional services included timely diagnostic, evaluation, and treatment services to prevent	1401		

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I 401	<p>Continued From page 2</p> <p>deterioration or further loss of functioning, for two of the two sampled residents. (Resident #1 and #2)</p> <p>The findings includes:</p> <p>1. During the entrance conference on July 9, 2010, beginning at 8:45 a.m., the house manager (HM) stated that Resident #1 was admitted to the facility in January 2010. Review of the resident's record confirmed that the resident was admitted to the facility on January 22, 2010. Further review revealed the resident's ISP meeting was held on January 8, 2010. The ISP recommended the following services once the resident move to a lesser restrictive environment:</p> <ul style="list-style-type: none"> - Behavior Support Diagnostic assessment; - Speech and Language assessment; - Occupational Therapy assessment; - Physical Therapy assessment; and - Nutritional assessment. <p>Record review on July 9, 2010, at approximately 11:00 a.m., revealed a diagnostic assessment dated March 19, 2010. The diagnostic assessment recommended the resident would benefit from a behavior support plan (BSP) in order to develop and improve her general coping skills and reduce incidents of maladaptive behaviors. The BSP should be developed, implemented, monitored and rendered on a weekly basis. Further record revealed no evidence of a BSP.</p>	I 401	<p>1. Upon review of individuals waiver services all service providers were contacted and assessments to be performed. Will file with DDS/service Coordinator on development of BSP and Diagnos Diagnostic assessment recommendations as waiver only authorized assessment. Additionally, Program Director will review waiver services quarterly to ensure all waiver supports are utilized.</p>	8/5/10

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I 401	Continued From page 3 Interview with the qualified mental retardation professional (QMRP) and HM on July 9, 2010, at approximately 11:50 a.m., confirmed that Resident #1 did not have a BSP developed as recommended diagnostic assessment. According to the record there were no occupational therapy assessment, physical therapy assessment, nutritional assessment or speech and language assessment. Interview with the qualified mental retardation professional (QMRP) on July 9, 2010, at approximately 11:50 a.m., confirmed that Resident #1 did not have the following assessment completed. However she would contact each consultant and schedule the aforementioned assessments. 2. During the entrance conference on July 9, 2010, beginning at 8:45 a.m., the house manager (HM) stated that Resident #2 was admitted to the facility in January 2010. Review of the resident's record confirmed that the resident was admitted to the facility on January 22, 2010. Further review revealed the resident's ISP meeting was held on September 21, 2009. The ISP recommended the following services once the resident move to a lesser restrictive environment: - Behavior Support Diagnostic assessment; - Speech and Language assessment; - Occupational Therapy assessment; - Physical Therapy assessment; and - Nutritional assessment.	I 401	2. See ^{Tag#} 1401 #1.	8/5/10

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I 401	<p>Continued From page 4</p> <p>Record review on July 9, 2010, at approximately 1:00 p.m., revealed a diagnostic assessment dated February 15, 2010. The diagnostic assessment recommended the resident would benefit from a behavior support plan (BSP) in order to develop and improve her general coping skills and reduce incidents of maladaptive behaviors. The BSP should be developed, implemented, monitored and rendered on a weekly basis. Further record revealed no evidence of a BSP.</p> <p>Interview with the qualified mental retardation professional (QMRP) and HM on July 9, 2010, at approximately 1:50 p.m., confirmed that Resident #2 did not have a BSP developed as recommended diagnostic assessment.</p> <p>According to the record there was no occupational therapy assessment, physical therapy assessment, nutritional assessment or speech and language assessment.</p> <p>Interview with the qualified mental retardation professional (QMRP) on July 9, 2010, at approximately 1:50 p.m., confirmed that Resident #1 did not have the following assessment completed. However she would contact each consultant and schedule the aforementioned assessments.</p> <p>3. The GHMRP failed to ensure that the health status was reviewed by the Registered Nurse (RN) staff on a quarterly or more frequent basis, for one of the two residents clients included in the sample. (Resident #1)</p> <p>Interview with the facility's Licensed Practical Nurse (LPN) on July 9, 2010, at approximately 10:00 a.m., revealed that the facility's Registered</p>	I 401	<p>③ Individual [redacted] was admitted to Ward 4, Ward on 1-22-10. An initial nursing assessment was completed on 1-22-10 and f/u by PCP physical Exam on 2/25/10. The nursing team transitioned to the next quarter and a nursing assessment was completed on 6/30/10. The next scheduled quarterly is for Sept. 2010.</p>	8-2-10

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1401	<p>Continued From page 5</p> <p>Nurse (RN) was responsible for completing quarterly physical nursing exams. Review of Client #1's medical record revealed an annual nursing assessment dated January 8, 2010. Further record review revealed that a quarterly nursing assessment was completed on June 30, 2010. Further interview with the LPN, on the same date, at 10:45 a.m., confirmed that a quarterly nursing physical examination was not available in the record.</p> <p>There was no evidence that Resident #1's health status had been reviewed quarterly by the nursing staff since her current ISP.</p> <p>4. The GHMRP failed to ensure that residents who received psychotropic medications and/or had an Axis diagnosis received an initial psychiatric assessment, for two of the two residents included in the sample. (Residents #1 and #2)</p> <p>a. During the observation of the medication administration conducted on July 8, 2010, at 5:15 p.m., Resident #1 was administered Seroquel 300 mg and Amoxapine 100 mg. The resident's physician order dated July 2010, reflected that the resident had an Axis I diagnosis of behavior disorder. It was written that the medication was prescribed to decrease her maladaptive behaviors.</p> <p>Although Resident #1's record identified that monthly psychotropic reviews had been conducted by the Psychiatrist, there was no evidence that resident # 1 had been provided an initial comprehensive psychiatric assessment to reflect the clinical diagnoses in support of the use of the prescribed psychotropic medications prescribed.</p>	1401	<p>A. [REDACTED] was admitted to Ward & Ward on 1-22-10, To facilitate the transition she continued services with the same Psychiatrist ([REDACTED]). [REDACTED] initial assessment was done over 5 years ago and subsequent assessments have been done annually. Ward & Ward will obtain a comprehensive psychiatric assessment on 8-16-10.</p>	8-16-10

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1401	Continued From page 6 b. During the observation of the medication administration conducted on July 8, 2010, at 5:18 p.m., Resident #2 was administered Haloperidol 1 mg and Naltrexone Hydrochloride 25 mg. The resident's physician order dated July 2010, reflected that the resident had an Axis I diagnosis of schizophrenia. It was written that the medication was prescribed to decrease her maladaptive behaviors. Although Resident #2's record identified monthly psychotropic reviews had been conducted by the Psychiatrist, there was no evidence that resident had been provided an initial comprehensive psychiatric assessment to reflect the clinical diagnoses in support of the use of the prescribed psychotropic medications prescribed. 5. The GHMRP failed to ensure residents received self medication assessments, for two of the two residents included in the sample. (Residents #1 and #2) a. During medication administration observation on July 8, 2010, at 5:15 p.m., Resident #1 was observed arriving at the nurse's station and obtaining a cup of water from the faucet independently. The registered nurse (RN) was observed preparing the resident's medication and placing the medication cup on the counter top. The client picked up the medication cup and consumed her medications independently. Interview with the RN, after the medication administration, indicated that the resident does not participated in a self medication program. The resident only gets her water. Further interview revealed that she did not feel safe for the resident to obtain her medications independently.	1401	B. ④ [redacted] was admitted to Ward & Ward on 1-22-10. To facilitate the transition she continued services with the same psychiatrist ([redacted]). [redacted] initial assessment was done over 5 years ago and subsequent assessments have been annually. Ward & Ward will obtain a comprehensive psychiatric assessment on 8-16-10. ⑤ A. Ward & Ward nursing team will complete the self medication assessment form, developed by DDS/DCHRP Health and wellness unit for residents #1 and #2 by 8-16-10. (See attached form)	8-16-10 8-16-10

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1401	<p>Continued From page 7</p> <p>Review of Resident #1's IPP dated February 17, 2010, on July 8, 2010, at 7:30 p.m., revealed no program goal or objective for Resident #1 to receive training in self medication.</p> <p>b. During medication administration observation on July 8, 2010, at 5:18 p.m., Resident #2 was observed arriving at the nurse's station and the direct care staff poured the resident a cup of water and placed it on the table. The registered nurse (RN) was observed preparing the resident's medication and placing the medication cup on the counter top. The client picked up the medication cup and consumed her medications independently. Interview with the RN, after the medication administration, indicated that the resident does not participated in a self medication program. The resident only gets her water. Further interview revealed that she did not feel safe for the resident to obtain her medications independently.</p> <p>Review of Resident #2's IPP dated September 21, 2010, on July 8, 2010, at 7:30 p.m., revealed no program goal or objective for Resident #2 to receive training in self medication.</p> <p>After the medication administration, the RN confirmed that there was no self medication assessments to teach the residents to become independently in self medication administration.</p>	1401 ⑤	B. See Tag 1401 #5A.	8/16/10
1410	<p>3520.11 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Each GHMRP shall ensure that when another agency assumes responsibility for services to a resident, a summary of the appropriate record is forwarded to that agency.</p>	1410		

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1410	Continued From page 8 This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure an outside service monitored the health and well-being of a resident, for one of two residents included in the sample. (Resident #1) The finding includes: Review of Resident #1's medical record on July 9, 2010, beginning at 8:00 a.m., revealed a gynecology consult dated December 4, 2009. The consultation sheet recommended that the receive a mammogram. According to the mammogram consultation sheet the resident had a mammogram examination on February 10, 2010. However, there was no evidence on file at the home at the time of survey to substantiate that there were results of examination. Interview with the licensed practical nurse (LPN) on July 9, 2010, at approximately 8:30 a.m., revealed that she would attempt to located the consultation sheet. Approximately 2 hours later, the LPN could not provide the mammogram results.	1410	Please find attached mammography report dated 2-15-10 as requested by GYN on 12-9-09. Additionally an ultra sound has been scheduled for 8-16-10 as recommended by report.	8-16-10
1473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group for Mentally Retarded Persons (GHMRP) failed to report any irregularities to the Primary Care Physician (PCP), for one of the two	1473		

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1473	Continued From page 9 residents included in the sample. (Residents #3) The finding includes: During the medication administration observations, on July 8, 2010, at 5:35 p.m., the medication nurse was observed preparing Resident #3's medications to include trazodine HCL 50 mg. Reconciliation of the physician orders (POS) dated July 2010, and the medication observations, the resident was prescribed trazodine HCL 50 mg, by mouth at bedtime. Interview with medication nurse, after the administration revealed that the resident was scheduled to receive trazodine HCL 50 mg, at bedtime (scheduled time was 8:00 p.m.). She further indicated that the medication was "only" a few hours early and should not affect her sleep during the night. There was no evidence that the GHMRP followed the resident's POS as written.	1473	Ward & Ward gave the medication nurse a corrective action memo (see attached) for early medication dispensing to resident #3. Additionally resident #3 was monitored and there were no adverse effects/side effects reported or observed by nursing staff on 7-8-10.	8/2/10
1474	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, staff interview, and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure medication administration records (MARs) were maintained for one of the four residents residing in the facility. (Resident #3) The finding includes: 1. During the medication administration	1474		

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1474	Continued From page 10 observations, on July 8, 2010, at 5:35 p.m., the medication nurse was observed preparing Resident #3's medications to include: Naproxen 375 mg, trazodine HCL 50 mg, Lithium Carbonate 600 mg, Glucosan/CHON 750/600 mg, and Seroquel 400 mg. Reconciliation of the physician orders dated July 2010, the MARs and the medication observations, at 5:45 p.m., revealed that the MARs were signed on July 7, 2010 (p.m.) and July 8, 2010 (a.m., and p.m.). Interview with medication nurse, after the administration, indicated that when she arrived to administer medication on the evening of July 7, 2010, that were MARs available. However she re-wrote the medications on a blank MAR. At the time of the survey, the GHMRP failed to maintain MARs for the entire month of July 2010 for Resident #3.	1474	Director of Nursing Reviewed MAR protocol with RN on July 30, 2010. MAR for July is available for review. (at the time of survey RN was within 90 day probation and will continue to receive training on policy along with Chapter 35 of D.C. Code.)	8-2-10
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for two of the two residents	1500		

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I 500	Continued From page 11 included in the sample. (Residents #1 and #2) The finding includes: 1. Medication administration observation on July 8, 2010, at 5:15 p.m., revealed that Resident #1 received Amoxapine 100 mg and Seroquel. Interview with the medication nurse after the medication administration indicated that the resident received the aforementioned medication for her meladapive behaviors. During the entrance conference on July 9, 2010, 8:45 AM, an interview was conducted with the house manager revealed the Resident #1 did not have the capacity to give informed consent for the use of medications and habilitation services. Further interview revealed the resident had involved family members to assist her in decision making. Review of Resident #1's record on July 9, 2010, beginning at 8:00 a.m., revealed a diagnostic assessment dated March 9, 2010, verified the HM's statement. According to the assessment, Resident #1 "is not able to make independent decisions concerning her residential or day placements. She lacked the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. She lacks the judgment and insight required to make decisions independently." Review of the Resident #1's medical record and additional interview with the HM on July 9, 2010, at approximately 10:30 a.m., failed to provide evidence that the resident treatment needs, including the benefits and potential side effects associated with her medications, and the right to refuse treatment, had been explained to her	I 500	① Ward & Ward's nursing team and program team will complete the DDS Health and Wellness/ DCHRP Behavioral Health forms (see attached) to review psychotropic medications and obtain individuals consent for psychotropic medication(s) by 8-16-10.	8-16-10

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I 500	<p>Continued From page 12</p> <p>and/or a legally authorized representative.</p> <p>At the time of the survey, the facility failed to provide evidence that the potential risks involved in using these medications, or his right to refuse treatment had been explained to the resident and/or family member representative.</p> <p>2. Medication administration observation on July 8, 2010, at 5:18 p.m., revealed that Resident #2 received Halopendol 1 mg and Revia 25 mg. Interview with the medication nurse after the medication administration indicated that the resident received the aforementioned medication for her maladaptive behaviors.</p> <p>During the entrance conference on July 9, 2010, 8:45 AM, an interview was conducted with the house manager revealed the Resident #2 did not have the capacity to give informed consent for the use of medications and habilitation services. Further interview revealed the resident had involved family members to assist her in decision making.</p> <p>Review of Resident #2's record on July 9, 2010, beginning at 11:00 a.m., revealed a diagnostic assessment dated February 15, 2010, verified the HM's statement. According to the assessment, Resident #2 "is not able to make independent decisions concerning her residential or day placements. She lacked the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. She lacks the judgment and insight required to make decisions independently."</p> <p>Review of the Resident #2's medical record and additional interview with the HM on July 9, 2010, at approximately 12:30 a.m., failed to provide</p>	I 500	<p>② See Tag # 1500 #1.</p>	8-16-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2010
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NAME OF PROVIDER OR SUPPLIER WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 806 FLORAL PL, NW WASHINGTON, DC 20012
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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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I 500	<p>Continued From page 13</p> <p>evidence that the resident treatment needs, including the benefits and potential side effects associated with her medications, and the right to refuse treatment, had been explained to her and/or a legally authorized representative.</p> <p>At the time of the survey, the facility failed to provide evidence that the potential risks involved in using these medications, or his right to refuse treatment had been explained to the resident and/or family member representative.</p>	I 500		
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