STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0093	A. BUILDING: _____ B. WING _____	08/21/2026

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WARD & WARD MENTAL HEALTH SERVICES,	221 VAN BUREN STREET, NW WASHINGTON, DC 20012

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I 000	Initial Comments An annual licensure survey was conducted at this facility from 08/19/2026 through 08/21/2026. A sample of two persons was selected from a census of four. The findings of the survey were based on observations, interviews, and record reviews.	I 000	Please start typing your responses here:	
I5300	3503.3 Housekeeping 3503.3 The interior and exterior of each CRFPID shall be maintained in a safe, clean, orderly, attractive, and sanitary manner, and be free of clutter, accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the interior and exterior of the facility were properly maintained in accordance with the needs of the four persons residing in the home (Persons #1, #2, #3, and #4). Findings included: Observations on 08/21/2026, during the environmental walkthrough of the facility beginning at 9:17 AM, with Direct Support Professional (DSP) #5, revealed the following: - A light bulb was missing in Person #1's bedroom.	I5300		

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I5300	Continued From page 1 - The facility's front screen door netting was in disrepair. - The kitchen's overhead vent was very dirty and had not been cleaned. During an interview at the conclusion of the walkthrough, DSP #5 acknowledged the findings.	I5300		
I5700	3503.7 Housekeeping 3503.7 No cleaning agent, bleach, insecticide or any other poisonous, dangerous, or flammable material shall be accessible to a person where access to such substance is contraindicated in the person's ISP. This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that hazardous cleaning agents were stored in a manner that will prevent access to the four persons residing in the home (Persons #1, #2, #3, and #4). Findings included: During the environmental walkthrough of the facility on 08/21/2026 at 9:19 AM with Direct Support Professional (DSP) #5, cleaning agents-including an all-purpose cleaner containing bleach, Clorox, and disinfecting wipes-were observed on the floor inside an unlocked closet. The closet was open and did not have a lock, allowing unrestricted access to the cleaning agents.	I5700		

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I5700	Continued From page 2 During an interview on 08/21/2026 at 9:20 AM, conducted during the walkthrough, DSP #5 acknowledged the findings.	I5700		
I7690	3511.9 MANAGEMENT OF OPERATIONS 3511.9 Each CRFPID shall maintain a full and complete accounting of each person's personal funds entrusted to the facility on behalf of the person. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a full and complete accounting of the persons personal funds for the two persons in the sample (Person #1 and #2). Findings included: During a meeting on 08/20/2026 at 10:09 AM, the surveyor requested the financial records for the two persons in the sample. At 12:18 PM, the facility provided the financial records for Person #2 but did not provide any records for Person #1. Beginning at 12:27 PM, a review of Person #2's financial records indicated that the facility was authorized to manage the person's funds. Further review showed monthly bank statements received by the facility reflecting Supplemental Security Income deposits into the person's checking account. Additional review showed Person #2's October 2025, November 2025, December 2025, February 2026, March 2026, April 2026, May	I7690		

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I7690	Continued From page 3 2026, June 2026, and July 2026 bank statements were not available within the financial records binder provided by the Qualified Intellectual Disabilities Professional (QIDP). At 1:09 PM, the surveyor still had not received any accounting statements for Person #1. When asked during an interview on 08/20/2026 at 3:43 PM, about the record, the QIDP stated that she would provide Person #1's financial records the following day from the other home Person #1 transferred from. At the time of the survey exit, no records were provided for review, and during an interview on 08/21/2026 at 12:41 PM, the QIDP acknowledged the finding that no accounting records were available during the survey.	I7690		
I7920	3512.12 PERSONNEL 3512.12 Each employee, within ninety (90) days prior to employment and annually thereafter, shall provide certification from a physician attesting that he or she is fit to perform the required duties of the job and is free from any active communicable disease. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record reviews, the facility failed to ensure that one of the five Direct Support Professionals (DSPs) observed working in the facility obtained a health certificate/clearance from a physician at least annually, showing they were free from communicable diseases (DSP #2).	I7920		

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I7920	Continued From page 4 Findings included: Observations conducted from 08/19/2026 through 08/21/2026 showed that DSP #2 provided direct care services to the persons in the facility. A review of the facility's personnel files on 08/21/2026, beginning at 10:44 AM, showed no documented evidence of a current health certificate in the personnel file for DSP #2. During an interview at 11:32 AM, the Human Resources Director acknowledged that DSP #2 did not have a current health certificate after reviewing DSP #2's personnel file.	I7920		
I8780	3519.8 MEDICAL AND NURSING SERVICES 3519.8 The CRFPID shall ensure that a person's primary care physician receives reports of recommendations or orders from all other health or medical specialists to whom the person is referred within twenty-four (24) hours or the next business day. The CRFPID shall retain a copy of the signed recommendations or orders in the person's record. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that each person's physical therapy recommendations were communicated to the primary care physician (PCP) and documented in the person's record, for one of the two persons in the sample (Person #1). Findings included:	I8780		

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I8780	Continued From page 5 A review of Person #1's medical records revealed a discharge diagnosis dated 05/29/2026 reflecting a contusion of the right buttock, ambulation dysfunction, and effusion of the right knee. The review of Person #1's progress notes by the Registered Nurse (RN), dated 06/02/2026 at 4:00 PM, indicated that Person #1 had an initial assessment conducted by the Physical Therapist (PT), with the RN being present with the PT during the assessment. According to the note, Person #1 was able to slowly ambulate using a walker and gait belt for a few steps, and a consent for therapy was obtained from Person #1's medical guardian via telephone. The PT recommended outpatient therapy for Person #1, noting that access to therapy center equipment could support a faster recovery. The RN's note further revealed that the PT's recommendation was discussed with the Qualified Intellectual Disabilities Professional (QIDP) and administration, with plans to follow up with the medical guardian. The RN noted that monitoring would continue. A review of Person #1's physician orders sheet (POS) dated 07/22/2026 indicated that Person #1 fully ambulates and has two adaptive equipment items prescribed (hearing aid and glasses). Further review of the POS showed no documented evidence on the physician orders to reflect the PT recommendations, use of a gait belt, or the need for a walker. Observations on 08/19/2026 at 12:05 PM showed Direct Support Professional (DSP) #2 holding Person #1's gait belt while Person #1 was seated at the table. At 12:23 PM, Person #1 was observed eating a chopped ham and cheese sandwich with yogurt and water while wearing a	I8780		

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I8780	Continued From page 6 gait belt. On 08/21/2026 at 11:46 AM, Person #1 was observed seated at the table using an iPad while wearing a gait belt, with a walker positioned beside them. The QIDP on 08/21/2026 at 12:07 PM, when asked who ordered the gait belt for Person #1, stated that it was ordered by the physical therapist. When asked if the facility had an order for the gait belt in Person #1's record, the QIDP responded, "We do."	I8780		
I8990	3520.9 HABILITATION AND TRAINING 3520.9 The QIDP and/or Residential Director shall ensure that each person's ISP is updated as needed and approved by the IDT. The CRFPID shall maintain records of any revisions to the ISP, including any reasons for making or not making any changes. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility's Qualified Intellectual Developmental Professional (QIDP) failed to ensure that each person's Individual Support Plan (ISP) was updated and approved by the Interdisciplinary Team (IDT) for one of the two persons in the sample (Person #2). Findings included: On 08/18/2026 at 10:20 AM, the surveyor asked staff inside the facility why Person #2 was not attending the day program. Staff stated that the Qualified Intellectual Disabilities Professional	I8990		

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I8990	Continued From page 7 (QIDP) would notify the surveyor regarding the reason Person #2 did not attend. At 10:39 AM, observations showed Person #2 sitting on the couch interacting with sensory blocks while listening to music from the television. When asked on 08/19/2026, beginning at 11:05 AM, about Person #2 attending day program, the QIDP stated that Person #2 does not attend the day program due to a recent diagnosis of breast cancer. On 08/19/2026, beginning at 2:47 PM, a review of Person #2's progress notes dated 06/24/2026 indicated that the person received the first chemotherapy treatment during the week prior to 06/24/2026. At 3:17 PM, further review of Person #2's ISP dated 03/11/2025 showed the last completion date of March 2026. There was no documented evidence that Person #2's ISP had been updated for the current year or revised to reflect the cancer diagnosis and changes in service needs. On 08/21/2026 at 12:09 PM, the QIDP was asked whether Person #2 had an updated ISP or if a current ISP could be provided. The QIDP stated that the current ISP "should be in the book." At 12:10 PM, the QIDP was asked when Person #2 was diagnosed with cancer. The QIDP stated, "I believe it was three months ago, and I need to check in the system for it."	I8990		
I9670	3523.7 EMERGENCIES 3523.7 Each CRFPID shall ensure that telephones are accessible for emergency purposes, and shall make available near each	I9670		

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I9670	Continued From page 8 telephone, emergency numbers which include at least fire and rescue squads, the local police department, the nearest hospital, a poison control center, each person's physician, Director of Nursing, Service Coordinator (if applicable) and the Residence Director. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that all emergency contact numbers were posted near each telephone as required for the four persons residing in the facility (Persons #1, #2, #3, and #4). Findings included: On 08/21/2026, beginning at 9:17 PM, during the environmental inspection of the facility, the Direct Support Professional (DSP) #5 was asked where the emergency phone numbers were posted. DSP #5 directed the surveyor where the emergency phone numbers were posted. At 9:44 AM, after observing the posted emergency phone numbers with DSP #5, it was noted that several required emergency contact numbers were missing from the list. During an interview at 9:47 AM, DSP #5 acknowledged that the list was missing required emergency contact numbers, including the poison control center, each of the four persons' primary care physicians, nearest hospital, local police department, fire and rescue squads.	I9670		
I9730	3523.13 EMERGENCIES 3523.13 In addition to the reporting requirement	I9730		

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I9730	Continued From page 9 in Subsection 3523.10, each CRFPID shall notify the Department, of any other unusual incident that substantially interferes with a person's health, welfare, living arrangement or well-being or in any other way places a person at risk. Such notification shall be made by telephone immediately when the staff is aware and shall be followed up by written notification within twenty-four (24) hours or the next business day. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure that all incidents that present a risk to the residents' health, safety and/or living arrangement were reported immediately to the Department of Health (DOH) for one of the two persons in the sample (Person #1). Findings included: A review of the facility's incident report dated 05/18/2026 for Person #1 revealed that Person #1 slipped and fell in the shower. The report indicated that Person #1 appeared to be in pain and complained of pain in the right leg and was transported by ambulance to Washington Hospital Center emergency room. The section for verbal notifications indicated that the facility did not notify the Department of Health, and there was no documentation showing that the Department was notified. A review of Person #1's medical records showed a discharge diagnosis dated 05/29/2026 reflecting a contusion of the right buttock, ambulation dysfunction, and effusion of the right knee. During the entrance conference on 08/19/2026,	I9730		

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I9730	Continued From page 10 beginning at 11:05 AM, when asked why Person #1 was transferred to the current home, the Qualified Intellectual Disabilities Professional (QIDP) indicated that the physician recommended transfer because the prior facility had too many stairs. On 08/21/2026 at 12:08 PM, when asked again for the reason for the transfer, the QIDP stated that management initiated the transfer and that Person #1 could not safely walk up or down stairs. On 08/21/2026 at 12:53 PM, the Department confirmed that it had not received any notification regarding the incident and the transfer involving Person #1.	I9730		
I9780	3523.18 EMERGENCIES 3523.18 Each CRFPID shall conduct fire drills in order to test the effectiveness of the plan at least once every three months for each shift. An actual evacuation must be documented during at least one drill, each year on each shift. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, the facility failed to conduct fire drills at least once every three months, for each shift, for five of the five assigned shifts operated by the facility (Weekday 8:00 AM - 4:00 PM, 4:00 PM - 12:00 AM, 12:00 AM - 8:00AM, Weekend 8:00 AM - 8:00 PM, and 8:00 PM - 8:00 AM). Findings included: During an interview on 08/19/2026 at 11:14 AM,	I9780		

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I9780	Continued From page 11 the Qualified Intellectual Disabilities Professional (QIDP) reported that the facility operated five designated shifts (8:00 AM - 4:00 PM; 4:00 PM - 12:00 AM; and 12:00 AM - 8:00 AM), Monday through Friday and (8:00 AM - 8:00 PM and 8:00 PM - 8:00 AM) on the weekend (Saturday/Sunday). On 08/20/2026, beginning at 11:45 AM, a review of the facility's fire drill records showed no documented evidence that fire drills were conducted during the weekday 8:00 AM - 4:00 PM, 4:00 PM - 12:00 AM, or 12:00 AM - 8:00 AM shifts from October 2025 through February 2026. Further review showed no documented evidence that fire drills were conducted during the weekend 8:00 AM - 8:00 PM or 8:00 PM - 8:00 AM shifts during the same period. On 08/21/2026 at 12:49 PM, the QIDP acknowledged the findings.	I9780		