

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER WARD & WARD		STREET ADDRESS, CITY, STATE, ZIP CODE 5810 8TH ST, NW WASHINGTON, DC 20011		
(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 An annual licensure survey was conducted at this facility from February 12, 2026, through February 13, 2026. A sample of two persons was selected from a census of four. The findings of the survey were based on observations, interviews, and a review of records.	I 000	Please start typing your responses here:	
I8730	3519.3 MEDICAL AND NURSING SERVICES 3519.3 The CRFPID shall ensure appropriate referral and follow-up to meet the routine, chronic and acute health care needs of the person and in accordance with the person's choice of provider. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure appropriate follow up and coordination of care for routine dental services, for one of the two persons in the sample (Person #1). Findings Included: A review of Person #1's medical record on 02/12/2026 at 1:41 PM revealed that during a dental appointment on 01/28/2025, the dentist documented that they were unable to see the person, no treatment was provided, and that the individual was referred to the center for sedation. Continued review of Person #1's record showed a second dental consultation form dated 06/20/2025 in which another dentist documented that Person #1 "did not cooperate for X ray and examination, sedation needed." A further review of Person #2's record showed no	I8730		

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

TITLE

(X6) DATE

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18730	Continued From page 1 documented evidence that the facility followed up with the dentist or attempted to obtain other dentistry services in response to either of the two dental visits. During an interview on 02/13/2026 at 12:00 PM, the Registered Nurse (RN) stated that Person #1 "has a habit of refusing medical appointments," and that most dentists were unwilling to accept him as a patient. The RN further explained that the facility "tried to get him another dental doctor that he could take him to." However, the RN was unable to provide any documentation verifying any follow up efforts or attempts to obtain a dental appointment in accordance with the recommendations made on 01/28/2025 or 06/20/2025.	18730		
19780	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 a interviews and record reviews, the facility failed to ensure that fire drills were conducted as required, at least once every three months for each shift, for two of the five shifts in the facility's staffing pattern (weekends: 7:00 AM -7:00 PM and weekends: 7:00 PM-7:00 AM). Findings included: During the entrance meeting on 02/12/2026 at 1:15 PM, the Qualified Intellectual Disability	19780		

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19780	Continued From page 2 Professional (QIDP) reported that the facility operates three primary weekday shifts (7:00 AM-3:00 PM; 3:00 PM-11:00 PM; and 11:00 PM-7:00 PM) and two weekend shifts (7:00 AM-7:00 PM and 7:00 PM-7:00 AM). On 02/12/2026 at 3:22 PM, a review of the binder containing the facility's completed fire drill report forms for 01/2025 through 02/2026, revealed no evidence that fire drills were conducted at least once every three months for either the day or night weekend shift during the six months (February through July 2025). On 02/13/2026 at 10:42 AM, after reviewing the binder with the survey, the QIDP acknowledged that only four weekend fire drills were conducted during the entire review period and that none occurred between February and July 2025. The QIDP stated that she would add additional drill dates to the facility's weekend schedule.	19780		
19930	3524.3 ABUSE AND NEGLECT 3524.3 The CRFPID shall immediately notify the Department of all suspected or alleged incidents of abuse, neglect, mistreatment, and exploitation, as well as deaths. The Department shall be notified by telephone immediately, and the CRFPID shall follow-up with written notification to the Department 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 an alleged incident was reported immediately by telephone and followed by written notification to the Department,	19930		

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19930	<p>Continued From page 3</p> <p>as required by regulation for one of the two persons in the sample (Person #2).</p> <p>Findings included:</p> <p>During the entrance conference on 02/12/2026 at 9:30 AM, the Qualified Intellectual Disability Professional (QIDP) reported that Person #2 had experienced an incident of nutritional neglect during the survey period. The QIDP indicated that she did not have access to the related documentation while onsite and would need to contact the administrative office to obtain the necessary records.</p> <p>On 02/12/2026 at 2:14 PM, the QIDP presented an Incident Investigation Report completed by a Department on Disability Services (DDS) investigator. The report indicated that on September 19, 2025, the facility received an allegation of neglect related to an incident that occurred on September 16. According to the report, a DDS Navigator observed Person #2 at his day program consuming food prepared by the facility staff that did not comply with the nutritional requirements outlined in his Health Care Management Plan and subsequently reported the concern to both the facility and DDS. The DDS investigation determined that the allegation of nutritional neglect was substantiated.</p> <p>On 02/13/2026 at 3:10 PM, the facility's Incident Investigator (IC) when asked during a phone interview about incident reports, acknowledged that the facility failed to report the incident to the Department of Health and did not conduct its own investigation. The IC explained that the incident occurred at the day program site and not in the house, and that the facility believed it had nothing to do with the matter.</p>	19930			

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19930	Continued From page 4 During the exit conference at 3:30 PM, the facility management was informed of the identified concerns related to the requirement to immediately report incidents to the Department, conduct an internal investigation, and submit the resulting investigation report. The facility management acknowledged the information presented and indicated they had no questions.	19930		
19960	3524.6 ABUSE AND NEGLECT 3524.6 The CRFPID shall complete an investigation of any alleged incident within five (5) working days unless additional time is requested of and approved by the Department. The result of such investigation shall be reported to the Department within two (2) days of the conclusion of the investigation. A copy of the investigative report shall be provided to the Department upon request. Any substantiated claim of abuse, neglect or mistreatment shall be reported to the appropriate law enforcement entities. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure that an alleged incident was reported immediately by telephone and followed by written notification to the Department, as required by regulation for one of the two persons in the sample (Person #2). Findings included: During the entrance conference on 02/12/2026 at 9:30 AM, the Qualified Intellectual Disability Professional (QIDP) reported that Person #2 had	19960		

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19960	<p>Continued From page 5</p> <p>experienced an incident of nutritional neglect during the survey period. The QIDP indicated that she did not have access to the related documentation while onsite and would need to contact the administrative office to obtain the necessary records.</p> <p>On 02/12/2026 at 2:14 PM, the QIDP presented an Incident Investigation Report completed by a Department on Disability Services (DDS) investigator. The report indicated that on September 19, 2025, the facility received an allegation of neglect related to an incident that occurred on September 16. According to the report, a DDS Navigator observed Person #2 at his day program consuming food prepared by the facility staff that did not comply with the nutritional requirements outlined in his Health Care Management Plan and subsequently reported the concern to both the facility and DDS. The DDS investigation determined that the allegation of nutritional neglect was substantiated.</p> <p>On 02/13/2026 at 3:10 PM, the facility's Incident Investigator (IC) when asked during a phone interview about incident reporting, acknowledged that the facility failed to report the incident to the Department of Health and did not conduct its own investigation. The IC explained that the incident occurred at the day program site and not in the house, and that the facility believed it had nothing to do with the matter.</p> <p>During the exit conference at 3:30 PM, the facility management was informed of the identified concerns related to the requirement to immediately report incidents to the Department, conduct an internal investigation, and submit the resulting investigation report. The facility management acknowledged the information</p>	19960		

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19960	Continued From page 6 presented and indicated they had no questions.	19960			