

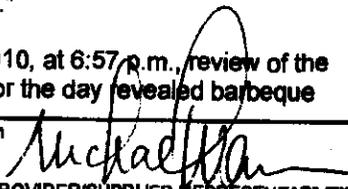
Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/20/2010
NAME OF PROVIDER OR SUPPLIER  WARD & WARD		STREET ADDRESS, CITY, STATE, ZIP CODE 807 FERN PL, NW WASHINGTON, DC 20012		
(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
1 000	INITIAL COMMENTS  A re-licensure survey was conducted on May 19, 2010, through May 20, 2010. A random sampling of two residents was selected from a population of four males with varying degrees of disabilities. The findings of this survey were based on observations at the group home, interviews with direct care staff, medical staff, facility management, and a review of the habilitation and administrative records including the unusual incident reports.	1 000	Received 6/24/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
1 040	3502.1 MEAL SERVICE / DINING AREAS  Each GHMRP shall provide each resident with a nourishing, well-balanced diet.  This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that residents received meals in accordance with their dietary needs for three of three residents residing in the GHMRP. (Residents #1, #2, #3)  The findings include:  Observation of the dinner meal on May 19, 2010, at 4:43 p.m., revealed the staff placing Resident #1, #2, and #3's dinner and drinks on the dining room table. Further observation of the meal revealed the residents received turkey cutlets, spinach and mashed potatoes for dinner. At 5:02 p.m., Resident #1 asked for more food. The direct support staff responded by saying, "No, you are on a 1800 calorie diet and I have to look out for your health."  On May 19, 2010, at 6:57 p.m., review of the dinner menu for the day revealed barbeque	1 040	QMRP provided staff in-service training on May 21, 2010 to review all of the individuals meal plans. Additionally a memo was placed in the menu record to instruct staff on substitution procedure (see attached) * Staff sign in sheet * training material * Substitution Protocol	6/18/10

Health Regulation Administration

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

STATE FORM



TITLE Program Director

(X6) DATE

6/23/10

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If continuation sheet 1 of 16

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I 040	Continued From page 1  turkey cutlets, roasted potatoes, green beans, pear halves and dinner roll were to be served. Interview with the direct support staff at 7:15 p.m., revealed he did not serve the residents dinner rolls because he is trying to eliminate starches from their diets. Further interview revealed that the residents did not receive pear halves or a different fruit because the facility did not have any other fruit to offer. Review of Resident #1's physician's orders dated May 1, 2010, on May 20, 2010, at 9:38 a.m., however, revealed the resident was prescribed a regular diet.  At the time of the survey, there was no evidence the facility ensured that the residents were provided meals in accordance with their diets and received a variety of food in accordance with the menu.	I 040		
I 082	3503.10 BEDROOMS AND BATHROOMS  Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.  This Statute is not met as evidenced by: Based on observation and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure two of three bathrooms were equipped with cup dispensers and/or hand soap as required by this section.  The finding includes:  During the environmental inspection on May 20, 2010, at approximately 5:45 p.m., there was no	I 082	Facility Manager will move the hand soap from under the sink cabinet to the counter top. The individuals have their disposable cups in their hygiene baskets. The cups no longer fit the dispensers. it will be removed.	6/18/10

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1082	Continued From page 2  cup dispenser or hand soap observed in the first floor bathroom located across from Resident #1 and Resident #3's bedroom. Further observation revealed there was no hand soap located in Resident #2's bathroom. Interview with the GHMRP's house manager (HM) at the same time revealed she would correct this problem immediately.	1082		
1090	<b>3504.1 HOUSEKEEPING</b>  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 GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for three of the three residents in the facility. (Residents #1, #2 and #3)  The findings include:  Observation and interview with the facility's qualified mental retardation professional (QMRP) on May 20, 2010, beginning at 5:45 p.m., revealed the following:  1. There were two large iron burn marks on the carpet located in the recreation room.  2. Resident #2's shower floor was peeling.  3. Rust stains were observed in the interior and exterior of several pots and pans. Additionally, there was tape observed securing the handle	1090	<i>Our Facility Managers are required to complete a facility checklist weekly to identify any maintenance or repair needs. Our QMRP's must sign off on the weekly checklist and our Programs Director reviews the checklist monthly to ensure a safe, clean, orderly, attractive and sanitary facility. Additionally our Maintenance team has completed the following: 1) Replaced burned carpet in recreation room 2) Resurfaced shower Resident #2 Bathroom.</i>	<i>6/21/10</i>

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I 090	Continued From page 3  onto one pot.  4. There was holes observed in both the carpet located in Resident #1's bedroom and in the dining room. The hole in the dining room carpet was covered with clear tape. Additionally, the carpet was observed to be unraveling in the hallway outside of the kitchen. This presented a potential safety hazard.  5. There were knobs missing from Resident #1, #2, and #3's dresser drawers.  9. Residents #1 and #2 had dresser drawers that were off track creating a potential safety hazard.  The QMRP acknowledged the above cited deficiencies at the conclusion of the environmental walk-through.	I 090	<i>Cont.</i> 3) Purchased new set of Pots and pans. 4) Carpet replaced in Resident #1 bedroom, dining room and hallway outside of kitchen. 5) Replaced knobs on dressers of residents #1, 2 & 3. 6) Repaired dresser drawer so they are on track also attached memo to FM.	
I 203	3509.3 PERSONNEL POLICIES  Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.  This Statute is not met as evidenced by: Based on interview and the review of records, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter, for three of seven employees. (Staff #1, #2, and #3)  The finding includes:  Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) on May 20, 2010, beginning at 5:00 p.m. revealed there was no evidence that Staff #1, #2, and #3	I 203	Human Resources had set the reminders for a (14) fourteen day notice to staff and job descriptions were not set up for reminders. We will reset reminders for 30 days and job descriptions will be included.	6/18/10

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I 203	Continued From page 4 discussed their job descriptions with their supervisor at the beginning of their employment and annually thereafter.	I 203	Cont. Job descriptions are current and available for review.	
I 227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;  This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR), for two of the seven staff (Staff #1 and #2), and current training in first aid, for one of the seven staff (Staff #2)  The finding includes:  Review of the personnel and training records on May 20, 2010, beginning at 5:00 p.m., revealed the GHMRP failed to provide documentation of staff training in CPR for Staff #1 and #2 and current training in first aid for Staff #2. Interview with the Qualified Mental Retardation Professional on May 20, 2010 at the same time, verified that there was no evidence of the aforementioned trainings.	I 227	Human Resources has reset reminders for 30 day notice to staff for all required certifications. Additionally staff were given notice on 6/18/10 to have CPR and first aid renewed by 7-1-10.	6/18/10
I 231	3510.5(h) STAFF TRAINING  Each training program shall include, but not be	I 231		

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I 231	Continued From page 5  limited to, the following:  (h) Orientation programs for each new employee which shall include philosophy, organization, programs, practices and goals of the GHMRP as well as a review of applicable laws, regulations and agreements important to the operation of the GHMRP for the care and treatment of persons with mental retardation in the District of Columbia; and...  This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to provide evidence of training in orientation, for four of the seven staff. (Staff #1, #2, #3 and #5)  The finding includes:  Review of the personnel files on May 20, 2010, beginning at 5:00 p.m., revealed the GHMRP failed to provide evidence that Staff #1, #2, #3 and #5 received orientation training. Interview with the qualified mental retardation professional on May 20, 2010 at 5:15 p.m., verified that there was no evidence of the aforementioned training.	I 231	HR has developed the Training Institute which consist of the 10 DDS policy courses and 30 phase I courses. The orientation training was incorporated in the phase I courses and must be completed by staff within 90 day of hire. Additionally DDS has reviewed our submission of all staff and we are 100% compliant. Those records are available for review. See attached DDS policies and Phase I courses.	6/18/10
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS  Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure records were available for inspection at all times by personnel of	I 261		

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1261	Continued From page 6  authorized regulatory agencies, for all consultants providing residential services to Residents #1, #2, and #3.  The finding includes:  On May 19, 2010, at approximately 5:30 p.m., personnel records were requested for each consultant working in the GHMRP. Review of personnel records on May 20, 2010, beginning at approximately 8:00 p.m., failed to evidence personnel records for the consultants providing services. In an interview with the QMRP on May 20, 2010, at approximately 5:30 p.m., it was acknowledged that the personnel records were not available for inspection during the survey.	1261	Our consultant personnel records are maintained at our main office with all other personnel records and will be available for review upon request.	6/22/10
1374	3519.5 EMERGENCIES  After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to promptly notify the resident's guardian or his or her next of kin after medical services were secured, followed by written notice and documentation no later than 48 hours after the incident, for one of five residents in the GHMRP. (Residents #1)  The findings include:  On May 19, 2010, beginning at 5:35 p.m., review	1374		

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I 374	<p>Continued From page 7</p> <p>of incident reports revealed the following injuries and medical services had not been reported to Resident #1's next of kin as required:</p> <p>a. An incident report dated October 19, 2009, revealed a direct support staff caught Resident #1 from falling. The primary care physician was notified and directed the staff to take the resident to the emergency room.</p> <p>b. An incident report dated April 28, 2010, revealed Resident #1 fell after he attempted to walk to the bathroom without his walker.</p> <p>Further review of Resident #1's record on May 20, 2010, beginning at 9:45 a.m., revealed primary care physician (PCP) notes that documented the following injuries and medical services:</p> <p>a. Review of a PCP note dated April 9, 2010, revealed Resident #1 had fallen at his day program.</p> <p>b. Review of the PCP note dated May 2009, revealed Resident #1 was taken to the emergency room for high blood pressure. According to the discharge papers, the resident was admitted on May 7, 2010, and discharged on May 8, 2010.</p> <p>Interview with the house manager on May, 19, 2010, at approximately 6:00 p.m., revealed Resident #1 had a brother who was active in his life. At the time of the survey, the GHMRP failed to provide evidence that notification of the aforementioned incidents was made to Resident #1's brother as required.</p>	I 374	<p>GHMRP's are required to review all incident reports to ensure accuracy and completeness. Further a Training will be provided on 6-28-10 to emphasize importance of contacting family and Dept. of Health. Further please find attached our revised Reporting requirements.</p>	6/22/10

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I 379	Continued From page 8	I 379		
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 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 review of the incident reports, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH), Health Regulation Administration, for one of the two residents (Resident #1) included in the sample.</p> <p>The findings include:</p> <p>Review of the facility's incident reports on May 19, 2010, beginning at 5:36 p.m., revealed the following:</p> <p>An incident report dated October 19, 2009, revealed a direct support staff caught Resident #1 from falling. The primary care physician was notified and directed the staff to take the resident to the emergency room.</p> <p>Review of the primary physician (PCP) notes on May 20, 2010, beginning at 9:45 a.m., revealed the following:</p>	I 379	See 1374.	6/22/10

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I 379	Continued From page 9  According to a PCP note dated May 2009, Resident #1 was taken to the emergency room for high blood pressure. The discharge papers revealed the resident was admitted on May 7, 2010, and discharged on May 8, 2010.  At the time of the survey, there was no documented evidence that the GHMRP notified the Department of Health (DOH) of the aforementioned incidents.	I 379		
I 401	<b>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</b>  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 GHMRP failed to ensure professional services were provided in accordance with the needs for two of the two residents in the sample. (Resident #1 and Resident #2)  The findings include:  1. The facility failed to provide evidence of a psychiatric assessment for Resident #2.  Observation of the evening medication administration on May 19, 2010, at 6:15 p.m., revealed Resident #2 received Tegretol and Thorazine. Interview with the licensed practical nurse (LPN) during the medication administration, indicated that the medication was prescribed for	I 401	1.) Ward & Ward will obtain an Annual Psychiatric assessment by 7-15-10. Further the LPN will review chart monthly and Clinical Director will review chart quarterly to ensure timely psychiatric services.	6/22/10

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I 401	<p>Continued From page 10</p> <p>behavior management.</p> <p>On May 20, 2010, review of Resident #2's physician orders dated May 2010, revealed that the aforementioned medications were used to treat his behavior disorder. Review of the resident's behavior support plan (BSP) dated January 13, 2010, on the same day at 3:24 p.m., revealed verbal threats and aggressive motions were his targeted behaviors.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and the LPN on May 20, 2010, at 3:34 p.m., revealed Resident #2 did not have a comprehensive psychiatric assessment. At the time of the survey, the GHMRP failed to provide evidence of an assessment that justified the use of psychotropic medications for Resident #2.</p> <p>2. The facility failed to provide evidence of a psychological assessment for Resident #2.</p> <p>Cross refer above. Resident #2 was observed receiving Tegretol and Thorazine during the evening medication administration on May 19, 2010, at 6:15 p.m. The resident had a BSP dated January 13, 2010, that addressed target behaviors of verbal threats and aggressive motions.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and the LPN on May 20, 2010 at 3:34 p.m. revealed Resident #2 did not have a comprehensive psychological assessment. Further review of the client's medical record revealed no documented evidence of a psychological assessment.</p> <p>3. The facility failed to ensure timely treatment</p>	I 401	<p>2.) As we are a CRF we will need referral from DDS to obtain a psychological assessment. Please find attached letter dated 6-17-10 to request a psychological assessment.</p> <p>3.) Resident # 2 did receive timely dental services. He was seen by [redacted] on 1-27-10 and indicated that RCT-v-Extraction note to begin 7 day ABT. on 2-17-10 was seen again by [redacted] and discussed saving tooth with RCT and if not extracting. RCT was unsuccessful and</p>	6/22/10

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I 401	Continued From page 11 services for the maintenance of dental health for Resident #2 as evidence below:  On May 20, 2010, at 2:46 p.m., review of Resident #2's dental consultation dated January 27, 2010, revealed tooth #8 required route canal treatment or extraction. Moments later, interview with the license practical nurse indicated she was not sure why his dental procedure was not conducted or addressed. At the time of the survey, there was no evidence Resident #2 had been provided timely dental treatment.  4. The facility failed to ensure Resident #1 utilized his leg brace as prescribed.  Observation on May 19, 2010, beginning at 4:15 p.m., revealed Resident #1 walking with an unsteady gait. During the environmental walk through a leg brace was observed in Resident #1's closet. At the time of the survey, the resident was not observed wearing a leg brace.  On May 20, 2010, at 9:38 a.m., review of Resident #1's physician orders revealed the resident wore a brace on his left foot. Interview with the license practical nurse and the QMRP on the same day, at approximately 3:00 p.m., revealed they were unaware of when the resident was required to wear his brace. At the time of the survey, the GHMRP failed to ensure Resident #1 utilized his leg brace as prescribed.	I 401	Tooth was extracted on 6-14-10. Next flr visit is scheduled for 6-28-10.  4) QMRP will request for a referral for Physical Therapy assessment to determine appropriate use of leg brace.	6/22/10  6/22/10
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter.	I 407		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/20/2010
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NAME OF PROVIDER OR SUPPLIER  WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 807 FERN 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 407	<p>Continued From page 12</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis, for one of the two residents residing in the facility. (Resident #1)</p> <p>The finding includes:</p> <p>Review of Resident #1's medical record on May 20, 2010, at 10:20 a.m., revealed an annual nursing assessment dated May 2009. Further review of the resident's record revealed there was only one quarterly assessment (December 30, 2009) available for review. Interview with the license practical nurse on May 20, 2010, at approximately 6:00 p.m., revealed the facility did not have all of the required quarterly nursing assessments.</p>	I 407	<p>Clinical Director has provided LPN's instructions on referring to electronic chart prior to reporting <del>missing</del> <del>by</del> <del>was</del> to print nursing quarterly assessments to place in charts. Quarterly assessment for 3-31-10 was placed in record for review.</p>	6/22/10
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I 436	<p>3521.7(f) HABILITATION AND TRAINING</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the two residents in the sample.</p>	I 436		
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Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>887 FERN PL, NW WASHINGTON, DC 20012</b>
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1436	<p>Continued From page 13 (Residents #1 and #2)</p> <p>The findings include:</p> <p>1. Review of the Resident #1's self medication assessment dated September 7, 2009, on May 20, 2010, at 9:32 a.m., indicated that the resident was recommended to participate in a self medication program. Review of Resident #1's Individual Program Plan (IPP) dated May 29, 2009, on May 20, 2010, at approximately 3:15 p.m., revealed no program goal or objective for the resident to receive training in self-medication skills development.</p> <p>Interview with the License practical nurse (LPN) on May 20, 2010, at approximately 3:45 p.m., revealed that Resident #1 does not participate in a self medication program.</p> <p>2. Review of Resident #2's self medication assessment dated September 7, 2009, on May 20, 2010, at 2:20 p.m., indicated that the resident was recommended to participate in a self medication program. Review of Resident #2's IPP dated March 16, 2010, on May 20, 2010, at approximately 3:40 p.m., revealed no program goal or objective for the resident to receive training in self-medication skills development.</p> <p>Interview with the LPN on May 20, 2010, at approximately 3:45 p.m., revealed that Resident #1 does not participate in a self medication program.</p>	1436	<p>1.) RN has reviewed self medication protocol with the residential LPN. Individuals are to be invited to participate in medication administration at their level of functioning. LPN will follow self med protocol to verbally prompt individuals of medication time, assist with getting water or what times are medications taken daily. Self med evals were done 9/09, 12/09 and 3/10.</p> <p>2.) See 1436 #1.</p>	6/22/10
1500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this</p>	1500		

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NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>807 FERN PL, NW WASHINGTON, DC 20012</b>		
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I 500	<p>Continued From page 14</p> <p>chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and record review, the 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 three residents in the sample. (Residents #1 and #2)</p> <p>The finding includes:</p> <p>The GHMRP failed to protect residents' rights by not informing the residents' medical guardians of the use of psychotropic medications and incorporating them in a behavior support plan as follows:</p> <p>During the entrance conference on May 19, 2010, beginning at 5:30 p.m., the House Manager indicated that Resident #2 received psychotropic medications to address his maladaptive behaviors. Further interview revealed the resident does not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Observation of the administration of medication on May 19, 2010, at 6:29 p.m., revealed Resident #1 received Tegretol and Thorazine for his behavior disorder. There was no documented evidence that the facility obtain consent prior to administering his medications.</p> <p>At the time of the survey, the GHMRP failed to</p>	I 500		

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I 500	Continued From page 15 provide evidence that informed consent was obtained from the guardian prior to the administration of the psychotropic medication.	I 500	Ward & Ward has contacted medical guardian and obtained informed consent.	6/22/10
I 999	FINAL OBSERVATIONS  The following observations were made during the survey process. It is recommended that these areas be reviewed and determinations be made regarding appropriate actions in order to prevent potential non-compliant practices:  During the environmental walk through on May 20, 2010, at approximately 5:45 p.m., seven of the eleven bath towels available in the linen closet were observed to have either tears or were unraveling around the edges. Interview with the qualified mental retardation professional at the same time revealed she would replace the seven towels.	I 999		