

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2011
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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 14TH STREET, NW WASHINGTON, DC 20011
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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 CRDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000 INITIAL COMMENTS

A recertification survey was conducted from April 6, 2011 through April 8, 2011. A sample of three clients was selected from a population of four males and two females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process.

The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.

W 125 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS

The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, for two of three clients in the sample. (Clients #2 and #3)

The finding includes:

During the environmental walk thru on April 8, 2011, beginning at 1:08 p.m., Client #2's and #3's bedroom was observed to have an exit/entrance door. The door was observed to sound when

W 000

W 125

5/9/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
999 North Capitol St., N.E.
Washington, D.C. 20002

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 125	<p>Continued From page 1 opened.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on April 8, 2011, at 1:10 p.m., revealed that it was a door alarm that sounded when the door was opened. Further interview revealed that the door alarm was activated at night. When asked, the QIDP was not sure why the door alarm was placed on the door. Clients #2 and #3 did not have a target behavior of elopement.</p> <p>Review of the facility's Human Rights Committee (HRC) minutes on April 8, 2011, at approximately 1:40 p.m., revealed no documented evidence that the HRC had approved the use of Client #2's and #3's door alarm.</p> <p>Review of Client #2's and #3's psychological assessments on April 7, 2011, at 2:18 p.m and 3:50 p.m., respectively, revealed both clients lack the capacity to make independent decisions on their behalf regarding habilitation planning, placement, treatment, financial or medical matters.</p> <p>Interview with the QIDP on April 8, 2011, at approximately 2:20 p.m., revealed that Clients #2 and #3 had a court appointed legal guardians to assist them with decision making.</p> <p>At the time of the survey, there was no evidence that the clients' involved family members and/or legal guardians had been made aware of the purpose of the door alarm and/or its use.</p>	W 125	<p>W 125 The door alarm was disconnected as none of the individuals had an elopement issue. In the future the QMRP and QA Dept. will ensure that the environmental QAs are conducted appropriately and comprehensively and do not interfere with the individuals' rights and freedom.</p>	5/4/11
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged</p>	W 154		

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W 154	<p>Continued From page 2 violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries of unknown origin, for one of three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On April 7, 2011, at 1:40 p.m., review of Client #2's medical records revealed a primary care physician (PCP) referral request dated June 22, 2010. According to the referral request, Client #2 was evaluated by the PCP for two swollen elbows etiology unknown. The PCP recommended that an x-ray be taken of the elbows to rule out fractures. Review of the x-ray dated June 22, 2010, on April 7, 2010, at approximately 1:50 p.m., revealed mild enthesopathy of both elbows.</p> <p>On April 8, 2011, at approximately 2:20 p.m., an interview was conducted with the qualified intellectual disability professional (QIDP) to determine how the injury to Client #2's elbows had occurred. The QIDP revealed that Client #2's self-injurious behaviors (i.e. head slapping, head punching) had increased during the month of June 2010 due to the reduction of his psychotropic medications. Further interview revealed that Client #2 exhibited a new behavior of banging his elbows during the medication change. When asked whether staff documented the new behavior of banging his elbow, the QIDP stated that she was unsure.</p> <p>Review of the behavior data collection sheets and staff progress notes for the month of June 2010</p>	W 154	<p>W 154 The individual's behavior was incidental and momentarily caused due to the titration and discontinuation of his psychotropic medication. This behavior of 'elbow banging' has not recurred and therefore there is no need for a 'target behavior' or 'data collection' to be endured. The investigation was completed as a reportable incident and concluded that the cause for the elbow swelling was the new 'precipitated' behavior secondary to psychotropic medication changes. The report was reviewed and signed by the VPO. In the future the IMC will ensure that all incidents are reported and investigated in accordance with DDS and Metro Homes, Inc. – Policy and Procedure on Incident Management and Reporting. The IMC was in serviced on Incident Management policy and procedure. See attached – in-service record</p>	5/4/11

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W 154 Continued From page 3
on April 8, 2011, at approximately 2:25 p.m., revealed that staff had not documented the episodes of elbow banging.

W 154

Continued interview with the QIDP on April 8, 2011, at approximately 2:35 p.m., revealed that the injuries to Client #2's elbows were not investigated to determine it cause.

W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS

W 156

The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.

W 156
The report was immediately reviewed and signed by the VP Operations.
In the future the IMC will ensure that all incidents are reported and investigated in accordance with DDS and Metro Homes, Inc. – Policy and Procedure on Incident Management and Reporting.
The IMC was in serviced on Incident Management policy and procedure.
See attached in-service record

5/4/11

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to report the results of all investigations of injuries of unknown origin to the administrator within five working days of the incident, for one of the six clients residing in the facility. (Client #4)

The finding includes:

On April 6, 2011, at 4:00 p.m., review of incident reports and corresponding investigations revealed that on February 26, 2011, Client #4 was transported to the emergency room for an x-ray of her legs due to complaints of right thigh pain. This was deemed necessary by the primary care physician since Client #4 has a history of hip fracture and was diagnosed with Osteoporosis. Further review revealed the administrator had not reviewed and signed the investigative report dated February 26, 2011.

Interview with the qualified intellectual disability

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W 156	Continued From page 4 professional (QIDP) on April 6, 2011, at approximately 4:22 p.m., acknowledged the administrator had not reviewed and signed the investigative report.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		
	<p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the qualified intellectual disability professional (QIDP) coordinated and integrated services, for one of three clients in the sample. (Clients #2)</p> <p>The finding includes:</p> <p>On April 6, 2011, from 1:08 p.m. to 1:28 p.m., observations conducted at the day program revealed that Client #2 was not observed to use a communication device. Later that evening during home observation at 5:20 p.m., Client #2 retrieved a communication device (Go Talk) from the activity area with staff supervision. The client returned back to the dining table and began manipulate the device. On April 7, 2011, additional observations conducted at the day program from 9:40 a.m. to 10:15 a.m., revealed that the "go talk device was not used.</p> <p>Interview with the direct care staff on April 6, 2011, at approximately 5:25 p.m., revealed that Client #2 was non-verbal. Further interview revealed that the "go talk" device was recommended to assist the client with identifying</p>	<p>W 159</p> <p>The QDDP has reviewed the program for the 'go talk' with the day program and a new IPP has been developed at the day program.</p> <p>In the future the QDDP will ensure that services are coordinated and integrated with the day program so as to ensure continuity of care.</p> <p>See attached in-service record on IPP, IPP</p>		5/5/11

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W 159	Continued From page 5 items and objects used during personal hygiene, grooming, leisure recreational activities, etc. The direct care staff stated that the communication device was part of Client #2's daily goals and objectives. Review of Client #2's individual support plan (ISP) records on April 8, 2011, at 9:15 a.m., revealed an ISP dated February 7, 2011, and a speech/language pathology assessment dated March 6, 2011. Both confirmed the direct care staff interview conducted on April 6, 2011, at 5:25 p.m. On April 8, 2011, at approximately 3:45 p.m., interview with the qualified intellectual disability professional (QDDP) revealed that the "go talk" device had not been integrated and coordinated as part of Client #2's active treatment while at the day program.	W 159		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the provision of nursing services in accordance with the needs of one of the three clients in the sample. (Client #1) The findings include: Cross Refer to W455. The facility's nursing services failed to ensure consistent implementation of an active program for the prevention and control of infection for the client.	W 331	W 331 The TME has been in-serviced on Medication Administration Policy and Procedure. In the future the RN will ensure that all TMEs are monitored according to Metro Homes, Inc.'s policy and procedure for TME - medication administration. See attached in-service record	5/5/11
W 382	483.460(l)(2) DRUG STORAGE AND	W 382		

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W 382	<p>Continued From page 6 RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep all drugs locked securely when not being prepared for administration, for one of three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On April 6, 2011, at 5:35 p.m., observation of the evening medication administration revealed the trained medication employee (TME) left Client #1's medications on the medication table unsecured. At 5:38 p.m., the TME left the medication station again without properly securing the client's medications. At 5:40 p.m., the facility's director of nursing (DON) who was in the facility on April 6, 2011, during the medication pass, observed the medications left unsecured. Direct care staff was observed to walk back and forth to the medication area during the medication administration.</p> <p>Interview with the DON on April 6, 2011, at approximately 5:45 p.m., acknowledged that the TME did not properly secure Client #1's medications each time he left the medication station.</p> <p>Note: It should be noted that Client #1 was administered psychotropic medications during the medication administration pass.</p>	W 382	<p>W 382</p> <p>The TME has been in-serviced on Medication Administration Policy and Procedure.</p> <p>In the future the RN will ensure that all TMEs are monitored according to Metro Homes, Inc.'s policy and procedure for TME – medication administration.</p> <p>See attached in-service record</p>	5/5/11
W 441	483.470(i)(1) EVACUATION DRILLS	W 441		

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W 441	Continued From page 7 The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The finding includes: On April 7, 2011, at 11:25 a.m., review of the facility's fire drill records revealed that most of the fire drills were conducted utilizing the front door, bedroom #1 and bedroom #3 exits. Interview with the residential director (RD) on April 7, 2011, at approximately 1:20 p.m., revealed that the facility had at least six method of egress (front door, back door #1, back door #2, bedroom #1, bedroom #3, and basement door). Further review of the fire drill records revealed that back door #1 and back door #2 exits had not been used from March 2010 through March 2011. This was acknowledged through continued interview with the RD on the same day at approximately 1:25 p.m. There was no evidence on file at the time of survey to substantiate that all exits were used.	W 441	W 441 The fire drill record has been modified to include all 6 methods of egress. All staff have been in-serviced on the fire drill procedure and policy.	5/6/11	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	W 455			

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W 455	<p>Continued From page 8</p> <p>failed to provide an active program for the prevention and control of infection and communicable diseases, for one of three clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On April 6, 2011, at 5:27 p.m., the trained medication employee (TME) was observed to wash his hands with soap and water prior to administering medications. At 5:30 p.m., the licensed practical nurse (LPN) opened the medication closet, retrieved the medication administration record (MAR), retrieved the pill crusher, retrieved Client #1's five (5) medications, and punched all medications from the blister pack into the medication cup. At 5:35 p.m., the TME retrieved the blood pressure (BP) monitor and checked the client's BP in the living room area. At 5:38 p.m., the TME returned back to the medication station with the BP monitor and placed it back on top of the medication cabinet. The TME then prepared Client #1's last medication by placing his finger inside the measuring cup and then pouring Senna Syrup 20 ml into the same medication cup. At this time, the TME was not observed to wash and/or sanitize his hands prior to pouring the Senna Syrup into the cup.</p> <p>Interview with TME on April 6, 2011, at approximately 5:45 p.m., acknowledged that he should have washed his hands prior to preparing and administering Client #1's last medication (Senna Syrup 20 ml).</p> <p>At the time of the survey, there was no evidence the facility's nursing staff provided an active program for the prevention and control of</p>	W 455	<p>W 455</p> <p>The TME has been in-serviced on Medication Administration Policy and Procedure and Infection Control. In the future the RN will ensure that all TMEs are monitored according to Metro Homes, Inc.'s policy and procedure for TME – medication administration. See attached in-service record</p>	5/5/11	

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W 455	Continued From page 9 infection.	W 455		
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Health Regulation Administration

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R 000	INITIAL COMMENTS A licensure survey was conducted from April 6, 2011 through April 8, 2011. A sample of three residents was selected from a population of four males and two female with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the interview and record review, the GHPID failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check, for three of thirteen staff employed. (Staff #3, #6, and #13) The finding includes: Interview with the qualified developmental disability professional (QDDP) and review of the personnel files on April 8, 2011, beginning at 11:41 a.m., revealed the GHPID failed to provide evidence of criminal background checks that disclosed a seven year listing of all jurisdictions	R 125	R 125 In the future the HR Dept will ensure that all staff complete a background check for all jurisdictions he/she may have been employed/lived in the past 7yrs. The staff have submitted their requests to Global Investigators. Metro Homes, Inc. has contracted with an IT company and is in the process of developing HR Auditing systems. See attached criminal back ground checks request forms	5/9/11

Health Regulation Administration

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

STATE FORM

6899

YH5X11

TITLE

VP Operations

(X6) DATE

5/4/11

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where three staff worked and/or resided at the time of the survey. For example:

- a. There was no background conducted from Client #3 who worked in the state of Virginia.
- b. There was no background conducted from Client #3 who worked in Washington DC.
- c. There was no background conducted from Client #3 who worked in the state of Texas.

R 125

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2011
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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 14TH STREET, NW WASHINGTON, DC 20011
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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 000 INITIAL COMMENTS

A licensure survey was conducted from April 6, 2011 through April 8, 2011. A sample of three residents was selected from a population of four males and two female with varying degrees of intellectual disabilities.

The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.

I 092 3504.3 HOUSEKEEPING

Each GHMRP shall be free of insects, rodents and vermin.

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 it was maintained free of roaches, for six of six residents residing in the facility. (Residents #1, #2, #3, #4, and #5)

The findings include:

During the environmental walk-thru on April 8, 2011, at 1:23 p.m., observation of the kitchen drawers and underneath the cabinets revealed several live roaches. Interview with the residential coordinator (RC) on April 8, 2011, at approximately 1:25 p.m., revealed that the GHPID had a contract with a pest control company. However, when asked, the RC was unable to locate any receipts and/or a service contract upon request.

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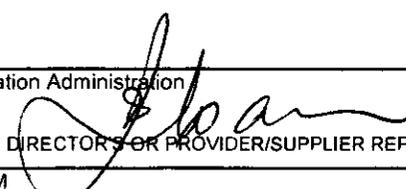
I 092

Metro Homes, Inc. has contracted with a Pest Control company who has a schedule for disinfecting the homes. In the future the QDDP and RC along with the QA Dept. will ensure that monthly environmental audits are conducted to ensure the homes are free from insects and vermin. See attached contract

5/5/11

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



TITLE

VP Operations

(X6) DATE

5/4/11

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I 180	Continued From page 1	I 180		
I 180	3508.1 ADMINISTRATIVE SUPPORT	I 180		
	<p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHPID failed to ensure the qualified developmental disability professional (QDDP) coordinated and integrated services, for one of three residents in the sample. (Residents #2)</p> <p>The finding includes:</p> <p>On April 6, 2011, from 1:08 p.m. to 1:28 p.m., observations conducted at the day program revealed that Resident #2 was not observed to use a communication device. Later that evening on April 6, 2011, at 5:20 p.m., Resident #2 was observed to retrieve a communication device (Go Talk) from the activity area with staff supervision during active treatment time at approximately 5:25 p.m. The resident returned back to the dining table and began to work with the device. On April 7, 2011, additional observations conducted at the day program from 9:40 a.m. to 10:15 a.m., revealed that the "go talk device was not used.</p> <p>Interview with the direct care staff on April 6, 2011, at approximately 5:25 p.m., revealed that Resident #2 was non-verbal. Further interview revealed that the "go talk" device was recommended to assist the resident with identifying items and objects used during personal hygiene, grooming, leisure recreational activities, etc. The direct care staff stated that the communication device was part of Resident #2's</p>	<p>I 180</p> <p>The QDDP has reviewed the program for the 'go talk' with the day program and a new IPP has been developed at the day program.</p> <p>In the future the QDDP will ensure that services are coordinated and integrated with the day program so as to ensure continuity of care.</p> <p>See attached in-service record on IPP, IPP</p>	<p>5/5/11</p>	

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I 180	Continued From page 2 daily goals and objectives. Review of Resident #2's individual support plan (ISP) records on April 8, 2011, at 9:15 a.m., revealed an ISP dated February 7, 2011, and a speech/language pathology assessment dated March 6, 2011. Both confirmed the direct care staff interview conducted on April 6, 2011, at 5:25 p.m. On April 8, 2011, at approximately 3:45 p.m., interview with the qualified developmental disability professional (QDDP) revealed that the "go talk" device had not been integrated and coordinated as part of Resident #2's active treatment while at the day program.	I 180		
I 401	3520.3 PROFESSION 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 intellectual disabilities (GHPID) failed to ensure the provision of nursing services in accordance with the needs of one of the three residents in the sample. (Resident #1) The finding includes: Cross Refer to W455. The GHPID's nursing services failed to ensure consistent implementation of an active program for the	I 401	I 401 The TME has been in-serviced on Medication Administration Policy and Procedure and Infection Control. In the future the RN will ensure that all TMEs are monitored according to Metro Homes, Inc.'s policy and procedure for TME – medication administration. See attached in-service record	5/5/11

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I 401	Continued From page 3 prevention and control of infection for the resident.	I 401		
I 500	<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 chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHPID failed to demonstrate how the rights of all residents were protected and failed to allow and encourage individual residents to exercise their rights as residents of the facility, and as citizens of the United States, for two of three residents in the sample. (Residents #2 and #3)</p> <p>The finding includes:</p> <p>During the environmental walk thru on April 8, 2011, beginning at 1:08 p.m., Resident #2's and #3's bedroom was observed to have an exit/entrance door. The door was observed to sound when opened.</p> <p>Interview with the qualified developmental disability professional (QDDP) on April 8, 2011, at 1:10 p.m., revealed that it was a door alarm that sounded when the door was opened. Further interview revealed that the door alarm was activated at night. When asked, the QDDP was not sure why the door alarm was placed on the door. Residents #2 and #3 did not have a target behavior of elopement.</p>	I 500	<p>I 500 The door alarm was disconnected as none of the individuals had an elopement issue. In the future the QMRP and QA Dept. will ensure that the environmental QAs are conducted appropriately and comprehensively and do not interfere with the individuals' rights and freedom.</p>	5/4/11

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I 500	<p>Continued From page 4</p> <p>Review of the facility's Human Rights Committee (HRC) minutes on April 8, 2011, at approximately 1:40 p.m., revealed no documented evidence that the HRC had approved the use of Resident #2's and #3's door alarm.</p> <p>Review of Resident #2's and #3's psychological assessments on April 7, 2011, at 2:18 p.m. and 3:50 p.m., respectively, revealed both residents' lacks the capacity to make independent decisions on their behalf regarding habilitation planning, placement, treatment, financial or medical matters.</p> <p>Interview with the QDDP on April 8, 2011, at approximately 2:20 p.m., revealed that Residents #2 and #3 had a court appointed legal guardians to assist them with decision making.</p> <p>At the time of the survey, there was no evidence that the residents' involved family members and/or legal guardians had been made aware of the purpose of the door alarm and/or its use.</p>	I 500		