



# METRO HOMES, INC.

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RECEIVED  
DEPARTMENT OF HEALTH  
HEALTH-REGULATION  
ADMINISTRATION

2007 MAY 29 P 3:48

May 29, 2007

Pat VanBuren  
Department of Health and Human Services  
Intermediate Care Facilities Division  
825 North Capitol Street NE 2<sup>nd</sup> Floor  
Washington, DC 20002

Dear Ms. VanBuren,

Attached you will find our plan of corrections for 1433 Northgate Road NW Washington, DC (Northgate). If any other additional information is needed please contact me at the above mentioned number.

Sincerely,

Susan Sloan  
Vice President of Operations

cc: Sheila Panell, Supervisor DOH  
Mark Clark, Quality Assurance Compliance Specialist



METRO HOMES, INC.

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

PRINTED: 05/21/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G141</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/03/2007</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012</b>
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from May 1, 2007 through May 3, 2007. The survey was initiated using the fundamental survey process. A random sample of three clients were selected from a population of six females with various disabilities.</p> <p>The findings of this survey were based on observations at the group home, two day programs, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.</p>	W 000		<p style="writing-mode: vertical-rl; transform: rotate(180deg);">RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">2007 MAY 29 P 3:48</p>
W 124	<p><b>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of three sampled clients. (Client #2)</p> <p>The finding includes:</p> <p>During the entrance conference on 5/1/07 beginning at 3:40 PM, an interview was</p>	W 124	<p><b>W 124</b></p> <p>A medical and psychological affidavit and a guardianship assessment have been sent to the DDS Case Manager to pursue guardianship. Routine HRC approval for medication treatment has been completed as per Policy and Procedure for Psychotropic medication administration. Presently a guardian is being pursued and as soon as one is appointed the risks and benefits will be explained to the person for their approval.</p> <p>The Agency has started the Guardianship process for all clients who do not have family or guardian and will ensure that guardianship is addressed at every ISP meeting and the appropriate documentation is completed.</p> <p>See attached – copies of medical and psychological affidavit and guardianship assessment forms.</p>	5/24/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Sharon M. Brown</i>	TITLE  <i>VFO</i>	(X6) DATE  <i>5/24/07</i>
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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 124	<p>Continued From page 1</p> <p>conducted with the Qualified Mental Retardation Professional (QMRP). The QMRP indicated that Client #2 was prescribed psychotropic medication in conjunction with the Behavior Support Plan (BSP) to address her maladaptive behaviors. The QMRP further indicated that the psychotropic medication was discontinued.</p> <p>Additional interview with the QMRP on 5/2/07 at approximately 3:45 PM revealed that Client #2 did not have a legal guardian and/or family member who provided consent for the use of the psychotropic medication during the time in which it was prescribed. Review of psychological assessment dated 7/17/06 on 5/3/07 at approximately 9:05 AM revealed that Client #2 functions at the profound level of mental retardation and was incapable of independent decisions regarding medical treatment. Further review of Client #2's medical records on the same day at approximately 9:35 PM, confirmed that Client #2 received Luvox 50 mg two times a day to address targeted behaviors of Self-Injurious Behavior, Property Destruction and grabbing.</p> <p>At the time of the survey, the facility failed to provide evidence that Client #2's treatment needs, including the risk and benefits and the right to refuse treatment, had been explained to her and/or a legally authorized representative.</p>	W 124			

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W 124	Continued From page 2	W 124		
W 130	<p>Review of Client #2's record, revealed that although the facility's Human Rights Committee had discussed and approved the use of this medication, there was no evidence of written, informed consent for the Megace. There was no evidence that the potential risks involved in using this medication had been explained to the client.</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to implement an effective system to protect the clients' right for privacy during medical and personal care needs for five of six clients residing in the facility. (Client #1, #2, #3, #4, and #5)</p> <p>The findings include:</p> <p>1. The facility failed to ensure that Clients received privacy during the evening medication administration as evidence below.</p> <p>a. During the evening medication administration observation on 5/1/07 beginning at 5:30 PM, the Licensed Practical Nurse (LPN) was observed administering medications to Client #1, #2, and</p>	<p>W 130</p> <p>W 130</p> <p>W 130</p> <p>The facility has had the nursing staff reorganized and the nurse involved has resigned. The new nurse has been in serviced on the Policy and Procedure for Medication Administration and Client's Rights and Protection. The agency has hired a Director of Nursing to ensure best practice and quality nursing care is delivered to the clients. In the future the agency will ensure that the client's right for privacy during medication administration and personal care is always maintained. All staff was trained, a new QMRP and House Manager have been appointed to the Facility.</p> <p>See attached – in service sheet for medication administration and clients rights and protection</p>	5/30/07	

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W 130	Continued From page 3 #5 at the dinner table. The LPN was also observed to leave the medication door wide open while administering medications to Client #2. At the time, staff were assisting clients with their eating dinner.  b. During the evening medication administration observation at approximately 5:42 PM on the same day, the LPN was observed administering medications to Client #3 in front of staff and peers in the living room area. At approximately 4:48 PM, the LPN was further observed administering medications to Client #4 in front of staff and peers in the living room area.  2. The facility failed to ensure that Client #2 received privacy during care of personal needs.  Observations conducted on 5/1/07 at 5:47 PM revealed Client #2 entering the bathroom located on the main level with her pants down and buttock exposed. Further observations revealed Client #2 with her shirt up exposing her bra. At no time did staff redirect the client to undress herself in the bathroom.	W 130		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that Client #3 was clothed with the appropriate clothing for the weather.	W 137	W 137 The Facility has reorganized the management staff and a new QMRP and House Manager have been appointed to the Facility. All staff was trained in Client's rights and Privacy and Protection of clients. In the future the facility will ensure that clients will be appropriately dressed according to the weather conditions and the new House Manager will be overseeing this.  See attached – in service sheet for clients rights and protection and clothing.	5/30/07

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W 137	Continued From page 4 The finding includes:  Observations conducted on 5/2/07 at 9:22 AM revealed Client #3 sitting around the table with staff and peers with a stripped turtle neck shirt and a light jacket on. Interview with the classroom Coordinator on the same day at approximately 9:25 AM revealed that Client #3 arrived at the day program wearing a turtle neck shirt, a light jacket, and a brown thick wool coat. The Coordinator further revealed that the client had been arriving at the day program the past two weeks with inappropriate clothing for the weather. The Coordinator indicated that she had addressed the concerns with the facility's driver on several occasions.  Later that day, interview conducted with the Qualified Mental Retardation Professional (QMRP) and the House Manager at approximately 1:00 PM revealed that they were unaware of the day programs concerns and would address the issues with staff immediately. At the time of the survey, the facility failed to ensure that Client #3 received clothing appropriate for the weather conditions. It should be noted that on 5/2/07, the temperature reached over 80 degrees outside.	W 137					
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.  This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that each	W 159					

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W 159	Continued From page 5 client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP).  The findings include:  1. The QMRP failed to ensure that an effective system was implemented to protect the clients' rights for privacy during personal care needs. [See W130]  2. The QMRP failed to ensure that Client #3 was clothed with appropriate clothing for the weather. [See W137]  3. The QMRP failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. [ See W189]  4. The QMRP failed to ensure that staff implemented Client #2's Behavioral Support Plan (BSP). [See W193]  5. The QMRP failed to ensure that each employee received effective training on infectious control. [See W 455]  6. The QMRP failed to ensure adaptive equipment recommended by the interdisciplinary team was provided and maintained in good repair. [See W436]	W 159	W 159 - 1 Refer to W 137  W 159 - 2 Refer to W 137  W 159 - 3 All staff was trained by the Psychologist on client # 2's BSP to enable them to perform their duties efficiently. The new QMRP and House Manger will ensure that there is close supervision of staff.  W 159 - 4 All staff was trained by the Psychologist on the BSP for client # 2. The QMRP and the House Manger will ensure that the BSP is followed.  W 159 - 5 All staff was trained in Infection Control. The QMRP and House Manger along with the Director of training will ensure that there is on going training and oversight with close supervision of staff.  W 159 - 6 Wheelchair repair has been scheduled for 5/29/07 by Essential Rehab In the future the QMRP and the nurse will ensure the wheelchair repairs and maintenance is completed promptly and the DON and VP are notified.  See attached 719 A form, Wheelchair maintenance form	5/29/07
W 189	483.430(e)(1) STAFF TRAINING PROGRAM  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively,	W 189		

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W 189	<p>Continued From page 6 efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that initial and continuing training was provided for each employee to enable them to perform duties effectively, efficiently, and competently to address the needs of one of three clients included in the sample. (Clients #2)</p> <p>The finding includes:</p> <p>During the entrance conference on 5/1/07 at approximately 3:35 PM, Client #2 was observed with a small amount of dried up blood located at the bottom outside left nostril. At approximately 6:30 PM, the House Manager (HM) was interview regarding Client #2's nose. The HM indicated that she thought it was red juice from the bottle had been drinking out of all day. The HM further indicated that Client #2 has a targeted behavior of Self-Injurious Behavior (SIB; Skin Picking).</p> <p>Review of Client #2's behavior Support Plan (BSP) dated 7/16/06 revealed a target behavior of SIB which included skin picking. Review of the behavior data sheets reflected that staff documented the behavior and provided basic First Aid and Safety.</p> <p>Observations of Client #2's nose on 5/2/07 and 5/3/07 revealed that a scab had formed.</p> <p>Additional interview with the Qualified Mental Retardation Professional (QMRP) and HM on 5/3/07 at 3:00 PM revealed a "Skin Assessment/ Equipment Accessories" sheet that each shift</p>	W 189	<p>W 189 All staff were trained by the psychologist on the BSP for Client # 2. All staff was trained in the documentation for SIB and Target behaviors for this client. In the future the new House Manager and the QMRP will ensure there is close supervision and oversight of staff.</p> <p>See attached – in service sheet for client # 2's BSP</p>	5/29/07	

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W 189	Continued From page 7 (1st, 2nd, and 3rd) are to document on daily. The Skin Assessment indicated to mark a plus (+) if the clients are observed with unusual injuries, fractures, bruises, rash, scratches, scabs, and minus (-) if there's nothing to report. According to the documentation for 5/1/07 and 5/2/07 all shifts, staffs marked a minus for nothing to report.  Review of the in service training book on 5/3/07 at approximately 2:30 PM revealed that all staff had received training on documentation on 1/22/07. There was no evidence that training was effective.	W 189			
W 193	<b>483.430(e)(3) STAFF TRAINING PROGRAM</b>  Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.  This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility staff failed to demonstrate competency in implementation of Clients #2's Behavior Support Plan (BSP).  The finding includes:  Evening observations conducted on 5/1/07 at approximately 4:40 PM, Client #2 was observed to sit beside surveyor. The client grabbed the surveyor left arm while attempting to stick her nails in my arms. Further observations conducted at 6:53 PM revealed Client #2 attempting to grab my me again but was verbally redirected by surveyor. Both times staffs were observed to be within a few feet of Client #2. Interview with the direct care staff working with Client #2 on the same day at approximately 7:15	W 193	W 193 Refer to W 189		

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W 193	<p>Continued From page 8</p> <p>revealed that Client #2 has behaviors of skin picking, property destruction, scratching self, touching women breasts.</p> <p>Review of Client #2's Behavior Support Plan (BSP) dated 7/16/07 on 5/3/07 at approximately 9:40 AM revealed the following targeted behaviors: 1) Self-Injurious Behavior - slapping or banging head, scratching self, and picking skin; 2) Property Destruction - tearing; and 3) Grabbing - (especially women's breast). Further review of the BSP revealed the following objectives to reducing grabbing as detailed below:</p> <p>1). Verbal Redirection - If the client is grabbing at other individuals; use one-step verbal command to stop and perform an alternate task.</p> <p>2). Manual Guidance - If the client refuses to respond to the physical prompt, staff should pair the verbal prompt with Manuel guidance (i.e. staff should provide hand-over-hand assistance/guidance).</p> <p>3). Re-entering the Environment - staff should remind the client of other means of affectingly approaching people (i.e. shaking hands).</p> <p>There was no evidence that staff demonstrated competency in the implementation of Client #2 ' s BSP.</p>	W 193		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p>	W 263	<p>W 263 Refer to W 124</p>	

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W 263	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consents, for one of three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 5/1/07 and record verification on 5/3/07 revealed that Client #2 received Luvox 50 mg for behavior management. There was no legally signed, written consent for these restrictive programs in the client's records. According to the Psychological Assessment dated 7/16/07, Client #2 functions at the profound level of mental retardation and was incapable of independent decisions regarding medical treatment.</p> <p>Review of the Human Rights Committee (HRC) Minutes on 5/2/07 at 1:46 PM failed to provide documented evidence that the facility had informed Client #2 or a legally-authorized representative of the health benefits and risks of treatment associated with the use of his psychotropic medication and corresponding BSP. Additionally, the facility's HRC failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. [See W124]</p>	W 263		
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p>	W 322		

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W 322	Continued From page 10  This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed provide general preventive care for one of three clients included in the sample. (Client #2)  The finding includes:  The facility failed to ensure that Client #2 received laboratory studies as prescribed by the physician's orders.  Observations of the evening medication pass conducted on 5/1/07 at 5:30 PM revealed that Client #2 was administered Depakote 125 mg (4) capsules (500 mg). Interview the medication nurse and review of the Medication Administration Record revealed the above medication is prescribed for the client's seizures.  Review of the current Physician's Order (PO) on 5/3/07 at 9:05 AM revealed that Client #2 was to have her Depakote drug levels tested every ninety (90) days. Review of the lab reports revealed that Client #2's last laboratory studies were completed on 3/07 and 12/06, two times since the last survey date 5/06. Further review of the lab reports revealed, the next time drug levels were tested for Client #2 was on 10/24/05. Interview with the facility's Licensed Practical Nurse (LPN) and Director of Nursing (DON) the same day at approximately 3:00 acknowledged the drugs levels were not tested as ordered.	W 322	W 322  The Agency has hired 2 RN coordinators and a Director of Nursing to oversee the medical and nursing care the clients receive. An nursing audit system has been instituted to ensure that there is no delay in clients receiving their treatments.  See attached nursing QA forms	5/24/07	
W 331	483.460(c) NURSING SERVICES  The facility must provide clients with nursing services in accordance with their needs.	W 331			

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

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W 331	Continued From page 11	W 331	W 331 Refer to W 322	
W 382	<p>483.460(l)(2) DRUG STORAGE AND 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 of the medication administration, the facility 's medication nurse failed to ensure all biological and drugs were locked when not being prepared for one of three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>During the evening medication administration observation on 5/1/07 beginning at 5:30 PM, the Licensed Practical Nurse (LPN) was observed administering medications to Client #2 at the dinner table. The LPN was also observed to leave the medication door wide open while administering medications to Client #2.</p> <p>Interview with the Registered Nurse (RN) on 5/2/07 at approximately 1:45 PM acknowledged</p>	W 382	<p>W 382</p> <p>The nurse involved has resigned and the new LPN has been in serviced on P &amp; p of Medication Administration. The DON and the RN Supervisor will ensure there is close supervision and oversight of the nurses along with on going training.</p> <p>See attached – In service sheet for Policy and Procedure of Medication Administration</p>	5/34/07

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W 382	Continued From page 12 that the medication door should be locked at all times when medications are not being prepared. There was no evidence of the LPN ensuring the medication door was locked during medication administration.	W 382			
W 436	483.470(g)(2) SPACE AND EQUIPMENT  The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure wheelchairs were maintained in good repair for one of three clients in the sample. (Clients #3)  The finding includes:  Observation of Client#3's wheelchair conducted on 5/107 at 4:00 PM revealed that the right armrest of the wheelchair was torn. Interview with the Qualified Mental Retardation Professional (QMRP) on 5/3/07 at approximately 3:25 PM acknowledged that the wheelchair needed to be repaired. There was no evidence that Client#3's wheelchair was maintained in good repair.	W 436	W436 Client # 3 will have her arm rest fixed on  See attached 719 A form 5/29/07	5/29/07.	
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.	W 455			

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W 455	Continued From page 13  This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the implementation of infection control procedures to prevent communicable infectious for two of six clients residing in the facility.  The findings include:  1. Observations conducted on 5/1/07 at 5:47 PM revealed Client #2 entering the bathroom located on the main level with her pants down and buttock exposed. Further observations revealed Client #2 with her shirt up exposing her bra. The client was observed after using the bathroom to walk straight to her bedroom without flushing the toilet or washing her hands. At no time did staff direct Client #2 to go back and wash her hands.  2. Observations conducted on the same day at 6:57 PM revealed that Client #5 spit in her hand and put her hands back into her mouth. Staff was observed standing directly beside the client, but never redirected Client #5 to wash her hands.	W 455	W455 All staff were in serviced on Infection Control and hand washing Practices. The QMRP, House Manager and the RN will ensure there is close supervision of staff.  See attached – in service sheet for Infection Control, Hand washing	5/29/07	

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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from May 1, 2007 through May 3, 2007. The survey was initiated using the fundamental survey process. A random sample of three clients were selected from a population of six females with various disabilities.</p> <p>The findings of this survey were based on observations at the group home, two day programs, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.</p>	I 000		
I 192	<p><b>3508.8(c) ADMINISTRATIVE SUPPORT</b></p> <p>Each GHMRP licensee shall carry or ensure that the premise carries the following insurance in at least the following amounts:</p> <p>(c) Professional Liability</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review professional liability insurance for consultants.</p> <p>The findings include:</p> <p>Review of the personnel records on 5/3/07 at approximately 2:20 PM revealed the GHMRP failed to have evidence of professional liability insurance for consultants C4, C5, C6, C9, and C13.</p>	I 192	<p>I 192 See attached Liability Insurances In the future the Agency is in the process of hiring a new HR Director to ensure on going updates are maintained for all personnel.</p>	5/29/07
I 206	<p><b>3509.6 PERSONNEL POLICIES</b></p>	I 206		

Health Regulation Administration

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

STATE FORM

6899

VMIR11

If continuation sheet 1 of 5

*Suzanne S. Spawls, BS, MA* TITLE *VPO* (X6) DATE *5/29/07*

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I 206	Continued From page 1  Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees.  The finding includes:  Review of the personnel files on 5/3/07, the GHMRP failed to provide current health certification Pharmacist (C6).	I 206	I 206 See attached Physical report for the Pharmacist	5/2/907
I 226	3510.5(c) STAFF TRAINING  This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the implementation of infection control procedures to prevent communicable infectious diseases for two of six residents residing in the facility. (Resident #2 and #5)  The findings include:  1. Observations conducted on 5/1/07 at 5:47 PM revealed Resident #2 entering the bathroom located on the main level with her pants down and buttock exposed. Further observations revealed Resident #2 with her shirt up exposing her bra. The client was observed after using the bathroom to walk straight to her bedroom without	I 226	I 226 - 1 Refer to W 455	

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I 226	Continued From page 2  flushing the toilet or washing her hands. At no time did staff direct Resident #2 to go back and wash her hands.  2. Observations conducted on the same day at 6:57 PM revealed that Client #5 spit in her hand and put her hands back into her mouth. Staff was observed standing directly beside the client, but never redirected Resident #5 to wash her hands.	I 226	I 226 - 2 Refer to W 455	
I 227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (c) Infection control for staff and residents;  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in first Aid and CPR for employees.  The findings include:  1. On 5/3/07, review of personnel records/training records revealed that the following direct care staff are without First Aid (FA), CPR, or both.  First Aid - (S8)  2. On 5/3/07, review of personnel records/training records revealed that the following consultants are without current First Aid and CPR, or both.  a. First Aid - (C7) b. CPR - (C2 and C7)	I 227	I 227 - 1 See attached - CPR and First Aid cards	5-29-07

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I 228	Continued From page 3	I 228			
I 228	3510.5(e) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (e) Resident ' s rights;  This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure staff were effectively trained in residents rights.  The findings include:  See Federal Deficiency Report Citations W130 and W137	I 228	I 228  See attached – In service sheet for Client Protection and Privacy	5/29/07	
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:  (a) Medicine;  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure that a copy of the professional license was maintained for review for each individual providing professional services at the GHMRP as	I 391	I 391  See attached - copy of license	5/29/07	

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I 391	Continued From page 4 required by District of Columbia law.  The finding includes:  Record review on 5/3/07 at approximately 2:20 PM revealed the facility failed to maintain a copy of the professional license for consultant #8.	I 391		