

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

PRINTED: 08/07/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G179</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/23/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5701 13TH STREET, NW WASHINGTON, DC 20011</b>
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from July 22, 2009 through July 23, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of five women with various disabilities.</p> <p>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.</p>	W 000	<p><i>Received 8/17/09</i></p> <p><b>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</b></p>	
W 112	<p><b>483.410(c)(2) CLIENT RECORDS</b></p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the confidentiality of personal information, for five of the five clients (Clients #1, #2, #3, #4 and #5) residing in the facility.</p> <p>The findings include:</p> <p>On July 23, 2009 at 2:00 PM, the surveyor observed a list of the individual client diets posted on the facility's refrigerator and a bulletin board located in the kitchen. The diet chart listed the specialized, prescribed diets with each of the client's individual names.</p> <p>At the time of the survey, the facility failed to ensure confidentiality of each of the client's individual prescribed diet orders.</p>	W 112	<p>W 112</p> <p>The Agency has a Policy and Procedure for securing and maintaining confidentiality of all information contained in individual's records.</p> <p>All staff were in serviced on HIPPA policy and client's rights, privacy and confidentiality.</p> <p>In the future the Facility QMRP and Residential Coordinator will ensure that all client information will be kept confidential.</p>	8/16/09
W 120	<p><b>483.410(d)(3) SERVICES PROVIDED WITH</b></p>	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sharon J. Sloan* TITLE: *VP Operations* (X6) DATE: *8/13/09*

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 120	<p>Continued From page 1 <b>OUTSIDE SOURCES</b></p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the day program provided services in accordance to the needs outlined in a client's individual service plan for two of three sampled clients. (Clients #1 &amp; #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Staff interview and record review at Client #2's Day Program on July 22, 2009 at 12:21 PM revealed her Individual Service Plan (ISP) was completed on February 19, 2009 and it included a Day Program recommendation for the following habilitation plan:             <ol style="list-style-type: none"> <li>a. Outcome: Relationships</li> <li>b. Goal: Choose a peer to engage in an activity for 10 minutes, daily.</li> <li>c. Frequency: 1 time a day.</li> </ol> </li> </ol> <p>Interview and record review with the Quality Assurance Coordinator (QAC) and the Program Coordinator (PC) on July 23, 2009 at 12:29 PM revealed the program wasn't initiated until March 9, 2009. Further record review revealed there was no data on file for the months of March 2009 and April 2009. In addition, there was missing data for the week of 5/25/2009. For the month of June 2009, only the week of June 8, 2009 was available. In addition, there was also no data available to review between July 1, 2009 and July</p>	W 120	<p>W 120</p> <ol style="list-style-type: none"> <li>1. Day Program staff were in serviced on the peer activity program and are following the IPP.</li> <li>2. Day Program staff were in serviced on the exercise program and are following the IPP.</li> <li>3. Nursing staff and staff were in serviced on the fluid restriction and Intake / Output documentation.  In the future the QMRP and RN/LPN will ensure that the programs are being followed by monitoring the day program at least monthly and documenting the same.</li> </ol>	8/16/09
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W 120	<p>Continued From page 2 22, 2009.</p> <p>2. Staff interview and record review on July 22, 2009 at 12:40 PM at Client #1's Day Program revealed her Individual Service Plan (ISP) was completed on April 29, 2009 and it included a Day Program recommendation for the following habilitation plan:</p> <p>a. Outcome: Health and Wellness b. Goal: Actively participate in a physical fitness activity for at least 30 minutes, 3 times a week. c. Frequency: 3 times a week.</p> <p>Interview and record review with the QAC and the PC on July 23, 2009 at 12:46 PM revealed they are still waiting on a finalized copy of the ISP from the Department of Disability Services. Further record review revealed the only data on file to review for this habilitation program was for 6/1/2009, 6/4/2009, 6/16/2009, 6/17/2009, 6/19/2009, and 6/22/2009.</p> <p>The facility failed to ensure the day program maintained accurate and measurable data on this "health and wellness" program.</p> <p>3. Staff interview and record review on July 23, 2009 at 12:52 PM revealed the facility failed to ensure the day program implemented Client #1's 1500mls per day fluid restriction as recommended by the Nutritionist on April 21, 2009. [See W460]</p>	W 120		
W 137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients</p>	W 137		

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W 137	<p>Continued From page 3</p> <p>have the right to retain and use appropriate personal possessions and clothing.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to failed to ensure the right of each client to retain the use of appropriately fitting clothing, for one of the three clients (Client #2) included in the sample.</p> <p>The finding includes:</p> <p>Observation on July 22, 2009 at 4:35 PM revealed a direct care staff (Staff #1) to verbally prompt Client #2 to pull up her pants. Further observation of the client at 5:06 PM revealed the client walking up the facility's basement stairs with direct care staff (Staff #2). The surveyor walked up the stairs behind them, and observed the client's pants falling off her waist exposing her buttocks. Although the staff was observed walking directly behind the client, she did not verbally prompt the client to pull up her pants until the surveyor brought it to her attention.</p> <p>Interview with the direct care staff revealed that the elastic in the client's pants may have been loose. It should be noted that Client #2's pants was falling off her waist throughout the survey.</p> <p>At the time of the survey, the facility failed to ensure the client wore appropriately fitting clothing.</p>	W 137	<p>W 137</p> <p>Staff have been in serviced on client grooming and appropriate clothing. The individual's ill fitting clothing has been discarded and a clothing inventory has been completed.</p> <p>In the future the QMRP and Residential Coordinator will ensure that all individuals in the facility are dressed appropriately.</p>	8/16/09
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit</p>	W 149		

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W 149	<p>Continued From page 4 mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its established policy on Medication Storage to ensure the health and safety for five of five clients in the facility. (Client # 1, Client #2, Client #3, Client # 4 and Client # 5)</p> <p>The finding include:</p> <p>Cross refer to W381. On July 22, 2009 at approximately 6:45AM, a large paper bag was observed on top of the television entertainment center in the living room area. Further observation revealed Licensed Practical Nurse #1 (LPN#1) removed four (4) medication blister packages of Gabapentin 600 mg tablets from the paper bag and placed the medication in the medication room. In an interview with LPN#1 on July 22, 2009 at approximately 6:50AM, it was acknowledged the medication was left unsecured in the facility.</p> <p>Interview with the Registered Nurse Supervisor on July 22, 2009 at approximately 8:25AM revealed all medications were to be stored securely in the medication room.</p> <p>Review of the Medication Storage Policy (undated) on July 23, 2009 at approximately 1:15 PM revealed " all medications is to be stored in a locked area".</p> <p>There was no evidence the facility implemented its established policy on Medication Storage to ensure all drugs were stored under proper</p>	W 149	<p>W 149</p> <p>The facility has created a locked cabinet for after hour medication drop off. All staff and nursing staff have been in serviced on Medication Administration Policy and Procedure.</p>	8/16/09
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W 149	Continued From page 5 conditions of security.	W 149		
W 159	<p><b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <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 interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for three of three clients (Clients #1, #2, and #3 ) included in the sample.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The QMRP failed to ensure that clients' individual program plans (IPP) included training in personal skills for Client #3. [See W242]</li> <li>2. The QMRP failed to ensure data relative to the accomplishment of the criteria specified in each client's Individual Program Plan (IPP) objective was documented in measurable terms. [See W252]</li> <li>3. The QMRP failed to ensure staff were effectively trained to implement the Clients' nutritional regimen. [See W189]</li> <li>4. The QMRP failed to ensure Clients' fluid restrictions were monitored and implemented as prescribed. [See W120 &amp; W460]</li> <li>5. The QMRP failed to ensure Clients' meals were provided in the form and texture/consistency</li> </ol>	W 159	<p><b>W 159</b></p> <ol style="list-style-type: none"> <li>1. This individual achieved her goal for the IPP for 'wiping mouth'. All staff were in serviced for 'wiping mouth' which will be done on an informal basis. In the future the QMRP and Residential Coordinator will ensure that all staff follows the programs, by monitoring the staff at least twice weekly.</li> <li>2. The QMRP has re written the IPP to ensure that the objective can be documented in measureable terms. All staff were in serviced on the IPP and on program documentation.</li> <li>3. All staff were in serviced on the individual's diet. In the future the QMRP and Residential Coordinator will ensure that all staff will follow the nutritional regimen by monitoring the staff at least monthly at the day program.</li> </ol>	

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W 159 W 189	Continued From page 6 as prescribed. [See W474] 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, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently.  The finding include:  1. [Cross Refer to W455]. The facility failed to provide effective, efficient, and competent training for the prevention and control of infection and communicable diseases for one of one staff in the facility. (LPN #1)  2. [Cross Refer to W252] The facility failed to provide effective, efficient, and competent training to ensure data for each client's Individual Program Plan (IPP) objective was documented in measurable terms.  3. [Cross Refer to W460] During dinner observations on July 22, 2009 at approximately 6:00 PM, the residential staff poured Client #1 a cup of Crystal Lite and a cup of water to drink during her meal. The staff was not observed to measure the amount of fluid she provided to Client #1.	W 159 W 189	4. The QMRP and the nursing staff have trained all the staff at the facility and day program, on the Intake and Output measurement and documentation for the individual.  5. All staff were in serviced on the individual's diet texture. In the future the QMRP and the Residential Coordinator will ensure that staff will follow the appropriate diet, by monitoring the staff at least twice weekly.  See attached in service record for – diet texture, intake/ output, day program in service record, IPP with measurable objectives, in service record for 'wiping mouth' and exercise documentation.  W 189  1. The LPN has been in serviced on OSHA and Infection control. In the future the RN will ensure that the LPN is monitored at least monthly to ensure that infection control is observed.	8/16/09

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W 189	Continued From page 7 Interview with the facility's Qualified Mental Retardation Professional (QMRP) and record review on July 23, 2009 at 12:51 PM revealed Client #1's Nutritional Assessment dated April 21, 2009 recommended a dietary fluid restriction of 1500mls of fluid per day to manage her Edema and that staff receive "ongoing training on portion control and compliance to menu(s)". Further interview revealed, there was no evidence at the time of survey to substantiate the facility kept a log of the amount of fluids Client #1 was receiving at the home.  The facility failed to ensure staff were effectively trained to implement Client #1's fluid restrictions as prescribed.	W 189	2. The QMRP has re written the IPP to ensure that the objective can be documented in measureable terms. All staff were in serviced on the IPP and on program documentation. 3. The QMRP and the nursing staff have trained all the staff at the facility and the day program, on the Intake and Output measurement and documentation for the individual.	8/16/09
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN  The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills, for one of the three clients (Clients #2) included in the sample.  The finding includes:  The facility failed to ensure Client #2 was taught	W 242	W 242  All staff were in serviced on the IPP for 'wiping mouth'. In the future the QMRP and the Residential Coordinator will ensure that the program is followed, by monitoring the staff at least twice weekly. See attached in service record	8/16/09

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W 242	<p>Continued From page 8 to wipe her mouth appropriately.</p> <p>Observation of Client #2 on July 22, 2009, at 5:08 PM revealed the client dancing with the facility's House Manager (HM). Continued observation revealed the client was drooling and saliva was hanging from her mouth. The HM was not observed to verbally prompt the client to wipe her mouth. It should be noted that Client #2 entered the facility wearing two clothing protectors that was observed to be wet. At 5:09 PM, Client #1 was observed to take Client #2's clothing protector, lift it up to the client's mouth and proceeded to wipe it. At that time, the HM instructed Client #1 to get a napkin.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on July 22, 2008, revealed Client #2 wore clothing protectors to protect her chest from getting wet. Review of the client's Individual Program Plan (IPP) on July 22, 2009, beginning at 12:20 PM failed to provide evidence of a training objective to assist the client with wiping her mouth.</p> <p>At the time of the survey, the facility failed to ensure an IPP training objective was developed to assist the client with wiping her mouth.</p>	W 242		
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record</p>	W 252		

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W 252	<p>Continued From page 9</p> <p>review, the facility failed to ensure data relative to the accomplishment of the criteria specified in each client's Individual Program Plan (IPP) objective was documented in measurable terms, for one of the three clients (Client #3) included in the sample.</p> <p>The findings include:</p> <p>Observations on July 22, 2009, beginning at 5:00 PM until approximately 6:00 PM revealed the direct care staff playing music to dance with the clients. One of the direct care staff was observed dancing with Client #3 while she sat in a chair until the completion of the song, approximately 3-4 minutes. It should be noted that the client was observed to be obese, however, she was ambulatory. At no time was the staff observed to verbally prompt Client #3 to stand-up and dance in order for her benefit from the exercise activity.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's habilitation record on July 23, 2009, at 1:48 PM revealed the client had an exercise program. The client's habilitation record verified an Individual Program Plan (IPP), that required her to participate in cardiovascular activities programming for twenty minutes walking in the community or dancing in the house. Additionally, review of the client's record revealed a nutritional assessment dated May 19, 2009. The nutritionist recommended exercise to promote weight loss.</p> <p>Review of the program data revealed that the program was being implemented, however, the data was not an accurate reflection of the aforementioned observation. Further review of the data revealed a key using a (+ = task</p>	W 252	<p>W 252</p> <p>The QMRP has re written the IPP for exercise, to include measurable objectives. All staff were in service on the exercise program. In the future the QMRP and the Residential Coordinator will ensure that all staff follow and document the program accomplishment appropriately. See attached IPP and in service record.</p>	8/16/09
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5701 13TH STREET, NW WASHINGTON, DC 20011</b>
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W 252	Continued From page 10 accomplished), and (- = attempted task but did not complete). The direct staff documented a plus (+) meaning that the task was accomplished, however, the client was not observed to exercise for twenty minutes. It should be noted that Client #3 was not observed to walk in the community or participate in any other exercises for twenty minutes.  At the time of survey, the facility failed to provide evidence that the data for Client #3's cardiovascular program was documented in measurable terms.	W 252		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE  The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that its Human Rights Committee (HRC) thoroughly monitored and made suggestions about the facility's practice of administering a sedation for a client's anxiety prior to and during medical appointments without the use of a less restrictive technique, for one of the three clients (Client #3) included in the sample.  The findings include:	W 264		

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W 264	<p>Continued From page 11</p> <p>The facility's Human Rights Committee (HRC) meeting minutes failed to provide evidence that the HRC met, monitored and discussed the facility's practices regarding the use of sedation for Client #3.</p> <p>Interview with the facility's Licensed Practical Nurse (LPN) on July 23, 2009, at 9:55 AM and review of Client #3's medical record revealed the following physician's orders:</p> <p>September 24, 2008: Valium 5 mg 1/2 hour prior to EEG appointment, administered on September 30, 2008;</p> <p>October 20, 2008: Valium 5 mg, 1/2 hour prior to dental appointment, administered on October 27, 2008;</p> <p>March 6, 2009: Klonopin 2 mg 1 hour prior to gynecological appointment, administered March 23, 2009, and;</p> <p>March 26, 2009: Klonopin 3 mg 1 hour prior to dental appointment and Klonopin 1 mg during dental appointment if needed, administered April 3, 2009.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on July 23, 2009 at 12:30 PM was conducted to ascertain information regarding whether the client had a desensitization plan to address potential behaviors during medical appointments prior to administering sedative medications. According to the the QMRP, Client #3 had a desensitization plan that recommended that she would be taken to the physician's office prior to her medical appointments. Further interview with the QMRP,</p>	W 264	<p>W 264</p> <p>The Agency has a Policy for Behavior Management and the use of Restrictive techniques and the HRC Policy. The Agency has a Policy for using desensitization prior to using a more restrictive method is used to obtain the completion of medical appointments.</p> <p>In the future the Facility will ensure all pre-sedation medication orders are approved by the HRC and that the individual has completed the desensitization program.</p> <p>See attached in service record on HRC Policy and desensitization.</p>	8/16/09
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W 264	<p>Continued From page 12</p> <p>revealed that this process was recommended to ensure the client's familiarity with the physician's office and to prevent anxiety during her appointments.</p> <p>Interview with the nurse and review of the HRC minutes on July 23, 2009, revealed the facility's HRC failed to provide evidence that a review/monitoring of prescribed sedation was conducted prior to the administration of (Valium 5 mg) on September 30, 2009, and (Valium 5 mg) on October 27, 2008. Although the facility's HRC reviewed the sedation administered on March 23, 2009, (Klonopin 2 mg) it was reviewed two days after (March 25, 2009) the sedation had been administered. Additionally, on April 3, 2009, (Klonopin 3 mg) had not been reviewed/monitored until the facility's HRC met on May 6, 2009.</p> <p>At the time of the survey, the facility's HRC failed to ensure they had monitored and made suggestions about the practice of administering a sedation prior to ensuring a less restrictive technique had been implemented.</p>	W 264		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for five of five clients in the facility. (Client # 1, Client #2, Client #3, Client # 4 and Client # 5)</p>	W 331	<p>W 331</p> <ol style="list-style-type: none"> <li>1. The LPN was in service on Infection control. In the future the RN will monitor the LPN during medication administration, to ensure that infection control is practiced during medication administration.</li> </ol>	

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W 331	Continued From page 13  The finding includes:  1. Cross Refer to W455. The facility's nursing staff failed to provide an treatment program for the prevention and control of infection for one of three clients included in the sample. (Client #2)  2. Cross Refer to W149. The facility's nursing staff failed implement it's established policy on Medication Storage to ensure the health and safety for five of five clients in the facility. (Client # 1, Client #2, Client #3, Client # 4 and Client # 5).  3. The facility's nursing staff failed to ensure that a new diagnosis was added to Client #3's Health Management Care Plan (HMCP) as evidenced below:  Review of Client #3's medical record on July 23, 2009 at 10:54 AM, revealed a physician's order dated April 10, 2009. Continued review of the order revealed "add diagnosis of Nystagmus to current list of diagnosis." Interview with the facility's nursing staff verified that she had overlooked the new diagnosis and did not include it in the client's HMCP.	W 331	2. All staff were in serviced on Medication Administration Policy and Procedure-storage of medications. The facility has identified a locked cabinet to store medications dropped off by the pharmacy during after hours.  3. The HMCP has been amended to include the diagnosis of 'Nystagmus'. In the future the RN will ensure that she reviews and updates the HMCP at least monthly and when needed – new diagnosis, ER visit or Hospitalization, change in individual's status.  See attached in service record – infection control, medication administration policy and procedure, HMCP	8/16/09
W 381	At the time of the survey, Client #3's HMCP failed to evidence the new diagnoses (Nystagmus). <b>483.460(I)(1) DRUG STORAGE AND RECORDKEEPING</b>  The facility must store drugs under proper conditions of security.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility	W 381		

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W 381	<p>Continued From page 14</p> <p>failed to store drugs under proper conditions of security for five of five clients in the facility. (Client # 1, Client #2, Client #3, Client # 4 and Client # 5)</p> <p>The finding includes:</p> <p>On July 22, 2009 at approximately 6:45AM, Client #1 and Client #4 were viewing television in the living room area and a large paper bag was observed on top of the television entertainment center. Further observation revealed Licensed Practical Nurse #1 (LPN#1) removed four (4) medication blister packages of Gabapentin 600 mg tablets dispensed for Client #4 from the paper bag. In an interview with LPN#1 on July 22, 2009 at approximately 6:50AM, it was acknowledged the paper bag contained four (4) medication blister packages of Gabapentin 600 mg tablets and that the medication was left in the facility on the evening of July 21, 2009 by pharmacy staff.</p> <p>There was no evidence that all drugs were stored under proper conditions of security.</p>	W 381	<p>W 381</p> <p>All staff were in serviced on Medication Administration Policy and Procedure-storage of medications. The facility has identified a locked cabinet to store medications dropped off by the pharmacy during after hours.</p>	8/16/09
W 455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for one of three clients in the sample. (Client #2)</p> <p>The finding includes:</p>	W 455		

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W 455	Continued From page 15  During medication administration observation on July 22, 2009, at approximately 7:05 AM, the Licensed Practical Nurse #1 (LPN #1) was observed to wash her hand prior to administrating medications. However LPN #1 unlocked and touched the the medication door, touched the Medication Administration Records (MAR's) and than touched the rim of the medication cup as she administered Client #2's medication.  In an interview with LPN #1 on July 22, 2009, at approximately 7:10 AM, it was acknowledged after washing her hands she unlocked and opened the medication door, touched the MAR's and than touched the rim of the medication cup when administering Client #2's medication.  There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.	W 455	W 455  The LPN was in serviced on Infection control. In the future the RN will monitor the LPN during medication administration, to ensure that infection control is practiced during medication administration.	8/16/09
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES  Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients received their meals as outlined in their dietary plan for one of three sampled clients. [Client #1]  The finding includes:  Observation at Client #1's Day Program on July 22, 2009 at approximately 12:30 PM revealed she	W 460	W 460  The QMRP and the nursing staff have trained all the staff at the facility and the day program, on the Intake and Output measurement and documentation for the individual.	8/16/09

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W 460	<p>Continued From page 16</p> <p>received a small container of juice and a small container of chocolate milk during lunch. At approximately 6:00 PM, the residential staff poured Client #1 a cup of Crystal Lite and a cup of water to drink during her meal. The staff was not observed to measure the amount of fluid she provided to Client #1.</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) and record review on July 23, 2009 at 12:51 PM revealed Client #1's Nutritional assessment dated April 21, 2009 recommended a dietary fluid restriction of 1500mls of fluid per day to manage her Edema. The nutritional report further recommended that the facility implemented the following schedule for meals, snacks and medications:</p> <p>(1). AM medications      4oz water  (2). Breakfast            8oz skim milk and 4oz juice  (3). Mid-Morning Snack    4oz water or Crystal Lite  (4). Noon Meds            4oz water  (5). Lunch                8oz skim milk  (6). Mid-afternoon Snack   4oz water or Crystal Lite  (7). PM-Medications      4oz water  (8). Dinner                8oz skim milk  (9). Evening Snack        4oz water or Crystal Lite</p> <p>Interview with the facility's Licensed Practical Nurse (LPN) and QMRP on July 23, 2009 at 1:09 PM revealed the facility did not keep an accurate recording of Client #1's daily fluid intake and did not implement the " schedule for meals and snacks " as identified above. Further interview with the LPN and QMRP on the same day at approximately 1:15 PM revealed, they also had</p>	W 460		
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W 460	Continued From page 17 no record of how much fluids Client #1 was consuming at her day program as well.	W 460		
W 474	The facility failed to ensure Client #1 received her fluid restrictions as recommended by the Nutritionist. <b>483.480(b)(2)(iii) MEAL SERVICES</b> Food must be served in a form consistent with the developmental level of the client.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients received their meals in the texture outlined in their dietary plan for one of three sampled clients. [Client #2]  The finding includes:  Observation at Client #2 on July 22, 2009 at approximately 12:35 PM revealed Client #2 received a meal of battered fried fish, mixed vegetables, corn bread and potato wedges at her Day Program.  At approximately 6:05 PM during dinner, the residential staff was observed cutting up Client #2's food into "bite sized" pieces before she was allowed to eat.  Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of Client #2's current (June 2009) Physician's Order Sheets on July 23, 2009 at approximately 1:10 PM revealed Client #2 was prescribed to receive her meals in a "bite sized" texture on March 1, 2004.	W 474	W 474 All staff at the day program were in serviced on the individual's diet texture. In the future the QMRP and the Residential Coordinator will ensure that staff will follow the appropriate diet, by monitoring the day program staff at least monthly.	8/16/09

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W 474	Continued From page 18  The facility failed to ensure Client #2 received her meals in the form and consistency as prescribed in her physician's orders.	W 474		
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1 000	INITIAL COMMENTS  A licensure survey was conducted from July 22, 2009 through July 23, 2009. A random sample of three residents was selected from a resident population of five women with various 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.	1 000		
1 047	3502.5 MEAL SERVICE / DINING AREAS  Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that residents received their meals as outlined in their dietary plan for two of three sampled residents. [Resident #1 and #2]  The findings include:  1. Observation at Resident #1's Day Program on July 22, 2009 at approximately 12:30 PM revealed she received a small container of juice and a small container of chocolate milk during lunch. At approximately 6:00 PM, the residential staff poured Resident #1 a cup of Crystal Lite and a cup of water to drink during her meal. The staff was not observed to measure the amount of fluid she provided to Resident #1.	1 047	1 047  1. The QMRP and the nursing staff have trained all the staff at the facility and the day program, on the Intake and Output measurement and documentation for the individual.	8/16/09

Health Regulation Administration

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

STATE FORM

*Swant Span*

*VP* TITLE

(X6) DATE  
**8/13/09**

Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER  METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
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I 047	<p>Continued From page 1</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) and record review on July 23, 2009 at 12:51 PM revealed Resident #1's Nutritional assessment dated April 21, 2009 recommended a dietary fluid restriction of 1500mls of fluid per day to manage her Edema. The nutritional report further recommended that the facility implemented the following schedule for meals, snacks and medications:</p> <p>(1). AM medications      4oz water  (2). Breakfast              8oz skim milk and 4oz juice  (3). Mid-Morning Snack    4oz water or Crystal Lite  (4). Noon Meds              4oz water  (5). Lunch                    8oz skim milk  (6). Mid-afternoon Snack   4oz water or Crystal Lite  (7). PM-Medications      4oz water  (8). Dinner                  8oz skim milk  (9). Evening Snack        4oz water or Crystal Lite</p> <p>Interview with the facility's Licensed Practical Nurse (LPN) and QMRP on July 23, 2009 at 1:09 PM revealed the facility did not keep an accurate recording of Resident #1's daily fluid intake and did not implement the " schedule for meals and snacks " as identified above. Further interview with the LPN and QMRP on the same day at approximately 1:15 PM revealed, they also had no record of how much fluids Resident #1 was consuming at her day program as well.</p> <p>The facility failed to ensure Resident #1 received her fluid restrictions as recommended by the Nutritionist.</p> <p>2. Observation at Resident #2 on July 22, 2009 at</p>	I 047		

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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5701 13TH STREET, NW WASHINGTON, DC 20011</b>		
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I 047	Continued From page 2  approximately 12:35 PM revealed Resident #2 received a meal of battered fried fish, mixed vegetables, corn bread and potato wedges at her Day Program.  At approximately 6:05 PM during dinner, the residential staff was observed cutting up Resident #2's food into "bite sized" pieces before she was allowed to eat.  Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of Resident #2's current (June 2009) Physician's Order Sheets on July 23, 2009 at approximately 1:10 PM revealed Resident #2 was prescribed to receive her meals in a "bite sized" texture on March 1, 2004.  The facility failed to ensure Resident #2 received her meals in the form and consistency as prescribed in her physician's orders.	I 047		
I 161	<b>3507.2 POLICIES AND PROCEDURES</b>  The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the governing body approved and reviewed its policies and procedures annually.  The finding includes:  Interview with the Qualified Mental Retardation Professional (QMRP) and review of the policy and procedures manual on July 22, 2009.	I 161	I 161  The Agency reviews the Policy and Procedure Manual annually. In the future the Agency will ensure that the records in each of the facilities are updated at least annually and as needed.	8/16/09

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I 161	Continued From page 3  beginning at 11:26 AM failed to provide evidence that the manual had been reviewed and approved by the governing body as required since March 1, 2008.	I 161		
I 206	<p><b>3509.6 PERSONNEL POLICIES</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties for five (5) of the twenty (20) records reviewed.</p> <p>The findings include:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on July 22, 2009, at 11:34 AM and review of the personnel records revealed that the GHMRP failed to provide evidence that current health certificates were on file for three direct care staff and two consultants.</p>	I 206	<p>I 206</p> <p>The Agency has a system of record keeping / inventory to ensure all employees have a current health certificate to allow him or her to be employed. In the future the QMRP and Residential Coordinator will ensure that monthly QA is completed at the facility which also includes personnel information. See attached health certificates.</p>	8/16/09
I 226	<b>3510.5(c) STAFF TRAINING</b>	I 226		

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I 228	<p>Continued From page 4</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(c) Infection control for staff and residents;</p> <p>This Statute is not met as evidenced by: Based on observation and interview the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for one of one nursing staff in the facility. (LPN #1)</p> <p>The finding includes:</p> <p>During medication administration observation on July 22, 2009, at approximately 7:05 AM the Licensed Practical Nurse #1 (LPN #1) was observed to wash her hand prior to administrating medications. However LPN #1 unlocked and touched the medication door, touched the Medication Administration Records (MAR's) and than touched the rim of the medication cup when administering Resident #2's medication.</p> <p>In an interview with LPN #1 on July 22, 2009, at approximately 7:10 AM, it was acknoleged after washing her hands she unlocked and touched the medication door, touched the MAR's and than touched the rim of the medication cup as she administered Resident #2's medication.</p> <p>There is no evidence that the facility's nursing staff had effective training on infection control.</p>	I 226	<p>I 226</p> <p>The LPN was in serviced on Infection control. In the future the RN will monitor the LPN during medication administration, to ensure that infection control is practiced during medication administration.</p>	8/16/09
I 230	<p>3510.5(g) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p>	I 230		

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I 230	<p>Continued From page 5</p> <p>(g) Habilitation planning and implementation;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives was documented consistently and accurately for one of the three (Resident #3) residents included in the sample.</p> <p>The finding includes:</p> <p>Observations on July 22, 2009, beginning at 5:00 PM until approximately 6:00 PM revealed the direct care staff playing music to dance with the clients. One of the direct care staff was observed dancing with Resident #3 while she sat in a chair until the completion of the song, approximately 3-4 minutes. It should be noted that the resident was observed to be obese, however, she was ambulatory. At no time was the staff observed to verbally prompt Resident #3 to stand-up and dance in order for her benefit from the exercise activity.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of Resident #3's habilitation record on July 23, 2009, at 1:48 PM revealed the client had an exercise program. The client's habilitation record verified an Individual Program Plan (IPP), that required her to participate in cardiovascular activities programming for twenty minutes walking in the community or dancing in the house. Additionally, review of the client's record revealed a nutritional assessment dated May 19, 2009. The nutritionist recommended exercise to promote weight loss.</p> <p>Review of the program data revealed that the program was being implemented, however, the data was not an accurate reflection of the</p>	I 230	<p>W 230</p> <p>The QMRP has re written the IPP for exercise, to include measurable objectives. All staff were in service on the exercise program. In the future the QMRP and the Residential Coordinator will ensure that all staff follow and document the program accomplishment appropriately. See attached IPP and in service record.</p>	8/16/09

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I 230	Continued From page 6 aforementioned observation. Further review of the data revealed a key using a (+ = task accomplished), and (- = attempted task but did not complete). The direct staff documented a plus (+) meaning that the task was accomplished, however, the resident was not observed to exercise for twenty minutes. It should be noted that Resident #3 was not observed to walk in the community or participate in any other exercises for twenty minutes.  At the time of survey, the facility failed to provide evidence that the data for Resident #3's cardiovascular program was documented in measurable terms.	I 230		
I 432	<b>3521.7(c) HABILITATION AND TRAINING</b>  The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:  (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care);  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents' individual program plans (IPP) included training in personal skills, for two of the three residents (Resident #3) included in the sample.  The finding includes:  The facility failed to ensure Resident #2 was taught to wipe her mouth appropriately.  Observation of Resident #2 on July 22, 2009, at 5:08 PM revealed the client dancing with the	I 432	The QMRP has re written the IPP for exercise, to include measurable objectives. All staff were in service on the exercise program. In the future the QMRP and the Residential Coordinator will ensure that all staff follow and document the program accomplishment appropriately. See attached IPP and in service record.	8/16/09

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I 432	Continued From page 7  facility's House Manager (HM). Continued observation revealed the client was drooling and saliva was hanging from her mouth. The HM was not observed to verbally prompt the client to wipe her mouth. It should be noted that Resident #2 entered the facility wearing two clothing protectors that was observed to be wet. At 5:09 PM, staff was observed to take Resident #2's clothing protector, lift it up to the client's mouth and proceeded to wipe it. At that time, the HM instructed Resident#1 to get a napkin.  Interview with the Qualified Mental Retardation Professional (QMRP) on July 22, 2008, revealed Resident #2 wore clothing protectors to protect her chest from getting wet. Review of the resident's Individual Program Plan (IPP) on July 22, 2009, beginning at 12:20 PM failed to provide evidence of a training objective to assist the resident with wiping her mouth.  At the time of the survey, the facility failed to ensure an IPP training objective was developed to assist the resident with wiping her mouth.	I 432		
I 500	<b>3523.1 RESIDENT'S RIGHTS</b>  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.  This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the confidentiality of personal information, for five of the five residents (Resident #1, #2, #3, #4 and #5) residing in the facility.	I 500	<b>I 500</b>  The Agency has a Policy and Procedure for securing and maintaining confidentiality of all information contained in individual's records.  All staff were in serviced on HIPPA policy and client's rights, privacy and confidentiality. In the future the Facility QMRP and Residential Coordinator will ensure that all client information will be kept confidential.	8/16/09