

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

PRINTED: 04/20/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/19/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>		
(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) COMPLETION DATE
W 000	<p><b>INITIAL COMMENTS</b></p> <p>A re-certification survey was conducted from 03/18/2009 to 03/19/2009. A random sampling of three clients was selected from a population of five individuals with varying degrees of disabilities. This survey was initiated and completed utilizing the fundamental process. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff, medical staff, facility management, and a review of the habilitation and administrative records including the unusual incident reports.</p> <p>W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</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 staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services as required by this section.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The QMRP failed to ensure the effective implementation of a client's "one-on-one" behavioral support program. [See W249]</li> <li>The QMRP failed to ensure the proper implementation, use and sanitary condition of a client's adaptive equipment. [See W455]</li> </ol> <p>W 249 483.440(d)(1) PROGRAM IMPLEMENTATION</p>	W 000	<p><i>Received 4/20/09</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> <p>W 159</p> <p>1. The staff was in serviced on 1:1 job expectations at the day program. In the future the staff will abide by the 1:1 contract and the QMRP and the day program Case Coordinator will ensure that there is compliance with providing safety to the individual by at least monthly communication.</p> <p>2. All staff were re in serviced on the use of the bib. In the future the QMRP and the Residential Coordinator will monitor the staff daily to ensure that the adaptive equipment is used appropriately.</p> <p>W 249</p>	4/24/09

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

*Swain, Shawn, BSN, MA*

TITLE

*VP*

(X6) DATE

*4/26/09*

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 249	<p>Continued From page 1</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the correct and consistent implementation of a client's behavioral support plan as recommended for one of three sampled clients. [Client #1]</p> <p>The finding includes:</p> <p>Upon arrival at the day program on the morning of 3/18/2009 at 11:08am, the "one-on-one" staff assigned to Client #1 was not in the room with her. There was one attending staff in the room with approximately eight other clients. The attending staff was not in close proximity to Client #1 as he attended to setting up the room for an activity. Approximately five minutes later, the "one-to-one" staff returned to the classroom and sat in a chair next to Client #1.</p> <p>Record review on 3/18/2009 at approximately 11:25am revealed, Client #1's Psychology assessment dated 9/12/2008 detailed, "[Client #1] has problems with self-injurious behaviors (head banging on hard surfaces, picking her skin and fingernails), invading the personal space of others (standing too closely to others, holding other's hands, and resting her hands on the shoulders of</p>	W 249	<p>W 249</p> <p>1. The staff was in serviced on 1:1 job expectations at the day program In the future the staff will abide by the 1:1 contract and the QMRP and the day program Case Coordinator will ensure that there is compliance with providing safety to the individual by at least monthly communication.</p> <p>4/24/09</p>

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W 249	<p>Continued From page 2</p> <p>others) and elopement (leaving the classroom without permission). This behavior support plan was revised on 9/12/2008 to include the following information. [Client #1] now attends [her day program] on a half-day schedule (until noon) Monday through Friday. She also receives 1:1 staffing."</p> <p>Interview with management staff at the day program on the same day at approximately 11:10am revealed the "one-on-one" staff left the classroom because she had to use the bathroom, but she should have transitioned her duties to another staff prior to leaving the classroom. Interview with the QMRP and LPN on 3/19/2009 at 5:30pm revealed the "one-on-one" staff knew she was not supposed to leave Client #1 in the classroom without proper oversight.</p>	W 249	
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, staff interview and record review, the facility failed to ensure the implementation of an infection control protocol to ensure staff was properly maintaining and utilizing a client's bib for one of five sampled clients. [Client #2]</p> <p>The finding includes:</p> <p>Evening observations on 3/18/2009 revealed Client #2 arrived home at approximately 4pm. Staff escorted Client #2 to his bedroom, redressed him for the evening and later brought</p>	W 455	

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W 455	<p>Continued From page 3</p> <p>him back out to the living room wearing a large blue bib and sat him in an armchair at approximately 4:30pm. Client #2's bib covered his chest and most of his upper abdomen.</p> <p>Client #2 sat in his chair, occasionally played with his hands in his mouth and drooled over his bib. At approximately 5:15pm, the attending staff took Client #2 and Client #3 out for a community walk. By that time, the bib was soiled with saliva. Client #2 went out on the community walk with the bib on and also returned home with it on. Upon re-entering the home, he was resealed back in the arm chair in the living room. Throughout the evening, Client #2 was observed drooling and wearing the same bib, even during dinner. At 7:12pm he was seated for dinner and he was still wearing the same blue bib he had on when he went out for his community walk.</p> <p>Record review on 3/19/2009 at 3:17pm revealed Client #2's Speech assessment dated 12/22/2007 recommended using the bib as an adaptive equipment during mealtimes. Further record review revealed Client #2's Nutrition assessment dated 11/8/2008 also recommended using the bib as a mealtime adaptive equipment. It was not clear why Client #2 was allowed to wear the soiled bib throughout the evening, be allowed to walk the community and return home to eat dinner later in the evening with the same soiled bib.</p> <p>Interview with the facility's QMRP on 3/19/2009 at 5:47pm revealed she was not aware of the recommendations and indicated she would address the problem by training staff on the use of the bib. The facility failed to ensure Client #2 was not utilizing a soiled bib in the home and</p>	W 455	<p>W 455</p> <p>All staff were re in serviced on the use of the bib. In the future the QMRP and the Residential Coordinator will monitor the staff daily to ensure that the adaptive equipment is used appropriately.</p> <p>4/24/09</p>

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W 455	Continued From page 4 failed to ensure he was equipped with a clean bib during meals.	W 455		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/19/2009</b>
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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A re-licensure survey was conducted from 03/18/2009 to 03/19/2009. A random sampling of three residents was selected from a population of five individuals with varying degrees of disabilities. This survey was initiated and completed utilizing the fundamental process. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff, medical staff, facility management, and a review of the habilitation and administrative records including the unusual incident reports.</p>	I 000	
I 183	<p><b>3508.4 ADMINISTRATIVE SUPPORT</b></p> <p>Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services as required by this section.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The QMRP failed to ensure the effective implementation of a resident's "one-on-one" behavioral support program. [See Federal Deficiency Report W249]</li> <li>The QMRP also failed to ensure the proper implementation, use and sanitary condition of a resident's adaptive equipment. [See Federal Deficiency Report W455]</li> </ol>	I 183	<p><b>I 183</b></p> <p>1. The staff was in serviced on 1:1 job expectations at the day program. In the future the staff will abide by the 1:1 contract and the QMRP and the day program Case Coordinator will ensure that there is compliance with providing safety to the individual by at least monthly communication.</p> <p>2. All staff were re in serviced on the use of the bib. In the future the QMRP and the Residential Coordinator will monitor the staff daily to ensure that the adaptive equipment is used appropriately.</p> <p>4/24/09</p>

Health Regulation Administration

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

STATE FORM

*Grant Sloan*

TITLE  
*VPO*

(X6) DATE

*4/26/09*

Health Regulation Administration

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I 422	Continued From page 1	I 422	
I 422	<p><b>3521.3 HABILITATION AND TRAINING</b></p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the correct and consistent implementation of a resident's behavioral support plan as recommended for one of three sampled residents. [Resident #1]</p> <p>The finding includes:</p> <p>Upon arrival at the day program on the morning of 3/18/2009 at 11:08am, the "one-on-one" staff assigned to Resident #1 was not in the room with her. There was one attending staff in the room with approximately eight other residents. The attending staff was not in close proximity to Resident #1 as he attended to setting up the room for an activity. Approximately five minutes later, the "one-to-one" staff returned to the classroom and sat in a chair next to Resident #1.</p> <p>Record review on 3/18/2009 at approximately 11:25am revealed, Resident #1's Psychology assessment dated 9/12/2008 details, "[Resident #1] has problems with self-injurious behaviors (head banging on hard surfaces, picking her skin and fingernails), invading the personal space of others (standing too closely to others, holding other's hands, and resting her hands on the shoulders of others) and elopement (leaving the classroom without permission). This behavior support plan was revised on 9/12/2008 to include the following information: [Resident #1] now attends [her day program] on a half-day schedule (until noon) Monday through Friday. She also</p>	I 422	<p>I 422</p> <p>Staff was in serviced on the individual's accurate documentation and implementation of the BSP. In the future the staff will abide by the 1:1 contract and the QMRP and the day program Case Coordinator will communicate at least monthly, to ensure that there is compliance with providing safety to the individual.</p> <p>4/24/09</p>

Health Regulation Administration

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I 422	Continued From page 2  receives 1:1 staffing."  Interview with management staff at the day program on the same day at approximately 11:10am revealed the "one-on-one" staff left the classroom because she had to use the bathroom, but she should have transitioned her duties to another staff prior to leaving the classroom. Interview with the QMRP and LPN on 3/19/2009 at 5:30pm revealed the "one-on-one" staff knew she was not supposed to leave Resident #1 in the classroom without proper oversight.	I 422		

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<p>W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</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 staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services as required by this section.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The QMRP failed to ensure the effective implementation of a client's "one-on-one" behavioral support program. [See W249]</li> <li>2. The QMRP failed to ensure the proper implementation, use and sanitary condition of a client's adaptive equipment. [See W455]</li> </ol> <p>W 249 483.440(d)(1) PROGRAM IMPLEMENTATION</p>	<p>W 159</p> <p>1. The staff was in serviced on 1:1 job expectations at the day program. In the future the staff will abide by the 1:1 contract and the QMRP and the day program Case Coordinator will ensure that there is compliance with providing safety to the individual by at least monthly communication.</p> <p>4/24/09</p> <p>W 159</p> <p>2. All staff were re in serviced on the use of the bib. In the future the QMRP and the Residential Coordinator will monitor the staff daily to ensure that the adaptive equipment is used appropriately.</p> <p>W 249</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *(Signature)* TITLE *VPO* (X6) DATE *4/20/09*

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W 249	Continued From page 2  others) and elopement (leaving the classroom without permission). This behavior support plan was revised on 3/12/2008 to include the following information: [Client #1] now attends [her day program] on a half-day schedule (until noon) Monday through Friday. She also receives 1:1 staffing."  Interview with management staff at the day program on the same day at approximately 11:10am revealed the "one-on-one" staff left the classroom because she had to use the bathroom, but she should have transitioned her duties to another staff prior to leaving the classroom. Interview with the QMRP and LPN on 3/19/2009 at 5:30pm revealed the "one-on-one" staff knew she was not supposed to leave Client #1 in the classroom without proper oversight.	W 249	
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, staff interview and record review, the facility failed to ensure the implementation of an infection control protocol to ensure staff was properly maintaining and utilizing a client's bib for one of five sampled clients. [Client #2]  The finding includes:  Evening observations on 3/18/2009 revealed Client #2 arrived home at approximately 4pm. Staff escorted Client #2 to his bedroom, redressed him for the evening and later brought	W 455	

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

PRINTED: 04/20/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/19/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
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W 455 Continued From page 3  
him back out to the living room wearing a large blue bib and sat him in an armchair at approximately 4:30pm. Client #2's bib covered his chest and most of his upper abdomen.

Client #2 sat in his chair, occasionally played with his hands in his mouth and drooled over his bib. At approximately 5:15pm, the attending staff took Client #2 and Client #3 out for a community walk. By that time, the bib was soiled with saliva. Client #2 went out on the community walk with the bib on and also returned home with it on. Upon re-entering the home, he was reseated back in the arm chair in the living room. Throughout the evening, Client #2 was observed drooling and wearing the same bib, even during dinner. At 7:12pm he was seated for dinner and he was still wearing the same blue bib he had on when he went out for his community walk.

Record review on 3/19/2009 at 3:17pm revealed Client #2's Speech assessment dated 12/22/2007 recommended using the bib as an adaptive equipment during mealtimes. Further record review revealed Client #2's Nutrition assessment dated 11/8/2008 also recommended using the bib as a mealtime adaptive equipment. It was not clear why Client #2 was allowed to wear the soiled bib throughout the evening, be allowed to walk the community and return home to eat dinner later in the evening with the same soiled bib.

Interview with the facility's QMRP on 3/19/2009 at 5:47pm revealed she was not aware of the recommendations and indicated she would address the problem by training staff on the use of the bib. The facility failed to ensure Client #2 was not utilizing a soiled bib in the home and

W 455

W 455  
All staff were re in serviced on the use of the bib. In the future the QMRP and the Residential Coordinator will monitor the staff daily to ensure that the adaptive equipment is used appropriately.

4/24/09

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

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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>	
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W 455	Continued From page 4 failed to ensure he was equipped with a clean bib during meals.	W 455	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/19/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
I 000	INITIAL COMMENTS  A re-licensure survey was conducted from 03/18/2009 to 03/19/2009. A random sampling of three residents was selected from a population of five individuals with varying degrees of disabilities. This survey was initiated and completed utilizing the fundamental process. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff, medical staff, facility management, and a review of the habilitation and administrative records including the unusual incident reports.	I 000	
I 183	3508.4 ADMINISTRATIVE SUPPORT  Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.  This Statute is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services as required by this section.  The findings include:  1. The QMRP failed to ensure the effective implementation of a resident's "one-on-one" behavioral support program. [See Federal Deficiency Report W249]  2. The QMRP also failed to ensure the proper implementation, use and sanitary condition of a resident's adaptive equipment. [See Federal Deficiency Report W455]	I 183	I 183  1. The staff was in serviced on 1:1 job expectations at the day program. In the future the staff will abide by the 1:1 contract and the QMRP and the day program Case Coordinator will ensure that there is compliance with providing safety to the individual by at least monthly communication.  2. All staff were re in serviced on the use of the bib. In the future the QMRP and the Residential Coordinator will monitor the staff daily to ensure that the adaptive equipment is used appropriately.  4/24/09

Health Regulation Administration

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

*Grant J. Sloan*

TITLE

*VPO*

(X6) DATE

*4/26/09*

STATE FORM

6899

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If continuation sheet 1 of 3

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/19/2009</b>
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I 422	Continued From page 1	I 422		
I 422	3521.3 HABILITATION AND TRAINING	I 422		
	<p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the correct and consistent implementation of a resident's behavioral support plan as recommended for one of three sampled residents. [Resident #1]</p> <p>The finding includes:</p> <p>Upon arrival at the day program on the morning of 3/18/2009 at 11:08am, the "one-on-one" staff assigned to Resident #1 was not in the room with her. There was one attending staff in the room with approximately eight other residents. The attending staff was not in close proximity to Resident #1 as he attended to setting up the room for an activity. Approximately five minutes later, the "one-to-one" staff returned to the classroom and sat in a chair next to Resident #1.</p> <p>Record review on 3/18/2009 at approximately 11:25am revealed, Resident #1's Psychology assessment dated 9/12/2008 details, "[Resident #1] has problems with self-injurious behaviors (head banging on hard surfaces, picking her skin and fingernails), invading the personal space of others (standing too closely to others, holding other's hands, and resting her hands on the shoulders of others) and elopement (leaving the classroom without permission). This behavior support plan was revised on 9/12/2008 to include the following information: [Resident #1] now attends [her day program] on a half-day schedule (until noon) Monday through Friday. She also</p>		<p>I 422 Staff was in serviced on the individual's accurate documentation and implementation of the BSP. In the future the staff will abide by the 1:1 contract and the QMRP and the day program Case Coordinator will communicate at least monthly, to ensure that there is compliance with providing safety to the individual.</p>	4/24/09

Health Regulation Administration

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1422	Continued From page 2  receives 1:1 staffing."  Interview with management staff at the day program on the same day at approximately 11:10am revealed the "one-on-one" staff left the classroom because she had to use the bathroom, but she should have transitioned her duties to another staff prior to leaving the classroom. Interview with the QMRP and LPN on 3/19/2009 at 5:30pm revealed the "one-on-one" staff knew she was not supposed to leave Resident #1 in the classroom without proper oversight.	1422		