

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2009
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NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 4424 20TH STREET, NE WASHINGTON, DC 20019
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from January 5, 2009 through January 7, 2009. Initially, the fundamental survey process was utilized, however, due to concerns in Active Treatment, the survey was extended in that area.</p> <p>A random sample of three clients was selected from a residential population of three females and two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and the review of records, including unusual incident reports.</p> <p>As a result of the findings, a determination was made that the facility failed to be in compliance with the Condition of Participation requirements in Active Treatment.</p>	W 000	<p><i>Recewel 2/1/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</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 observation, interview and record review, the facility failed to ensure the rights of each client and/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 the three clients (Client #1)</p>	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>VP-Operations</i>	(X8) DATE <i>2/9/09</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 the 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 included in the sample.</p> <p>The finding includes:</p> <p>The facility failed to ensure that informed consent was obtained from Client #1's surrogate decision maker prior to the administration of her psychotropic medication.</p> <p>Observation of the medication administration on January 5, 2009, beginning at 5:53 PM revealed Client #1 received medications including Carbamazepine and Moban. Interview with the medication nurse on January 5, 2009, revealed the aforementioned medications were used to address the client's behaviors.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 5, 2008, at 9:17 AM revealed that Client #1 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on January 6, 2009, at 1:57 PM through review of Client 1's psychological assessment dated January 17, 2008. According to the assessment, Client #1 "is not competent to make independent or informed decisions concerning her treatment, placement, medical/psychological treatment or finances based on her current level of cognitive and adaptive levels of functioning." The QMRP further revealed the client had family involvement to include her father to assist her in decision making.</p> <p>Record review on January 6, 2009, at 11:29 AM revealed Client #1 had a verbal physicians' order dated May 6, 2009. Review of the order revealed client's prescribed Moban was increased from 25</p>	W 124	<p>W 124</p> <p>Metro Homes, Inc. has a Policy and Procedure for Psychotropic medication usage. When psychotropic medication is used the QMRP and the nurse inform the legal guardian or relative of any medication dosage changes and obtain a verbal consent over the phone and only begin administering the medication after HRC and approval from guardian/family has been received. The QMRP had received a verbal consent from the family member the day the medication dosage was increased and prior to administering the medication and then mailed the consent to the family member for signature.</p> <p>See attached fax showing date on consent form faxed to relative, HRC consent with QMRP note and HRC approval for medication</p>	1/31/09

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W 124	Continued From page 2 mg twice daily to 50 mg twice daily. Continued review of Client #1's medical record revealed a Medication Administration Record (MAR) for the month of May 2008. According to the MAR, the increased Moban 50 mg was initiated on May 7, 2008. Review of the habilitation record on January 6, 2009, at 2:11 PM revealed Client #1's father signed a consent for the aforementioned medication (Moban), however, it was not signed until several weeks, after the medication was initially administered (June 3, 2008). At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication.	W 124		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure Client #4's parents/guardians were notified of serious incidents. The finding includes: Review of the facility's incident reports on January 5, 2009, beginning at 8:57 AM revealed the following:	W 148	W 148 The QMRP had inadvertently written the date as 5/18/08 instead of 5/15/08 on the incident report - this was an error made by the QMRP. Metro Homes has a Policy and Procedure for Incident management and the family / guardian is notified of all incidents immediately after it has occurred and this was done in this case. The QMRP has been re inserviced on Incident report documentation and reporting accuracy. See attached Incident management P/P reporting.	1/30/09

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W 148	<p>Continued From page 3</p> <p>On March 15, 2008, staff reported an incident that involved Client #4. According to the report, the client fell while reaching for his walker. Continued review of the incident report revealed the client sustained a laceration to his lip and was transported to the emergency room.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on January 5, 2009, at 11:01 AM revealed Client #4 did not have a legal guardian, but, he did have family (brother) involved in his care. The incident report revealed Client #4's brother was notified on March 18, 2008, (three days after the incident occurred).</p> <p>At the time of the survey, the facility failed to provide evidence that Client #4's brother had been promptly notified of the aforementioned incident.</p>	W 148	<p>W 159</p> <ol style="list-style-type: none"> 1.The psychologist has re assessed the client for behaviors of hoarding, SIB and non-compliance and see attached psychological update. 2.The client had been desensitized in 2007 and the desensitization plan was unsuccessful. The PCP and the IDT had agreed that this client would need pre-sedation for completion of medical appointments. The psychologist has included the need for pre-sedation in his BSP and the nurses follow the Procedure for administering pre-sedation. see attached desensitization record and psychological evaluation. 3.Refer to W 124 4.The second morning staff had called out sick and the House Manager accompanied the 2 staff to transport the clients to their day program. In the future Metro Homes shall ensure that staffing ratios will comply with regulations. The QMRP will monitor the schedule daily. See attached staffing schedule. 	2/09/09
W 159	<p>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 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).</p> <p>The findings include:</p>	W 159	<ol style="list-style-type: none"> 5. Metro Homes follows the P/P of Behavior Support Plans and whenever a BSP is amended or written annually - all staff is in serviced on it. See attached in service record 6. In the future the QMRP will monitor staff during mealtimes at least weekly to ensure the mealtime protocol is being followed. See attached in service record on mealtime protocol 	2/09/09

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W 159	Continued From page 4 1. The QMRP failed to ensure Client #2 was assessed for a Behavior Support Plan (BSP) to address her hoarding, self-injurious behaviors and non-compliance. [See W214] 2. The QMRP failed to ensure Client #2's desensitization plan had been revised/updated prior to the use of sedatives for medical appointments. [W214] 3. The QMRP failed to ensure that informed consent was obtained from Client #1's surrogate decision maker prior to the administration of her psychotropic medication. [See W124] 4. The QMRP failed to ensure sufficient direct care staff was on duty while the clients were transported to the various day programs and/or medical appointments. [See W186] 5. The QMRP 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. [See W189] 6. The QMRP failed to ensure that the staff were able to demonstrate competency in the implementation Client #1's "Mealtime Protocol." [See W194] 7. The QMRP failed to ensure that clients' individual program plans (IPP) included training in personal skills for Client #1. [See W242] 8. The QMRP failed to implement a system that provided an opportunity for clients' choice and self management, for Client #2. [See W247]	W 159	7.& 8. All staff were re in serviced on client's self help and management program and client's choices. See attached in service record on IPP and client choices 9. (Cross refer to W 196) Client's drooling has been assessed and a formal program has been put in place - all staff were in serviced on this program. (Cross refer to W 249) The client's desensitization program was completed in 2007 and it was determined that this client would need pre-sedation for completion of medical appointments. This desensitization program is not done continuously. See attached - inservice record on new program for drooling and desensitization program completion and psychological. 10. Cross refer to W 252 - The program for exercise is written by the PT as per the client's needs and requirements. The program is done daily and documentation is done 3-4 days a week. However the program has been re written to reflect daily documentation and all staff have been in serviced on it. See attached new IPP and in service record. 11. Cross refer to W 257 - This program has been discontinued. A new communication program has been written in the format of using a communication book using symbols and pictures. This program will continue as	2/09/09

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W 159	<p>Continued From page 5</p> <p>9. The QMRP failed to ensure each client received continuous active treatment services for Clients #1 and #2. [See W249 and W196]</p> <p>10. 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 for Client #2. [See W252]</p> <p>11. The QMRP failed to revise objectives identified in the individual program plans (IPPs) that had not been achieved for Client #1. [See W257]</p>	W 159	<p>per the IDT, even though the client does not respond. The QMRP will ensure the IPPs are reviewed at least monthly to monitor and document the status of an IPP and make necessary changes or discontinue an IPP if necessary.</p> <p>In the future the QMRP will ensure that all client's IPPs are monitored and measured at least monthly. The agency will ensure that a monthly QA is completed on all client records so as to avoid any recurrence of these issues.</p> <p>See attached monthly QA record</p>	
W 186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure sufficient direct care staff were on duty while the clients were transported to the various day programs and/or medical appointments, for six of the six clients (Clients #1, #2, #3, #4, #5, and #6) residing in the facility.</p> <p>The finding includes:</p> <p>Observation on January 5, 2009, beginning at 8:27 AM revealed two overnight direct care staff persons and a 1:1 staff person in the facility. At</p>	W 186	<p>W 186</p> <p>The 1:1 staff has been re trained on the 1:1 protocol. In the future the QMRP will ensure that the schedule is implemented so as to provide accurate ratios of staffing to provide safety of the clients.</p> <p>See attached in service record for 1:1 staff and staffing schedule</p>	2/09/09

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W 186	<p>Continued From page 6</p> <p>8:32 AM, staff was observed to assist clients with putting on their coats in preparation to leave the facility for their day programs. Continued observation revealed one staff person was assigned as the designated driver and the other staff person was a 1:1 staff assigned to Client #5. It should be noted that Clients #1, #2, #3, and #4 were also observed on the van. Additionally, the 1:1 staff was not observed seated within arm's length of Client #5 as noted in the 1:1 protocol. Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on January 5, 2009, revealed Client #5 received 1:1 services 24 hours per day.</p> <p>Interview on January 5, 2009, with the direct care staff/driver revealed the 1:1 remains on the van with Clients #1, #2, #3, and #4 while she escorts each of the client's into their individual day programs. Further interview with the staff person, revealed that the 1:1 staff person and Client #5 are the last to be dropped off.</p> <p>Interview with the QMRP and record review on January 6, 2009, revealed Client #5 had a "One:One Protocol for [Client's Name]." Review of the protocol revealed the 1:1 staff must be at an arm reach of the client at all times.</p> <p>At the time of the survey, the facility the facility failed to ensure staffing was adequate to monitor and assist the clients while in route to their day programs.</p>	W 186		
W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p>	W 189		

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W 189	<p>Continued From page 7</p> <p>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.</p> <p>The findings include:</p> <p>The facility failed to ensure direct care staff were retrained by the facility's Psychologist as recommended:</p> <p>Observation on January 6, 2009, at 5:43 PM revealed Client #1 stomping her feet on the floor of the living room approximately ten times. It should be noted that the Qualified Mental Retardation Professional (QMRP) was also in the living room, however, the observation did not evidence any staff intervention. At 5:46 PM, Client #1 started stomping her feet again. One of the facility's direct care staff entered the living room, but was not observed to intervene.</p> <p>The review of the facility's incident reports was conducted on January 5, 2009, beginning at 8:57 AM. The staff reported an incident involving Client #1 on May 10, 2008. Continued review of the incident report revealed Client #1 had difficulty walking. Additionally, the report documented that the client was "hollering and stomping her feet all evening." Further review of the report revealed that Client #1 was taken to a local hospital and diagnosed with a "strain right ankle and foot."</p> <p>Review of the facility's "Internal Investigative</p>	W 189	<p>W 189</p> <p>Staff was re in serviced on the BSP. In the future the QMRP will ensure that all recommendations made on an investigation are completed in a timely manner.</p> <p>See attached Client #1 - BSP in service record</p>	2/09/09

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W 189	<p>Continued From page 8</p> <p>Summary" report dated May 15, 2008, on January 5, 2009, revealed a recommendation to re-inserve the staff on Client #1's Behavior Support Plan by May 30, 2008. Review of the facility's training record on January 7, 2009, revealed that the last inservice training for Behavior Support Plans (BSP) was held on January 18, 2008.</p> <p>Interview with QMRP during the entrance conference on January 5, 2009, at 9:17 AM revealed that Client #1 had a Behavior Support Plan. Review of Client #1's habilitation record on January 6, 2009, at 1:58 PM revealed a BSP dated May 22, 2008. According to the BSP, one of the clients' targeted behaviors included stomping her feet. Continued review of the BSP revealed a section entitled "Intervention for hollering, and/or stomping her feet." The plan outlined the following strategies to address the client's behaviors:</p> <ol style="list-style-type: none"> 1. When [client's name] begins to holler and/or stomp her feet, ask her for example, "[client's name], what is it I can help you with?" or say what is it that you want? Observe closely for gestures or eye contact in order to determine if she is attempting to identify her wants/needs. Redirect [client's name] to her task and praise her for cooperating. 2. Ignore the hollering or stomping while redirecting. Plan ignoring should only occur when the target behavior occurs with redirection. If [client's name] ignores staff's initial attempts to get her to stop hollering or stomping, staff should say to [client's name], with a strong and firm voice, "[client's name], stop screaming/stomping your feet!" or, [client's name] stop crying/stomping 	W 189		

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W 189	Continued From page 9 your feet and redirect her to another task or activity that is lest frustrating." 3. If [client's name] hollering and/or stomping her feet becomes disruptive to her peers and continues for at least five minutes she should be redirected to a quiet area where she could be alone and away from the environment where she was initially becoming agitated. 4. When she stops crying, screaming, and/or stomping her feet, staff should give her positive feedback/reinforcement. The staff person can say, "very good [client's name] you are calm." 5. The nurse should be notified when [client's name] has been exhibiting stomping behaviors. The nurse should examine [client's name] feet and ankles to rule out any soreness, tenderness, or swelling that would warrant further medical treatment. At the time of the survey, the facility failed to ensure the direct care staff was reserviced on Client #1's BSP as recommended.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM 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 the review of the record, the facility failed to ensure staff were able to demonstrate the skills and techniques necessary to administer interventions to manage each client's behaviors, for one of the three clients (Client #1) included in the sample.	W 193		

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W 193	Continued From page 10 The finding includes: The facility failed to ensure staff demonstrated the ability to implement Client #1's Behavior Support Plan (BSP). [See W189] Observation on January 6, 2009, at 5:43 PM revealed Client #1 stomping her feet on the floor of the living room approximately ten times. It should be noted that the Qualified Mental Retardation Professional (QMRP) was also in the living room during the observation, however, the QMRP did not intervene. At 5:46 PM, Client #1 started stomping her feet again. This time one of the facility's direct care staff entered the living room, but she was not observed to acknowledge the client's behavior or intervene Interview with the QMRP on January 6, 2009 and review of Client #1's habilitation record at approximately 2:10 PM revealed Client #1 had a BSP dated May 22, 2008. According to the BSP, in a section entitled "Intervention for hollering, and/or stomping her feet." The plan outlined the strategies to address the client's behaviors (See W189). At the time of the survey, the facility failed to provide evidence that staff were effectively trained to implement Client #1's BSP and intervene to address the client's stomping behavior.	W 193	W 193 All staff were re trained by the psychologist in this client's BSP. In the future the QMRP will ensure that staff follow the BSP by monitoring the staff and clients at least weekly and documenting the same in the progress notes. See attached weekly QMRP monitoring check list	2/09/09
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.	W 194		

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WV 194	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews and the review of records, the facility's staff failed to demonstrate competency in the implementation of each clients Individual Program Plan (IPP) for one of the three clients(Client #1) included in the sample.</p> <p>The finding includes:</p> <p>1. The facility failed to ensure the direct care staff were effectively trained on Client #1's "Mealtime Protocol."</p> <p>On January 5, 2009, Client #1 was observed to eat at a very rapid pace. The direct care staff was observed to verbally prompt the client to slow down, however, when the client refused, the staff was observed to hold Client #'s arm to prevent her from taking another bite.</p> <p>Review of Client #1's "Mealtime Protocol" on January 6, 2009, at 11:16 AM revealed the protocol recommended 1:1 supervision for mealtimes and snack times. The protocol also recommended to verbally prompt the client to slow down her eating pace. "If the verbal prompts were unsuccessful to help [client's name] to slow down her eating pace, provide hand over hand guidance with loading the spoon, bringing spoon to mouth slowly and placing spoon down on the table while chewing."</p> <p>At the time of the survey, the facility failed to ensure that staff were effectively trained on Client #1's mealtime protocol.</p> <p>2. The facility failed to ensure the direct care staff were effectively trained to teach Client #1 to wipe her mouth when drooling. [See W196]</p>	W 194	<p>W 194</p> <p>1. 1. When the client does not respond to verbal prompts, staff will provide hand over hand assistance to slow the eating pace as is in the protocol. Staff was re trained in client #1's mealtime protocol. In the future the QMRP will monitor staff during mealtimes at least weekly to ensure the mealtime protocol is being followed. See attached in service record on mealtime protocol</p> <p>2. (W 196) Client's drooling has been assessed and a formal program has been put in place - all staff were in serviced on this program.</p>	2/09/09

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W 195	<p>483.440 ACTIVE TREATMENT SERVICES</p> <p>The facility must ensure that specific active treatment services requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observation, staff 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 (See W189); failed to ensure staff were able to demonstrate the skills and techniques necessary to administer interventions to manage each client's behaviors (See W193); failed to ensure staff were able to demonstrate competency in the implementation of each client's Individual Program Plan (See W194); failed to ensure continuous active treatment services (See W196 and W249); 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); and failed to provide evidence that Individual Program Plans (IPP)s were reviewed and revised once the client had successfully completed an objective (See W257).</p> <p>The effects of these systemic practices resulted in the failure of the facility to ensure the delivery of continuous active treatment services.</p>	W 195	<p>W 195</p> <p>All staff were re trained in all client's IPPs and the QMRP monitors the staff at least weekly to ensure all IPPs are being followed and documents the findings in her weekly report. The QMRP will ensure that all staff receive on going training on IPPs. The QMRP will ensure the IPPs are reviewed at least monthly to monitor and document the status of an IPP and make necessary changes or discontinue an IPP if necessary.</p>	2/09/09
W 196	<p>483.440(a)(1) ACTIVE TREATMENT</p> <p>Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this</p>	W 196		

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W 196	<p>Continued From page 13 subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client received continuous active treatment, for two of the three clients (Clients #1 and #2) included in sample.</p> <p>The findings include:</p> <p>I. The facility failed to ensure Client #1 received continuous active treatment.</p> <p>a. On January 5, 2009, at 5:25 PM, Client #1 was observed entering the facility. Continued observation revealed the direct care staff immediately escorted the client to the facility's bathroom. It should be noted that when Client #1 entered the facility, she was observed drooling. The direct care staff that escorted the client made no attempts to prompt her to wipe her mouth. Upon the client's return from the bathroom at 5:29 PM, she was observed to still be drooling. Again, the staff was not observed to assist Client #1 with wiping her mouth. Further observation on January 5, 2009, at 1:57 PM revealed Client #1 at her day program eating her lunch. The day program staff was observed giving the client a napkin and the client independently wiped her mouth.</p>	W 196	<p>W196</p> <p>1a. Client #1 has a formal program to address the drooling problem at all times and during mealtimes and has been put in place - all staff were in serviced on this program.</p> <p>1b. Client #1 and #2 have a walking program - that particular day the weather was wet and very cold and the clients had put their jackets to go for a walk but stepped out and returned inside because it was raining. The client completed all her programs after the surveyors left that evening.</p> <p>1c. All clients' activity schedules have been changed to reflect time for leisure and relaxation for at least 30-45-60 minutes after returning from the day programs. All staff have been in serviced on each client's activity schedule.</p> <p>1d. All staff have been in serviced to follow clients' activity schedules and IPPs. The QMRP will monitor the staff at least weekly to ensure that all IPPs and activity schedules are followed and she will document the same weekly for at least 1 mth or till staff are absolutely familiar and follow the programs accurately.</p> <p>1e. Client # 1 was reevaluated by the psychologist for non compliance behaviors.</p> <p>See attached psychological update and staff in service record</p>	2/09/09

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W 196	<p>Continued From page 14</p> <p>Observation at the residential facility on January 5, 2009, at 6:44 PM revealed Client #1 eating her dinner. Once more, the client was observed drooling (in her food) and she was noted to eat rapidly. The direct care staff was overheard verbally prompting the client to slow down, but the staff member was not observed to offer the client a napkin to wipe her mouth.</p> <p>Interview was conducted with the Qualified Mental Retardation Professional (Qualified Mental Retardation Professional (QMRP)) on January 5, 2009 to ascertain information regarding a system implemented by the facility to address Client #1's rapid eating. The client's Mealtime Protocol was presented for review. According to the review of the protocol on January 6, 2009, at 11:16 AM, Client #1 required 1:1 supervision for mealtimes and snack times. The protocol further outlined the following procedures to address the client's rapid eating:</p> <ul style="list-style-type: none"> Verbally prompt the client to slow down her eating pace. If the verbal prompts are unsuccessful, provide hand over hand guidance with loading the spoon, bringing the spoon to mouth slowly and placing spoon down on the table while chewing. <p>Furthermore, review of Client #1's habilitation record on January 6, 2009, beginning at 12:59 PM revealed an Individual Support Plan (ISP) dated January 18, 2008. The plan documented an objective that required Client #1 to wipe her mouth after meals with physical assistance on 80% of the trials presented per month for 12 consecutive months by January 2009. At the time of the survey, the facility failed to ensure supports and service designed to address Client #1's</p>	W 196		

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W 196	<p>Continued From page 15</p> <p>rapid eating pace had been implemented. Additionally, the facility failed to provide evidence that Client #1's drooling had been addressed (See W212).</p> <p>b. On the evening of January 5, 2009 at 5:45 PM, Client #1 was observed sitting in the living room with one of her housemates (Client #2). At 5:50 PM, the QMRP was interviewed to ascertain information regarding the clients' active treatment for the evening. The QMRP revealed Client #1 had a walking program but it was 'too dark' for the clients to take a walk. The QMRP then instructed the direct care staff to "put the game on" at 5:55 PM. The staff was observed to put a Nintendo Wii game system on, but the game did not work. The QMRP tried to start the game, but had no knowledge of how to operate it. The direct care staff was interviewed and asked how long had the game been inoperable and replied "since November." The QMRP instructed the direct care staff to let Client #1 do her exercises after dinner.</p> <p>c. Review of Client #1's habilitation record on January 6, 2009, at 3:28 PM revealed an activity schedule entitled, "Weekly Schedule 2008." According to the schedule, Client #1 was to select an outfit and relax from 5:00 PM until 6:00 PM. Continued review of the client's record revealed Client #1 had an objective that required her to select with staff assistance, one out of two outfits presented to wear for the next day on 80% of the trials presented per month for 6 consecutive months by January 2009. At no time during the evening observation was Client #1 observed to be given the opportunity to select an outfit for the next day.</p> <p>d. Further review of the weekly schedule</p>	W 196			

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W 196	<p>Continued From page 16</p> <p>revealed that at 7:00 PM Relaxation and Passive Range of Motion was scheduled. Client #1 was observed to be relaxed after dinner and sat in the living room. At 7:37 PM, the direct care staff was observed to cut the client's fingernails, after which Client #1 continued idly sitting in the living room. It should be noted that Client #1 was not observed to do any exercises after dinner as previously recommended by the QMRP. Review of Client #1's Individual Program Plan (IPP) on January 6, 2009, revealed the client had an program objective to participate in her choice of exercise (aerobic exercise, dancing, etc.) with verbal prompts to promote physical fitness for 30 minutes, three days per week for 6 consecutive months by January 2009. Client #1 was observed to sit in the living room the entire evening not engaged in any activity (from approximately 5:30 PM through 8:00 PM) with the exception of eating her dinner and taking her medications.</p> <p>e. On January 6, 2009, at 4:54 PM, Staff #1 verbally prompted the client to come to the dining room area to participate in an activity. The client refused and continued sitting in a chair in the living room. It should be noted before the aforementioned observation an interview with the QMRP at 4:34 PM, revealed that Client #1 was non-compliant. Additionally, the QMRP revealed during the entrance conference conducted on January 5, 2009, that Client #1 had a Behavior Support Plan (BSP). Continued interview with the QMRP and review of the client's habilitation record on January 6, 2009, revealed a BSP dated May 22, 2008. According to the QMRP and record verification, Client #1's targeted behaviors consisted of aggression, hollering, stomping feet, and property destruction. There was no documented evidence that non-compliance was</p>	W 196		

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W 196	<p>Continued From page 17</p> <p>one of the client's targeted behaviors. [Also See W214]</p> <p>Note: Interview with the direct staff on January 6, 2009 was conducted to ascertain information regarding Client #1's participation in any activities on January 5, 2009. According to the staff interviewed, Client #1 completed her program objectives after 8:00 PM on January 5, 2009. Review of the facility's log on January 6, 2009, revealed the staff documented (on January 5, 2009), all individuals were watching TV at 8:00 PM and were in bed by 9 PM.</p> <p>f. Further review of Client #1's habilitation record on January 6, 2009, at 12:59 PM revealed an additional program objective recommended by the client's interdisciplinary team. The program was documented as detailed below:</p> <p>Staff will talk to [the client] on evening shift about her day and what was happening with her on 100% of the trials recorded per month for 3 consecutive months by January 2009.</p> <p>Observations conducted throughout the surveying process from January 5, 2009 through January 7, 2009 revealed no evidence of the staff communicating with the client about her and/or "what was happening with her." Interview with the QMRP during the entrance conference on January 5, 2009, revealed Client #1 had been diagnosed with profound mental retardation. Review of the client's habilitation record on January 6, 2009, at 1:57 PM revealed a psychological assessment dated January 17, 2008. According to the assessment, attempts to assess Client #1's "cognitive functioning was unsuccessful", because the client would not</p>	W 196	<p>Refer to W 257</p> <p>1f. This program has been discontinued. A new communication program has been written in the format of using a communication book using symbols and pictures. This program will continue as per the IDT, even though the client does not respond. The QMRP will ensure the IPPs are reviewed at least monthly to monitor and document the status of an IPP and make necessary changes or discontinue an IPP if necessary.</p>	2/5/09

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W 196	<p>Continued From page 18</p> <p>respond to the tasks presented to her to complete. Continued review of the assessment revealed the client was "inattentive, and evidenced minimum concentration and minimum eye contact. Additionally, the assessment revealed the client's weaknesses were in communication and socialization domains. Observations of Client #1 throughout the survey, revealed that she was non-responsive to the staff.</p> <p>At the time of the survey, the facility failed to provide continuous active treatment interventions and services to support Client #1 with achieving the objectives outlined in her IPP and address her identified needs.</p> <p>II. The facility failed to ensure Client #2 received continuous active treatment.</p> <p>a. Observations on January 5, 2009, from 5:45 PM through 8:00 PM revealed Client #2 refused to engage in any offered activities. The client was further observed to exhibit non-compliant behaviors as detailed below:</p> <p>At 5:45 PM, Client #2 was observed sitting in the living room with one of her housemates (Client #1). Interview with the QMRP at 5:50 PM was conducted to ascertain information regarding Client #2's activities for the evening. The QMRP revealed Client #2 had a walking program but it was 'too dark' for the clients to take a walk. The QMRP then instructed the direct care staff to "put the game on" at 5:55 PM. The staff was observed to put a Nintendo Wii game system on, but the game did not work. The QMRP tried to start the game, but had no knowledge of how to operate it. The direct care staff was interviewed and asked how long had the game been</p>	W 196	<p>II a- f - Client #2's psychological assessment has been updated to address her non-compliance and aggression. The client is usually very compliant and does not display these behaviors.</p> <p>In the future the QMRP will ensure the BSP/IPP's are reviewed at least monthly to monitor and document the status of an IPP/BSP and make necessary changes or discontinue an IPP if necessary.</p>	2/09/09
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W 196	<p>Continued From page 19</p> <p>inoperable and replied "since November." The QMRP instructed the direct care staff to let Client #2 do her exercises after dinner.</p> <p>b. Observation of the evening medication administration on January 5, 2009, at 6:06 PM revealed Client #2 refused to take her medication. The facility's Licensed Practical Nurse (LPN) called Client #2 to the dinning room to take her medication, when the client entered the dining room, the nurse asked her if she was ready to take her medication, and her response was "no." Client #2 was observed to return to the living room where she had been sitting throughout the observation. The nurse asked Client #2 again if she was ready to take her medication at 6:30 PM and at 6:32 PM. The client continued to refuse to take her medication. At 7:14 PM, one of the facility's Trained Medication Employees (TME) offered Client #2 another opportunity to take her medication, but the client continued to be resistant. Interview with the staff and record verification on January 6, 2009, revealed Client #2 did not receive her medication until 8:30 PM on January 5, 2009.</p> <p>Further observation of Client #2 on January 5, 2009, revealed her eating dinner independently at 6:39 PM. After dinner, at 7:01 PM, she was observed to return to the living room and insisted that one of her housemates (Client #3) get up out of the chair where she was sitting and to let her set in the chair. Although Client #3 did not want to move, the direct care staff and the QMRP verbally prompted Client #3 to move and sit someplace else so that Client #2 could sit in the chair. Client #2 was observed sitting in the chair until 8:00 PM.</p>	W 196		

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W 196	<p>Continued From page 20</p> <p>c. On January 6, 2009, at 4:54 PM, Staff #1 verbally prompted Client #2 to come to the dining room to participate in an activity. At 5:01 PM, the direct care staff was observed to place a mat on the floor and asked Client #2 if she was ready to do her exercises, and the client's response was "no." The staff member was observed to put an exercise tape on and asked the client again if she was ready to exercise. The client refused. At 5:05 PM, Client #2 was observed to leave the living room area and headed towards her bedroom. At 5:10 PM, the client was observed to return to the living room. The direct care staff periodically attempted to engage Client #2 to participate in some aerobic exercises, however, Client #2 continued to refuse. The staff asked the client to let them know when she was ready to do her exercises. It should be noted that interview with the House Manager (HM) on January 6, 2009, at 1:12 PM revealed Client #2 had a walking program and an aerobic program for which she had been non-compliant.</p> <p>At 5:30 PM, Client #2 was observed to hit herself on her thigh and at 5:43 PM, she punched herself in the stomach. She continued to exhibit self-injurious behaviors throughout the evening. The client appeared not to be interested in doing anything and was overheard saying no, whenever she was offered the opportunity to participate in taking her medication, completing her laundry, exercising or setting the table.</p> <p>At 5:48 PM, the staff asked Client #2 if she was going to set the table for dinner. The client's response was "no." At 6:02 PM, Client #2 was observed hitting her thigh repeatedly. According to interview with the staff, the client hits herself all the time, especially when she doesn't want to do</p>	W 196		

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NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 4424 20TH STREET, NE WASHINGTON, DC 20019		
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W 196	<p>Continued From page 21 something.</p> <p>d. Review of Client #2's activity schedule on January 6, 2009, revealed she was scheduled to set the table on Tuesdays and Thursdays at 5:00 PM. Review of her habilitation record revealed an IPP that required the client to set the table for dinner independently on 80% of the trials recorded per month for six consecutive months.</p> <p>At 7:37 PM, Client #2 was observed watching the television. The direct care staff attempted to engage the client in folding her laundry but, the client refused.</p> <p>Client #2 was observed on January 7, 2009, at 5:06 PM with a Jean tote bag. According to staff interview, the client was known to take the bag everywhere she went and it was further revealed that she exhibited hoarding behaviors. Additionally, the staff indicated that if they attempted to move the client's bag, she became upset. After the interview, staff was observed asking the client if she would like to paint her nails. The client responded "no."</p> <p>Further observation revealed Client #2 took a stuffed animal and some cotton out of the jean bag and began to fiddle with it. She was observed stuffing it in a knit cap until dinner was served. Staff #2 placed an exercise tape in the VCR and was overheard asking Client #2 if she would do her exercises or if she wanted to dance? The client responded "no."</p> <p>e. Interview with the direct care staff on January 7, 2009, at 4:03 PM revealed Client #2 was non-compliant with setting the table, washing her clothes and taking them to the dryer. Note:</p>	W 196		

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W 196	Continued From page 22 Additional interview with staff on January 7, 2009, revealed that Client #2 was engaged in programming activities after 8:00 PM on January 5, 2009. Documentation on Client #2's program data sheets revealed programs including walking and engaging in an exercise tape were completed. Review of the facility's log however, revealed that all individuals including Client #2 were watching TV at 8:00 PM and in bed by 9:00 PM. f. Interview with the day program Case Manager (CM) on January 7, 2009, at 9:46 AM revealed Client #2 had a Behavior Support Plan (BSP). According to the day program 's CM the client's targeted behaviors included physical aggression and non-compliance. Continued interview with the day program CM revealed Client #2 had exhibited physical aggression and self-injurious behaviors on January 6, 2009. Although Client #2 exhibited non-compliant behaviors throughout the survey, interview with the QMRP during the entrance conference on January 5, 2009, revealed interventions had not been designed to address the client ' s non-compliance in the residential facility. At the time of the survey, the facility failed to provide continuous active treatment interventions and services to support Client #2 with achieving the objectives outlined in her IPP and address her identified needs.	W 196		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes.	W 212		

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W 212	<p>Continued From page 23</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure comprehensive assessments were conducted to identify presenting problems and disabilities, for one of three clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>On January 5, 2009, at 5:25 PM, Client #1 was observed entering the facility. Continued observation revealed the direct care staff immediately escorted the client to the facility's bathroom. It should be noted that when Client #1 entered the facility, she was observed drooling. The direct care staff that escorted the client made no attempts to prompt her to wipe her mouth. Upon the client's return from the bathroom at 5:29 PM, she was observed to still be drooling. It should be noted that the staff was not observed to assist Client #1 with wiping her mouth.</p> <p>Observation on January 5, 2009, at 1:57 PM revealed Client#1 at her day program eating her lunch. The day program staff was observed giving the client a napkin and the client independently wiped her mouth. On January 5, 2009, at 6:44 PM Client #1 was observed eating her dinner. The client was observed drooling in her food while she ate rapidly. The direct care staff was observed to verbally prompt the client to slow down but, the staff was not observed to offer the client a napkin.</p> <p>Review of Client #1's habilitation record on January 6, 2009, beginning at 12:59 PM revealed an Individual Support Plan (ISP) dated January 18, 2008. Review of the plan revealed Client #1 had an objective to wipe her mouth after meals</p>	W 212	<p>W 212</p> <p>Refer: (W 196) Client's drooling has been assessed and a formal program has been put in place - all staff were in serviced on this program. In the future the QMRP will monitor the staff at least weekly to ensure that all IPPs and activity schedules are followed and she will document the same weekly for at least 1 mth or till staff are absolutely familiar and follow the programs accurately.</p>	2/09/09

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W 212	Continued From page 24 with physical assistance on 80% of the trials presented per month for 12 consecutive months by January 2009. Interview was conducted with the facility's Licensed Practical Nurse (LPN) on January 7, 2009, at 1:22 PM to ascertain information regarding the systems implemented by the facility to assist Client #1 with drooling. The nurse was asked how long the client had been drooling. According to the nurse, Client #1 had just started drooling approximately two weeks before the survey. At the time of the survey, the facility failed to ensure Client #1 had been assessed to address the drooling.	W 212		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comprehensive functional assessment of behavioral needs was conducted for two of three clients (Clients #1 and #2) included in the sample. The findings include: Cross Refer W196. The facility failed to provide evidence that Client #1 's known behavior of non-compliance was assessed and addressed. On January 6, 2009, at 4:54 PM a direct care staff was observed to verbally prompt Client #1 to come to the dining room area to participate in an activity. The client refused and continued sitting in	W 214		

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W 214	Continued From page 25 a chair in the living room. It should be noted that before the aforementioned observation an interview was conducted with the Qualified Mental Retardation Professional (QMRP) at 4:34 PM that revealed Client #1 was non-compliant. Additionally, the QMRP revealed during the entrance conference conducted on January 5, 2009, that Client #1 had a Behavior Support Plan (BSP). According to the QMRP and review of the client's BSP dated May 22, 2008. Client #1's targeted behaviors consisted of aggression, hollering, stomping feet, and property destruction. At the time of the survey, there was no documented evidence that Client #1's non-compliant behavior had been addressed.	W 214	W 214 The psychologist has re evaluated client #1's psychological assessment In the future the QMRP will ensure that the psychologist completes a functional assessment for all clients at least annually or as new behaviors surface. See attached psychological update and staff in service record	2/09/09
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement a system that provided an opportunity for client choice and self management, for one of the three clients (Client #2) in the sample. The finding includes: Observation of Client #2 on January 6, 2009, at 9:19 AM revealed a direct care staff assisting the client with her coat. Interview with the House Manager (HM) on the aforementioned date at 1:12 PM was conducted to ascertain information regarding the level of assistance Client #2 needed. According to the House Manager (HM), Client #2 was able to pack her purse	W 247		

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W 247	Continued From page 26 independently, answer questions with responses, use the bathroom independently, and she was capable of setting the table and taking her dishes to the kitchen with some prompting. Continued discussion with the HM revealed the client could also brush her teeth with verbal prompting. Additional observation of Client #2 during the dinner on January 5, 2009, beginning at 6:39 PM revealed the client eating her meal independently. At 6:51 PM, the direct care staff was observed to pour Client #2 a glass of crystal light. The client was not given the opportunity to try to pour her own drink. Record review on January 6, 2009, at 12:03 PM revealed Client #2 had a program objective to improve her self-help skills. At time of the survey, however, the facility failed to provide evidence that the client was availed the consistent opportunities to improve her self-help skills	W 247	W 247 cross refer W159-7&8 All staff were re in serviced on client's self help and management program and client's choices. In the future the QMRP will monitor the staff at least weekly to ensure that all IPPs and activity schedules are followed and she will document the same weekly for at least 1 mth or till staff are absolutely familiar and follow the programs accurately. See attached in service record on IPP and client choices	2/09/09
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each client received continuous active treatment services, for two of the three clients (Clients #1 and #2) included in the sample.	W 249		

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W 249	<p>Continued From page 27</p> <p>The finding includes:</p> <p>The facility failed to ensure Client #1 received continuous active treatment as evidenced below:</p> <p>1. On January 7, 2009, beginning at 11:54 AM, review of Client #2's medical records revealed that she frequently refused to cooperate with medical professionals.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 7, 2009, at 3:40 PM was conducted to ascertain information regarding Client #2's non-compliance with her medical appointments. The QMRP was asked if Client #2 had a desensitization plan to address her non-compliance. The QMRP verified through review of the client ' s record that she did have a desensitization plan dated April 3, 200. Continued discussion with the QMRP revealed the plan was old, but it was still being implemented. According to the QMRP, the documentation for the plan was discontinued because it was "not working." Review of the desensitization plan revealed a recommendation to use a sedative to calm Client #2 if the measures outlined in the plan were unsuccessful, and if the client refused an examination. Continued review of the plan revealed that if the physician/dentist believed that the examination was not necessary, the client could return to her residence. Further review of the Client #2 ' s record revealed the following:</p> <ul style="list-style-type: none"> - Client #2 was uncooperative on a December 1, 2008, ENT appointment; - Client #2 refused to cooperate with the dentist on October 7, 2008; and, - Client #2 refused to cooperate for a 	W 249	W 249 cross refer W189, W252	

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W 249	Continued From page 28 Mammogram on March 28, 2008. At the time of the survey, there was no documented in Client #2's records that the revealed the facility continually implemented Client #2's desensitization plan prior to administering sedations. 2. The facility failed to implement Client #1's Behavior Support Plan (BSP) to address her stomping behavior (See W189). 3. The facility failed to provide evidence that Client #2 was provided the required opportunities to participate with her cardiovascular program (See W252).	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record 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 #2) included in the sample. The findings include: 1 Observations on January 5, 2009, beginning at 5:45 PM until 8:00 PM revealed Client #2 was not	W 252		

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W 252	<p>Continued From page 29</p> <p>engaged in any program activities. Staff periodically asked the client to in aerobic exercises but, she refused.</p> <p>Interview with the House Manager (HM) on January 6, 2009, at 1:12 PM revealed Client #2 had a walking program and an aerobic program for which she had been non-compliant.</p> <p>Record review on January 6, 2009, beginning at 11:22 PM revealed Client #2 had an Individual Program Plan (IPP) dated January 18, 2008. According to the IPP, the client had an objective that required her to participate in cardiovascular activities to include but not limited to walking, dancing, using an exercise tape, treadmill etc. for thirty minutes four to five days a week for 12 consecutive months. Continued review of the program objective revealed that the program was being implemented, but the data was not being collected four to five days a week as recommended by the physical therapist. It should be noted that the physical therapist recommended this objective to improve Client #2's "cardiovascular conditioning." Further review of the data collection revealed that the client's exercise program was implemented for only three days per week.</p> <p>At the time of survey, the facility failed to provide evidence that data for Client #2 's cardiovascular program was being collected as outlined.</p>	W 252	<p>W252</p> <p>The exercise program is written by the PT as per the client's needs and requirements. The program is done daily and documentation is done 3-4 days a week. However the program is re written to reflect daily documentation and all staff have been in serviced on it. See attached new IPP and in service record.</p>	2/09/09
W 257	<p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives</p>	W 257		

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W 257	<p>Continued From page 30 after reasonable efforts have been made.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs) that had not been achieved for one of three clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>Review of Client #1's habilitation record on January 6, 2009 at 12:41 PM, revealed the client's Individual Support Plan (ISP) meeting was held on January 18, 2008. Interview with the QMRP and review of the client's corresponding IPP revealed the team recommended a program objective for the current ISP year that included:</p> <p>- Given physical assistance [the client] will participate in a reciprocal turn taking activity with 70% accuracy per session as measured by active treatment documentation.</p> <p>Interview with the QMRP on January 6, 2009, at 4:34 PM and continued review of the data revealed that Client #1 had not been responsive for three consecutive months (October 2008 through December 2008). Further interview with the QMRP was conducted to ascertain what had been done to address the client's lack of participation. Additionally, the QMRP was asked if there was data for any other months. The QMRP provided data for the months of January 2008 through September 2008 which revealed that the client continued to be non-responsive or refusing to participate on all the trials recorded.</p>	W 257	<p>W 257 This program has been discontinued and changed. This client will continue to have a communication program in the format of a communication book using pictures and symbols. This program will continue as per the IDT, even though the client does not respond.</p> <p>The QMRP will ensure the IPPs are reviewed at least monthly to monitor and document the status of an IPP and make necessary changes or discontinue an IPP if necessary.</p>	2/05/09

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W 257	Continued From page 31	W 257		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & 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> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for one of the three clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>The facility failed to ensure that written informed consent was obtained from Client #1 or legal guardian prior to the implementation of her Behavior Support Plan (BSP).</p> <p>Interview with the QMRP on January 5, 2009, during the entrance conference revealed Client #1's medication was used in conjunction with a</p>	W 263		

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W 263	<p>Continued From page 32</p> <p>BSP to manage the client's behaviors. Review of the client's habilitation record on January 6, 2009, verified that Client #1 had a BSP dated May 22, 2008. According to the BSP, Client #1 received psychotropic medications for Intermittent Explosive Disorder.</p> <p>Continued interview with the QMRP and record review revealed Client #1 was not capable of giving informed consent for the use of medications and habilitation services. The QMRP further revealed the client did not have a legal guardian to assist her in decision making, but she did have family involvement. At the time of the survey, there was no evidence that the facility's specially constituted committee ensured that written informed consent had been obtained for the use of Client #1's BSP that incorporated restrictive techniques.</p>	W 263	<p>W263 cross refer W124</p> <p>Metro Homes, Inc. has a Policy and Procedure for Psychotropic medication usage. When psychotropic medication is used the QMRP and the nurse inform the legal guardian or relative of any medication dosage changes and obtain a verbal consent over the phone and only begin administering the medication after HRC and approval from guardian/family has been obtained. The QMRP had received a verbal consent from the family member the day the medication dosage was increased and prior to administering the medication and then mailed the consent to the family member for signature.</p> <p>See attached QMRP progress note and consent form and HRC approval.</p>	2/09/09

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1000	INITIAL COMMENTS A licensure survey was conducted from January 5, 2009 through January 7, 2009. A random sample of three clients was selected from a residential population of three females and two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and a review of records, including unusual incident reports.	1.000		
1082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure all bathrooms were equipped adequate lighting. The finding includes: Observation of the GHMRP's environment and interview with the House Manager on January 7, 2009, during the environmental inspection, revealed the bathroom utilized by the residents failed to have adequate lighting. Continued observation revealed a lighting fixture that held three bulbs, however, at the time of the survey, the fixture was observed with one bulb.	1082	1082 A week before the survey there was a flood and ceiling tiles were leaking. All lighting fixtures have been fixed with adequate light bulbs.	2/09/09
1090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive,	1090		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Swan J. Swanford, MA

TITLE

VP Operations

(X6) DATE

2/9/09

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1090	<p>Continued From page 1</p> <p>and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner.</p> <p>The findings include:</p> <p>On January 7, 2009, at approximately 4:07 PM observation of the environment revealed the following deficiencies:</p> <ol style="list-style-type: none"> 1. Resident #4's first and second dresser drawers were off track creating a potential safety hazard. 2. Residents #1 and #2's bathroom light fixture was missing two light bulbs. 3. Resident #5's blinds on the window located near the exit door had broken slats. Additionally, two areas of the bedroom wall had patchwork and unfinished painting. It should be noted that the temperature in Resident #5's bedroom and the bathroom was approximately fifty (50) degrees. 4. The bathroom door located in the basement was detached, leaving an opening. Additionally, the door knob was loose. 5. The rail on the basement stairs was loose. 6. Electrical wires were exposed and hitting against the pantry door, whenever the door was shut. Additionally, several ceiling panels were 	1090	<p>1090</p> <ol style="list-style-type: none"> 1. The dresser has been fixed. 2. light bulbs have been replaced 3. the bedroom has been re painted after the water leak damage and patch work the blind and window pane has been replaced. the water temp. has been adjusted to within regulatory requirements. 4. the bathroom door has been replaced 5. the rail to the basement has been fitted and is secure 6. the ceiling tiles were replaced and the wiring was fixed - these were due to a water flood/leak 1 week prior to survey. 7. the facility has a new refrigerator 	2/09/09

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I 090	Continued From page 2 missing and it water damage was observed on the remaining panels. 7. The facility's refrigerator door gasket was broken and detached from the bottom of the door.	I 090		
H STA CITY STATE 161	3507.2 POLICIES AND PROCEDURES 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 January 5, 2009, failed to provide evidence that the manual had been reviewed and approved by the governing body as required since March 1, 2007.	I 161	I 161 The facility has obtained a copy of the updated Policy and Procedure manual. In the future the QMRP will complete a monthly QA so as to prevent any recurrences. See attached QMRP monthly QA record	2/09/09
I 206	3509.6 PERSONNEL POLICIES 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.	I 206		

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I 206	Continued From page 3 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. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on January 5, 2009, and review of the GHMRP's personnel records at 3:55 PM revealed that the GHMRP failed to provide evidence that current health certificates were on file for five direct care staff and four consultants.	I 206	I 206 Attached are the health certificates. The agency has hired new management personnel and is having a master database created to provide a system of having all employees health status documented at least annually and prior to employment.	2/09/09
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical services were secured, prompt notification of the resident's status would be made as soon as possible to the resident's guardian, his or her next of kin if the resident had no guardian, or the representative of the sponsoring agency, followed	I 374		

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I 374	<p>Continued From page 4</p> <p>by written notice and documentation no later than forty-eight (48) hours after the incident, for one of the three residents (Resident #4) included in the sample.</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on January 5, 2009, beginning at 8:57 AM revealed the following:</p> <p>On March 15, 2008, staff reported an incident that involved Resident #4. According to the report, the Resident fell while reaching for his walker. Continued review of the incident report revealed the Resident sustained a laceration to his lip and was transported to the emergency room.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on January 5, 2009, at 11:01 AM revealed Resident #4 did not have a legal guardian, but, he did have family (brother) involved in his care. The incident report revealed Resident #4's brother was notified on March 18, 2008, (three days after the incident occurred).</p> <p>At the time of the survey, the facility failed to provide evidence that Resident #4's brother had been promptly notified of the aforementioned incident.</p>	I 374	<p>I 374cross refer to W 148</p> <p>The QMRP had inadvertently written the date as 5/18/08 instead of 5/15/08 on the incident report – this was an error made by the QMRP. Metro Homes has a Policy and Procedure for Incident management and the family / guardian is notified of all incidents immediately after it has occurred and this was done in this case.</p> <p>The QMRP has been re in serviced on Incident report documentation and reporting accuracy.</p> <p>See attached Incident management P/P reporting.</p> <p>2/09/09</p>
I 420	<p>3521.1 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels</p>	I 420	

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1420	<p>Continued From page 5</p> <p>of physical, mental and social functioning.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each Resident received continuous active treatment, for two of the three clients (Clients #1 and #2) included in sample.</p> <p>The findings include:</p> <p>i. The facility failed to ensure Resident #1 received continuous active treatment.</p> <p>a. On January 5, 2009, at 5:25 PM, Resident #1 was observed entering the facility. Continued observation revealed the direct care staff immediately escorted the Resident to the facility's bathroom. It should be noted that when Resident #1 entered the facility, she was observed drooling. The direct care staff that escorted the Resident made no attempts to prompt her to wipe her mouth. Upon the client's return from the bathroom at 5:29 PM, she was observed to still be drooling. Again, the staff was not observed to assist Resident #1 with wiping her mouth. Further observation on January 5, 2009, at 1:57 PM revealed Resident #1 at her day program eating her lunch. The day program staff was observed giving the Resident a napkin and the Resident independently wiped her mouth.</p> <p>Observation at the residential facility on January 5, 2009, at 6:44 PM revealed Resident #1 eating her dinner. Once more, the Resident was observed drooling (in her food) and she was noted to eat rapidly. The direct care staff was overheard verbally prompting the Resident to slow down, but the staff member was not observed to offer the Resident a napkin to wipe</p>	1420	<p>W420</p> <p>a. Refer: (W 196) Client's drooling has been assessed and a formal program has been put in place - all staff were in serviced on this program. In the future the QMRP will monitor the staff at least weekly to ensure that all IPPs and activity schedules are followed and she will document the same weekly for at least 1 mth or till staff are absolutely familiar and follow the programs accurately.</p> <p>b. cross refer to W 214</p> <p>The psychologist has re evaluated client #1's psychological assessment</p> <p>In the future the QMRP will ensure that the psychologist completes a functional assessment for all clients at least annually or as new behaviors surface.</p> <p>See attached psychological update and staff in service record</p> <p>c. &d. All clients' activity schedules have been changed to reflect time for leisure and relaxation for at least 30-45-60 minutes after returning from the day programs. All staff have been in serviced on each client's activity schedule.</p>	<p>2/09/09</p> <p>2/09/09</p>

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1420	Continued From page 6 her mouth. Interview was conducted with the Qualified Mental Retardation Professional (Qualified Mental Retardation Professional (QMRP)) on January 5, 2009 to ascertain information regarding a system implemented by the facility to address Resident #1's rapid eating. The Resident's Mealtime Protocol was presented for review. According to the review of the protocol on January 6, 2009, at 11:16 AM, Resident #1 required 1:1 supervision for mealtimes and snack times. The protocol further outlined the following procedures to address the Resident's rapid eating: - Verbally prompt the Resident to slow down her eating pace. - If the verbal prompts are unsuccessful, provide hand over hand guidance with loading the spoon, bringing the spoon to mouth slowly and placing spoon down on the table while chewing. Furthermore, review of Resident #1's habilitation record on January 6, 2009, beginning at 12:59 PM revealed an Individual Support Plan (ISP) dated January 18, 2008. The plan documented an objective that required Resident #1 to wipe her mouth after meals with physical assistance on 80% of the trials presented per month for 12 consecutive months by January 2009. At the time of the survey, the facility failed to ensure supports and service designed to address Resident #1's rapid eating pace had been implemented. Additionally, the facility failed to provide evidence that Resident #1's drooling had been addressed (See W212). b. On the evening of January 5, 2009 at 5:45 PM, Resident #1 was observed sitting in the living room with one of her housemates (Resident #2).	1420		

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420	<p>Continued From page 7</p> <p>At 5:50 PM, the QMRP was interviewed to ascertain information regarding the clients' active treatment for the evening. The QMRP revealed Resident #1 had a walking program but it was 'too dark' for the clients to take a walk. The QMRP then instructed the direct care staff to "put the game on" at 5:55 PM. The staff was observed to put a Nintendo Wii game system on, but the game did not work. The QMRP tried to start the game, but had no knowledge of how to operate it. The direct care staff was interviewed and asked how long had the game been inoperable and replied "since November." The QMRP instructed the direct care staff to let Resident #1 do her exercises after dinner.</p> <p>c. Review of Resident #1's habilitation record on January 6, 2009, at 3:28 PM revealed an activity schedule entitled, "Weekly Schedule 2008." According to the schedule, Resident #1 was to select an outfit and relax from 5:00 PM until 6:00 PM. Continued review of the Resident's record revealed Resident #1 had an objective that required her to select with staff assistance, one out of two outfits presented to wear for the next day on 80% of the trials presented per month for 6 consecutive months by January 2009. At no time during the evening observation was Resident #1 observed to be given the opportunity to select an outfit for the next day.</p> <p>d. Further review of the weekly schedule revealed that at 7:00 PM Relaxation and Passive Range of Motion was scheduled. Resident #1 was observed to be relaxed after dinner and sat in the living room. At 7:37 PM, the direct care staff was observed to cut the client's fingernails, after which Resident #1 continued idly sitting in the living room. It should be noted that Resident #1 was not observed to do any exercises after</p>	420	

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I 420	Continued From page 8 dinner as previously recommended by the QMRP. Review of Resident #1's Individual Program Plan (IPP) on January 6, 2009, revealed the Resident had an program objective to participate in her choice of exercise (aerobic exercise, dancing, etc.) with verbal prompts to promote physical fitness for 30 minutes, three days per week for 6 consecutive months by January 2009. Resident #1 was observed to sit in the living room the entire evening not engaged in any activity (from approximately 5:30 PM through 8:00 PM) with the exception of eating her dinner and taking her medications. e. On January 6, 2009, at 4:54 PM, Staff #1 verbally prompted the Resident to come to the dining room area to participate in an activity. The Resident refused and continued sitting in a chair in the living room. It should be noted before the aforementioned observation an interview with the QMRP at 4:34 PM, revealed that Resident #1 was non-compliant. Additionally, the QMRP revealed during the entrance conference conducted on January 5, 2009, that Resident #1 had a Behavior Support Plan (BSP). Continued interview with the QMRP and review of the client's habilitation record on January 6, 2009, revealed a BSP dated May 22, 2008. According to the QMRP and record verification, Resident #1's targeted behaviors consisted of aggression, hollering, stomping feet, and property destruction. There was no documented evidence that non-compliance was one of the client's targeted behaviors. [Also See W214] Note: Interview with the direct staff on January 6, 2009 was conducted to ascertain information regarding Resident #1's participation in any activities on January 5, 2009. According to the staff interviewed, Resident #1 completed her	I 420	e. cross refer to W214	

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I 420	Continued From page 9 program objectives after 8:00 PM on January 5, 2009. Review of the facility's log on January 6, 2009, revealed the staff documented (on January 5, 2009), all individuals were watching TV at 8:00 PM and were in bed by 9 PM. f. Further review of Resident #1's habilitation record on January 6, 2009, at 12:59 PM revealed an additional program objective recommended by the client's interdisciplinary team. The program was documented as detailed below: Staff will talk to [the client] on evening shift about her day and what was happening with her on 100% of the trials recorded per month for 3 consecutive months by January 2009. Observations conducted throughout the surveying process from January 5, 2009 through January 7, 2009 revealed no evidence of the staff communicating with the Resident about her and/or "what was happening with her." Interview with the QMRP during the entrance conference on January 5, 2009, revealed Resident #1 had been diagnosed with profound mental retardation. Review of the client's habilitation record on January 6, 2009, at 1:57 PM revealed a psychological assessment dated January 17, 2008. According to the assessment, attempts to assess Resident #1's "cognitive functioning was unsuccessful", because the Resident would not respond to the tasks presented to her to complete. Continued review of the assessment revealed the Resident was "inattentive, and evidenced minimum concentration and minimum eye contact. Additionally, the assessment revealed the client's weaknesses were in communication and socialization domains. Observations of Resident #1 throughout the survey, revealed that she was non-responsive to	I 420	f. cross refer to W 257	

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1420	<p>Continued From page 10</p> <p>the staff.</p> <p>At the time of the survey, the facility failed to provide continuous active treatment interventions and services to support Resident #1 with achieving the objectives outlined in her IPP and address her identified needs.</p> <p>II. The facility failed to ensure Resident #2 received continuous active treatment.</p> <p>a. Observations on January 5, 2009, from 5:45 PM through 8:00 PM revealed Resident #2 refused to engage in any offered activities. The Resident was further observed to exhibit non-compliant behaviors as detailed below:</p> <p>At 5:45 PM, Resident #2 was observed sitting in the living room with one of her housemates (Resident #1). Interview with the QMRP at 5:50 PM was conducted to ascertain information regarding Resident #2's activities for the evening. The QMRP revealed Resident #2 had a walking program but it was 'too dark' for the clients to take a walk. The QMRP then instructed the direct care staff to "put the game on" at 5:55 PM. The staff was observed to put a Nintendo Wii game system on, but the game did not work. The QMRP tried to start the game, but had no knowledge of how to operate it. The direct care staff was interviewed and asked how long had the game been inoperable and replied "since November." The QMRP instructed the direct care staff to let Resident #2 do her exercises after dinner.</p> <p>b. Observation of the evening medication administration on January 5, 2009, at 6:06 PM revealed Resident #2 refused to take her medication. The facility's Licensed Practical</p>	1420	<p>II a-f - Client #2's psychological assessment has been updated to address her non-compliance and aggression. The client is usually very compliant and does not display these behaviors.</p> <p>In the future the QMRP will ensure the BSP/IPP's are reviewed at least monthly to monitor and document the status of an IPP/BSP and make necessary changes or discontinue an IPP if necessary.</p>	2/5/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 4424 20TH STREET, NE WASHINGTON, DC 20019		
(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
1420	<p>Continued From page 11</p> <p>Nurse (LPN) called Resident #2 to the dining room to take her medication, when the Resident entered the dining room, the nurse asked her if she was ready to take her medication, and her response was "no." Resident #2 was observed to return to the living room where she had been sitting throughout the observation. The nurse asked Resident #2 again if she was ready to take her medication at 6:30 PM and at 6:32 PM. The Resident continued to refuse to take her medication. At 7:14 PM, one of the facility's Trained Medication Employees (TME) offered Resident #2 another opportunity to take her medication, but the Resident continued to be resistant. Interview with the staff and record verification on January 6, 2009, revealed Resident #2 did not receive her medication until 8:30 PM on January 5, 2009.</p> <p>Further observation of Resident #2 on January 5, 2009, revealed her eating dinner independently at 6:39 PM. After dinner, at 7:01 PM, she was observed to return to the living room and insisted that one of her housemates (Resident #3) get up out of the chair where she was sitting and to let her set in the chair. Although Resident #3 did not want to move, the direct care staff and the QMRP verbally prompted Resident #3 to move and sit someplace else so that Resident #2 could sit in the chair. Resident #2 was observed sitting in the chair until 8:00 PM.</p> <p>c. On January 6, 2009, at 4:54 PM, Staff #1 verbally prompted Resident #2 to come to the dining room to participate in an activity. At 5:01 PM, the direct care staff was observed to place a mat on the floor and asked Resident #2 if she was ready to do her exercises, and the client's response was "no." The staff member was observed to put an exercise tape on and asked</p>	1420		

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1420	<p>Continued From page 12</p> <p>the Resident again if she was ready to exercise. The Resident refused. At 5:05 PM, Resident #2 was observed to leave the living room area and headed towards her bedroom. At 5:10 PM, the Resident was observed to return to the living room. The direct care staff periodically attempted to engage Resident #2 to participate in some aerobic exercises, however, Resident #2 continued to refuse. The staff asked the Resident to let them know when she was ready to do her exercises. It should be noted that interview with the House Manager (HM) on January 6, 2009, at 1:12 PM revealed Resident #2 had a walking program and an aerobic program for which she had been non-compliant.</p> <p>At 5:30 PM, Resident #2 was observed to hit herself on her thigh and at 5:43 PM, she punched herself in the stomach. She continued to exhibit self-injurious behaviors throughout the evening. The Resident appeared not to be interested in doing anything and was overheard saying no, whenever she was offered the opportunity to participate in taking her medication, completing her laundry, exercising or setting the table.</p> <p>At 5:48 PM, the staff asked Resident #2 if she was going to set the table for dinner. The client's response was "no." At 6:02 PM, Resident #2 was observed hitting her thigh repeatedly. According to interview with the staff, the Resident hits herself all the time, especially when she doesn't want to do something.</p> <p>d. Review of Resident #2's activity schedule on January 6, 2009, revealed she was scheduled to set the table on Tuesdays and Thursdays at 5:00 PM. Review of her habilitation record revealed an IPP that required the Resident to set the table for dinner independently on 80% of the trials</p>	1420		

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1420	<p>Continued From page 13</p> <p>recorded per month for six consecutive months.</p> <p>At 7:37 PM, Resident #2 was observed watching the television. The direct care staff attempted to engage the Resident in folding her laundry but, the Resident refused.</p> <p>Resident #2 was observed on January 7, 2009, at 5:06 PM with a Jean tote bag. According to staff interview, the Resident was known to take the bag everywhere she went and it was further revealed that she exhibited hoarding behaviors. Additionally, the staff indicated that if they attempted to move the client's bag, she became upset. After the interview, staff was observed asking the Resident if she would like to paint her nails. The Resident responded "no."</p> <p>Further observation revealed Resident #2 took a stuffed animal and some cotton out of the jean bag and began to fiddle with it. She was observed stuffing it in a knit cap until dinner was served. Staff #2 placed an exercise tape in the VCR and was overheard asking Resident #2 if she would do her exercises or if she wanted to dance? The Resident responded "no."</p> <p>e. Interview with the direct care staff on January 7, 2009, at 4:03 PM revealed Resident #2 was non-compliant with setting the table, washing her clothes and taking them to the dryer. Note: Additional interview with staff on January 7, 2009, revealed that Resident #2 was engaged in programming activities after 8:00 PM on January 5, 2009. Documentation on Resident #2's program data sheets revealed programs including walking and engaging in an exercise tape were completed. Review of the facility's log however, revealed that all individuals including Resident #2 were watching TV at 8:00 PM and in bed by 9:00</p>	1420		

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1420	Continued From page 14 PM. f. Interview with the day program Case Manager (CM) on January 7, 2009, at 9:46 AM revealed Resident #2 had a Behavior Support Plan (BSP). According to the day program 's CM the client's targeted behaviors included physical aggression and non-compliance. Continued interview with the day program CM revealed Resident #2 had exhibited physical aggression and self-injurious behaviors on January 6, 2009. Although Resident #2 exhibited non-compliant behaviors throughout the survey, interview with the QMRP during the entrance conference on January 5, 2009, revealed interventions had not been designed to address the Resident 's non-compliance in the residential facility. At the time of the survey, the facility failed to provide continuous active treatment interventions and services to support Resident #2 with achieving the objectives outlined in her IPP and address her identified needs. (See also Federal Report Citation W196)	1420		
1422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for two of the three clients (Clients #1 and #2) included in the sample.	1422		

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1422	<p>Continued From page 15</p> <p>The finding includes:</p> <p>The facility failed to ensure Resident #1 received continuous active treatment as evidenced below:</p> <p>1. On January 7, 2009, beginning at 11:54 AM, review of Resident #2's medical records revealed that she frequently refused to cooperate with medical professionals.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 7, 2009, at 3:40 PM was conducted to ascertain information regarding Resident #2's non-compliance with her medical appointments. The QMRP was asked if Resident #2 had a desensitization plan to address her non-compliance. The QMRP verified through review of the Resident 's record that she did have a desensitization plan dated April 3, 200. Continued discussion with the QMRP revealed the plan was old, but it was still being implemented. According to the QMRP, the documentation for the plan was discontinued because it was "not working." Review of the desensitization plan revealed a recommendation to use a sedative to calm Resident #2 if the measures outlined in the plan were unsuccessful, and if the Resident refused an examination. Continued review of the plan revealed that if the physician/dentist believed that the examination was not necessary, the Resident could return to her residence. Further review of the Resident #2 's record revealed the following:</p> <ul style="list-style-type: none"> - Resident #2 was uncooperative on a December 1, 2008, ENT appointment; - Resident #2 refused to cooperate with the dentist on October 7, 2008; and, - Resident #2 refused to cooperate for a 	1422	<p>The client had been desensitized in 2007 and the desensitization plan was unsuccessful. The PCP and the IDT had agreed that this client would need pre-sedation for completion of medical appointments. Desensitization is not done continuously. The psychologist has included the need for pre-sedation in his BSP and the nurses follow the Procedure for administering pre-sedation.</p> <p>See attached desensitization record and psychological evaluation.</p>	2/09/09

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1422	<p>Continued From page 16</p> <p>Mammogram on March 28, 2008.</p> <p>At the time of the survey, there was no documented in Resident #2's records that the revealed the facility continually implemented Resident #2's desensitization plan prior to administering sedations.</p> <p>2. The facility failed to implement Resident #1's Behavior Support Plan (BSP) to address her stomping behavior (See W189).</p> <p>3. The facility failed to provide evidence that Resident #2 was provided the required opportunities to participate with her cardiovascular program.</p> <p>(See Federal Deficiency Report Citations W249 and W252).</p>	1422		
1426	<p>3521.5(c) HABILITATION AND TRAINING</p> <p>Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client:</p> <p>(c) is failing to progress toward identified objectives after reasonable efforts have been made;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs) that had not been achieved for one of three clients (Client #1) included in the sample.</p> <p>The finding includes:</p>	1426		

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I 426	Continued From page 17 Review of Client #1's habilitation record on January 6, 2009 at 12:41 PM, revealed the client's Individual Support Plan (ISP) meeting was held on January 18, 2008. Interview with the QMRP and review of the client's corresponding IPP revealed the team recommended a program objective for the current ISP year that included: - Given physical assistance [the client] will participate in a reciprocal turn taking activity with 70% accuracy per session as measured by active treatment documentation. Interview with the QMRP on January 6, 2009, at 4:34 PM and continued review of the data revealed that Client #1 had not been responsive for three consecutive months (October 2008 through December 2008). Further interview with the QMRP was conducted to ascertain what had been done to address the client's lack of participation. Additionally, the QMRP was asked if there was data for any other months. The QMRP provided data for the months of January 2008 through September 2008 which revealed that the client continued to be non-responsive or refusing to participate on all the trials recorded. According to the QMRP, Client #1 was non-compliant and the client's non-compliance had been reported to the speech pathologist. The QMRP revealed that the speech pathologist recommended to continue the program.. It should be noted that there was no documented evidence that speech pathologist made the aforementioned recommendation. At the time of the survey, the QMRP failed to ensure Client #1's communication program had been reviewed and considered for revision.	I 426	I 426 Refer to W 257 This program has been discontinued. A new communication program has been written in the format of using a communication book using symbols and pictures. This program will continue as per the IDT, even though the client does not respond. In the future the QMRP will monitor the staff at least weekly to ensure that all IPPs and activity schedules are followed and she will document the same weekly for at least 1 mth or till staff are absolutely familiar and follow the programs accurately.	2/09/09

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1430	Continued From page 18	1430		
1430	<p>3521.7(a) HABILITATION AND TRAINING</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils);</p> <p>This Statute is not met as evidenced by: Based on observation, the GHMRP failed to provide training for its residents on wiping their mouths when drooling for one of the three residents (Resident #1) included in the sample.</p> <p>The finding includes:</p> <p>The facility failed to ensure Client #1 was taught to wipe her mouth appropriately.</p> <p>Observation of Client #1 on January 5, 2009, at 5:25 PM revealed the client entered the facility with saliva hanging from her mouth. The client was accompanied by a direct care staff that escorted her to the facility's bathroom. At 5:28 PM, the client was observed to return from the bathroom and enter the dining room area with the saliva still hanging from her mouth. It should be noted that the staff was not observed to provide assistance to Client #1 nor did the staff verbally prompt the client to wipe her mouth. Continued observation at 5:30 PM revealed that Client #1 had the physical capability to independently drink from a "sippy cup."</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #1's habilitation record on January 6, 2008, at 12:59 PM revealed the client had a program objective to</p>	1430	<p>1430</p> <p>Refer: (W 196) Client's drooling has been assessed and a formal program has been put in place - all staff were in serviced on this program. In the future the QMRP will monitor the staff at least weekly to ensure that all IPPs and activity schedules are followed and she will document the same weekly for at least 1 mth or till staff are absolutely familiar and follow the programs accurately.</p>	2/09/09

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I 430	Continued From page 19 wipe her mouth after meals with physical assistance on 80% of the trials recorded per month for 12 consecutive months. At the time of the survey, however, the client failed to receive supports to address wiping her mouth when drooling.	I 430	
I 438	3521.7(h) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (h) Interpersonal and social skills (including sharing, courtesy, cooperation, responsibility and age-appropriate and culturally normative social behaviors and relationships involving peers of the same and different sex, younger and older persons and person in authority); This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP failed to ensure training for interpersonal skills including sharing and courtesy and social behaviors for one of the three residents (Resident #2) included in the sample. The findings include: 1. Observation on January 5, 2009, at 7:01 PM, Client #2 had completed her dinner. The client was observed to return to the living room insisting that Client #3 get up out of the chair because she wanted to set in the chair. The staff and the QMRP were observed to verbally prompt Client #3 to move and sit someplace else to allow Client #2 to sit in that chair. At the time of the survey, the GHMRP failed to provide evidence that Resident #2 was provided training in sharing and courtesy.	I 438	I 438 Client #2 and client #1 have had a functional assessment completed and the psychological assessments have been updated to address non compliance. This client has a favorite couch in the living room and all are aware of that. This is include in her Psychological assessment.

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1 438	Continued From page 20 2. The GHMRP failed to train Client #2 to display appropriate behaviors in her home and in the community. [See also Federal Deficiency Report Citation W196]	1 438		
1 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for one of the three clients (Resident #1) included in the sample.</p> <p>The finding includes:</p> <p>The facility failed to ensure that written informed consent was obtained from Resident #1 or legal guardian prior to the implementation of her Behavior Support Plan (BSP).</p> <p>Interview with the QMRP on January 5, 2009, during the entrance conference revealed Resident #1's medication was used in conjunction with a BSP to manage the client's behaviors. Review of the client's habilitation record on January 6, 2009, verified that Resident #1 had a BSP dated May 22, 2008. According to the BSP,</p>	1 500	<p>1 500</p> <p>cross refer W124 W263</p> <p>Metro Homes, Inc. has a Policy and Procedure for Psychotropic medication usage. When psychotropic medication is used the QMRP and the nurse inform the legal guardian or relative of any medication dosage changes and obtain a verbal consent over the phone and only begin administering the medication after HRC and approval from guardian/family has been obtained. The QMRP had received a verbal consent from the family member</p>	2/09/09

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I 500	Continued From page 21 Resident #1 received psychotropic medications for Intermittent Explosive Disorder. Continued interview with the QMRP and record review revealed Resident #1 was not capable of giving informed consent for the use of medications and habilitation services. The QMRP further revealed the Resident did not have a legal guardian to assist her in decision making, but she did have family involvement. At the time of the survey, there was no evidence that the facility's specially constituted committee ensured that written informed consent had been obtained for the use of Resident #1's BSP that incorporated restrictive techniques.	I 500		

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R 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from January 5, 2009 through January 7, 2009. A random sample of three clients was selected from a residential population of three females and two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and a review of records, including unusual incident reports.</p>	R 000		
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Gwain D. Sloan LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE *VP- Operations* (X6) DATE *2/9/09*

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R 000	INITIAL COMMENTS A licensure survey was conducted from January 5, 2009 through January 7, 2009. A random sample of three clients was selected from a residential population of three females and two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and a review of records, including unusual incident reports.	R 000		
R 124	4701.4 BACKGROUND CHECK REQUIREMENT The facility shall obtain a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. This Statute is not met as evidenced by: Based on interview and review of the records the GHMRP failed to ensure all direct care staff had obtained a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. The finding includes: Review of the GHMRP's personnel files on January 5, 2009, revealed the GHMRP failed to provide evidence that police clearances were on file for two direct care staff.	R 124		

Health Regulation Administration

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

TITLE

(X6) DATE

STATE FORM

OK0711

If continuation sheet 1 of 1

Gwanti. Sloan VP-Operations 2/9/09