

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

PRINTED: 06/03/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	INITIAL COMMENTS  A recertification survey was conducted from May 17, 2011 through May 19, 2011. A sample of three clients was selected from a population of four females and two males with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process.  The findings of the survey were based on observations and interviews with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.	W 000	<i>Received 6/10/11</i> Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs, for one of the three clients included in the sample. (Client #1)  The finding includes:  The day program failed to ensure that Client #1 received food in a form consistent with his prescribed dietary needs, as evidenced below:  On May 17, 2011, at 12:36 p.m., observations conducted at the day program revealed, Client #1 was served pureed spinach, potatoes, and ground ham for lunch. The client consumed his meal slowly and without difficulty. At	W 120	W 120  The day program staff were in serviced on the diet and mealtime protocol. In the future the QDDP and RN will ensure that the monthly day program visits will include a mealtime observation for this individual. See attached – in service record	5/13/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Grant Gorn* TITLE: *J. Operations* (X6) DATE: *6/9/11*

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

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W 120	<p>Continued From page 1</p> <p>approximately 12:49 p.m., interview with the day program staff who served the meal indicated that Client #1's was prescribed a double portion pureed diet. Further interview with the day program's staff revealed that Client #1's ham was prepared as a ground texture. At 12:51 p.m., interview with the day program's director who observed the meal confirmed that Client #1's ham was not pureed.</p> <p>Interview with the facility's licensed practical nurse (LPN) coordinator on May 19, 2011, at 12:31 p.m., revealed that Client #1 meals should be pureed at each meal. Further interview revealed that Client #1 was at high risk for aspiration.</p> <p>On May 18, 2011, at 1:25 p.m., review of Client #1's current physician's orders dated May 2011 revealed that the client was prescribed a double portion pureed diet. Review of Client #1's mealtime protocol dated September 3, 2010, on the same day at 2:26 p.m., revealed a special note. "Process the food in the processor until pureed texture is achieved. Pureed texture should be smooth and lump free and not too runny."</p>	W 120		
W 159	<p><b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the</p>	W 159		

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W 159	Continued From page 2 qualified intellectual disabilities professional (QIDP) coordinated and monitored services, for two of the three clients in the sample. (Clients #1 and #2)  The finding includes:  1. Cross refer to W120. The facility's QIDP failed to ensure that outside services met the need of Client #1.  2. Cross refer to W460. The facility's QIDP failed to ensure Client #1 received his meals in accordance with their nutritional recommendations.	W 159	W 159 1.&2. The day program staff were in serviced on the diet and mealtime protocol. In the future the QDDP and RN will ensure that the monthly day program visits will include a mealtime observation for this individual. See attached – in service record	5/13/11
W 426	483.470(d)(3) CLIENT BATHROOMS  The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the temperature of the water did not exceed 110 degrees Fahrenheit for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)  The finding includes:  On May 19, 2011, at 3:39 p.m., Bathroom #1 (main hallway) and Bathroom #2 (located in Clients #1 and #6 bedroom) water temperature felt hot to touch during the environmental inspection. Readings from the surveyor's digital	W 426	W 426 The water temperatures are checked on every shift – at least 3x/day. In the future the QDDP will monitor the water temperature log at least once a day to ensure that the water temperature is below 110 degrees F. All staff were in serviced to report water temperatures above 110 degrees F. See attached in service record and temperature log.	5/13/11

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W 426	Continued From page 3 thermometer in both bathrooms was 117 degrees Fahrenheit. These temperatures were also observed by the qualified intellectual disabilities professional (QIDP) and house manager (HM). The QIDP instructed the HM to call and inform maintenance staff of the temperature readings. At approximately 4:09 p.m. on the same day, the hot water temperature was lowered to 104 degrees Fahrenheit by the facility's maintenance staff.	W 426		
W 440	483.470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)  The finding includes:  The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:  On May 18, 2011, at 11:23 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three designated shifts (8:00 AM - 4:00 PM; 4:00 PM -12:00 AM and 12:00 AM - 8:00 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (8:00 AM - 8:00 PM and 8:00 PM - 8:00 AM) for the weekend (Saturday/Sunday).	W 440	W 440 The RC, QDDP and staff were in serviced on Fire safety/ Drill and Evacuation procedures. In the future the RC will ensure that all fire drills are completed as scheduled and that proper procedures for egress use and timing are followed as per policy and procedures.  See attached in service record	5/13/11

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<p>W 440 Continued From page 4</p> <p>Review of the facility's fire drill log records on May 18, 2011, beginning at 11:27 a.m., revealed that no drills were held during the weekday morning shift from September 2010 through November 2010. In addition, there were no fire drills held during the weekend evening shifts from September 2010 through November 2010. This was acknowledged by the facility's QIDP and the house manager on May 18, 2011, at 12:05 p.m.</p> <p>W 441 483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills under varied conditions.</p> <p>This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)</p> <p>The finding includes:</p> <p>On May 18, 2011, beginning at 11:27 a.m., review of the facility's fire drill records revealed that most of the fire drills were conducted utilizing the front and side door exits. Interview with the qualified intellectual disabilities (QIDP) on May 18, 2011, at 11:23 a.m., revealed that the facility had at least three methods of egress (front door, side door, and the basement door). Further review of the fire drill records revealed that the basement door exit had not been used since May 2010. This was acknowledged through additional interview with the QIDP on the same day at approximately 12:05 p.m. There was no evidence on file at the time of survey to substantiate that all exits were</p>	<p>W 440</p> <p>W 441</p> <p>W 441</p> <p>The RC, QDDP and staff were in serviced 5/13/11 on Fire safety/ Drill and Evacuation procedures. In the future the RC will ensure that all fire drills are completed as scheduled and that proper procedures for egress use and timing are followed as per policy and procedures.</p> <p>See attached in service record</p>	<p>(X5) COMPLETION DATE</p>	

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W 441	Continued From page 5 used.	W 441			
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES  Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients received their prescribed modified diets as ordered by the physician, for one of three sampled clients. (Client #2)  The finding includes:  The facility failed to ensure that Client #2 received a well-balanced diet as prescribed by her primary care physician (PCP) to ensure their nutritional needs, as evidenced below:  a. On May 17, 2011, at 1:32 p.m., observations conducted at the day program revealed Client #2 appeared to be slightly overweight. Evening observations conducted later that evening at 6:17 p.m., revealed Client #2 was served Salisbury steak, mashed potatoes, broccoli, margarine, peaches, one biscuit, and 2% milk during dinner. At 6:38 p.m., Client #2 served herself additional servings of Salisbury steak and mash potatoes. On May 18, 2011, at approximately 6:20 p.m., direct care staff was observed to prepare Client #2's dinner which consisted of chicken, noodles, and string beans. Direct care staff placed approximately a cup and a half noodles onto Client #2's plate.	W 460	W 460  a.&b. All staff were in serviced on the diet and the measurements for a restricted calorie diet.  In the future the QDDP, RC and Nurse will ensure that mealtime observations are conducted at least twice a week to ensure staff are following dietary restrictions and procedures.  See attached in service record	5/13/11	

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W 460	<p>Continued From page 6</p> <p>Interview with the house manager (HM) on May 17, 2011, at approximately 6:50 p.m., acknowledged that Client #2 served herself additional Salisbury steak and mash potatoes. Interview with the qualified intellectual disabilities professional (QIDP), on May 18, 2011, at approximately 6:25 p.m., also acknowledged that Client #2 received approximately a cup and a half of noodles during dinner.</p> <p>Review of the current Physician's Orders (PO's) dated May 2011 on May 18, 2011, at approximately 12:26 p.m., revealed Client #2 had a diagnosis of Obesity and was prescribed a 1200 calorie, low fat, low sodium, low cholesterol, high fiber diet. Further review of the PO's indicated that the client should have a salad with her lunch and dinner. On May 19, 2011, at 10:10 a.m., review of the dinner menu for May 18, 2011, revealed that clients prescribed a 1200 calorie diets were to receive 3/4 cup of chicken, 1/2 cup of noodles, and no wheat bread.</p> <p>b. Observations of the dinner meals conducted on May 17, 2011 and May 18, 2011, revealed Client #2 was not given salad with her meal. This was acknowledged by both the HM on May 17, 2011, at approximately 6:50 p.m., and the QIDP on May 18, 2011, at approximately 6:25 p.m. Review of the current Physician's Orders (PO's) dated May 2011 on May 18, 2011, at approximately 12:26 p.m., revealed Client #2 had a diagnosis of Obesity and was prescribed a 1200 calorie, low fat, low sodium, low cholesterol, high fiber diet. Further review of the PO's revealed that Client #2 was to receive salads with her lunch and dinner.</p>	W 460		

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W 460	Continued From page 7  Note: It should be noted that Client #2's desirable body weight (DBW) is 103 lbs - 118 lbs. Client #2's current weight is 150 lbs.  W 474 483.480(b)(2)(iii) MEAL SERVICES  Food must be served in a form consistent with the developmental level of the client.  This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to serve each food in a form consistent with the prescribed texture, for one of the three sampled clients. (Client #1)  The finding includes:  Cross refer to W120. The day program failed to ensure that Client #1 received food in a form consistent with his prescribed dietary needs.	W 460    W 474	W 474  The day program staff were in serviced on the diet and mealtime protocol. In the future the QDDP and RN will ensure that the monthly day program visits will include a mealtime observation for this individual. See attached – in service record	5/13/11

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2011</b>
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R 000	INITIAL COMMENTS  A licensure survey was conducted from May 17, 2011 through May 19, 2011. A sample of three residents was selected from a population of four females and two males with varying degrees of intellectual disabilities.  The findings of the survey were based on observations, interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	R 000	
R 125	4701.5 BACKGROUND CHECK REQUIREMENT  The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.  This Statute is not met as evidenced by: Based on the interview and record review, the group for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check, for one of fifteen staff employed. (Staff #13)  The finding includes:  Interview with the qualified intellectual disabilities professional (QIDP) and review of the personnel files on May 19, 2011, beginning at 1:54 p.m., revealed the GHPID failed to provide evidence of criminal background checks that disclosed a seven year listing of all jurisdictions where one	R 125	5/13/11  R 125 See attached – criminal background check In the future the HR Dept. will ensure that all employees have a National Criminal Background check completed prior to employment.

Health Regulation & Licensing Administration

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

STATE FORM

6899

PQ0C11

TITLE

(X6) DATE

If continuation sheet 1 of 2

*Grant J. Sloan*

*VP Operations*

*6/9/11*

Health Regulation & Licensing Administration

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R 125	<p>Continued From page 1</p> <p>staff worked and/or resided at the time of the survey. For example:</p> <ul style="list-style-type: none"> <li>- There was no background conducted for Staff #13 who worked in Virginia.</li> </ul> <p>At approximately 2:30 p.m., on May 19, 2011, the surveyor reviewed the aforementioned finding listed above with the QIDP. The QIDP acknowledged that criminal background checks were not conducted in all jurisdictions where staff lived and/or worked within the past seven years.</p>	R 125		

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I 000	INITIAL COMMENTS  A licensure survey was conducted from May 17, 2011 through May 19, 2011. A sample of three residents was selected from a population of four females and two males with various cognitive and intellectual disabilities.  The findings of the survey were based on observations and interviews with residents and staff in the home and at two day programs, as well as a review of resident and administrative records, including incident/investigation reports.	I 000		
I 042	3502.2(b) MEAL SERVICE / DINING AREAS  Modified diets shall be as follows:  (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and...  This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure the therapeutic diet was provided as prescribed to meet the nutritional needs, for two of three residents in the sample. (Residents #1 and #2)  The finding includes:  1. The day program failed to ensure that Resident #1 received food in a form consistent with his prescribed dietary needs, as evidenced below:  On May 17, 2011, at 12:36 p.m., observations conducted at the day program revealed, Resident #1 was served pureed spinach, potatoes, and ground ham for lunch. The resident consumed	I 042	I 042 1&2. The day program staff were in serviced on the diet and mealtime protocol. In the future the QDDP and RN will ensure that the monthly day program visits will include a mealtime observation for this individual. See attached – in service record	5/13/11

Health Regulation & Licensing Administration

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

STATE FORM

6899

PQOC11

TITLE

(X8) DATE

If continuation sheet 1 of 7

*Sharon J. Spear* VP Operations 6/9/11

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1042	<p>Continued From page 1</p> <p>his meal slowly and without difficulty. At approximately 12:49 p.m, interview with the day program staff who served the meal indicated that Resident #1's was prescribed a double portion pureed diet. Further interview with the day program's staff revealed that Resident #1's ham was prepared as a ground texture. At 12:51 p.m., interview with the day program's director who observed the meal confirmed that Resident #1's ham was not pureed.</p> <p>Interview with the GHPID's licensed practical nurse (LPN) coordinator on May 19, 2011, at 12:31 p.m., revealed that Resident #1 meal should be pureed at each meal. Further interview revealed that Resident #1 was at high risk for aspiration.</p> <p>On May 18, 2011, at 1:25 p.m., review of Resident #1's current physician's orders dated May 2011 revealed that the resident was prescribed a double portion pureed diet. Review of Resident #1's mealtime protocol dated September 3, 2010, on the same day at 2:26 p.m., revealed a special note. "Process the food in the processor until pureed texture is achieved. Pureed texture should be smooth and lump free and not too runny."</p> <p>2. The GHPID failed to ensure that Resident #2 received a well-balanced diet as prescribed by her primary care physician (PCP) to ensure their nutritional needs, as evidenced below:</p> <p>a. On May 17, 2011, at 1:32 p.m., observations conducted at the day program revealed Resident #2 appeared to be slightly overweight. Evening observations conducted later that evening at 6:17 p.m., revealed Resident #2 was served Salisbury</p>	1042	

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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>	
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I 042	<p>Continued From page 2</p> <p>steak, mashed potatoes, broccoli, margarine, peaches, one biscuit, and 2% milk during dinner. At 6:38 p.m., Resident #2 served herself additional servings of Salisbury steak and mash potatoes. On May 18, 2011, at approximately 6:20 p.m., direct care staff was observed to prepare Resident #2's dinner which consisted of chicken, noodles, and string beans. Direct care staff placed approximately a cup and a half noodles onto Resident #2's plate.</p> <p>Interview with the house manager (HM) on May 17, 2011, at approximately 6:50 p.m., acknowledged that Resident #2 served herself additional Salisbury steak and mash potatoes. Interview with the qualified intellectual disabilities professional (QIDP), on May 18, 2011, at approximately 6:25 p.m., also acknowledged that Resident #2 received approximately a cup and a half of noodles during dinner.</p> <p>Review of the current Physician's Orders (PO's) dated May 2011 on May 18, 2011, at approximately 12:26 p.m., revealed Resident #2 had a diagnosis of Obesity and was prescribed a 1200 calorie, low fat, low sodium, low cholesterol, high fiber diet. Further review of the PO's revealed that the client was to have salad during lunch and dinner. On May 19, 2011, at 10:10 a.m., review of the dinner menu for May 18, 2011, revealed that residents prescribed a 1200 calorie diets were to receive 3/4 cup of chicken, 1/2 cup of noodles, and no wheat bread.</p> <p>b. Observations of the dinner meals conducted on May 17, 2011 and May 18, 2011, revealed Resident #2 was not given salads with her meal. This was acknowledged by both the HM on May 17, 2011, at approximately 6:50 p.m., and the QIDP on May 18, 2011, at approximately 6:25</p>	I 042	

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I 042	Continued From page 3  p.m. Review of the current Physician's Orders (PO's) dated May 2011 on May 18, 2011, at approximately 12:26 p.m., revealed Resident #2 had a diagnosis of Obesity and was prescribed a 1200 calorie, low fat, low sodium, low cholesterol, high fiber diet. Further review of the PO's revealed that Resident #2 was to receive salads with her lunch and dinner.  Note: It should be noted that Resident #2's desirable body weight (DBW) is 103 lbs - 118 lbs. Resident #2's current weight is 150 lbs.	I 042	
I 095	3504.6 HOUSEKEEPING  Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.  This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to store poisons and caustic agents in a locked cabinet and/or out of direct reach of each resident, for six of six residents residing in the GHPID.  The finding includes:  During the environmental walk-thru on May 19, 2011, beginning at 3:22 p.m., caustic agents (i.e. Lysol and a moping agent) were observed being stored openly underneath the residents' bathroom located in the main hallway. Client #3 was observed to use the bathroom prior to the environmental walk-thru. This was confirmed with interview with the house manager on the same day at approximately 3:30 p.m.	I 095	I 095 All staff were in serviced on OSHA and individual safety and protection. In the future the QDDP and RC, RN will ensure that all chemical agents are stored safely in a locked cabinet. The monthly environmental audits will be completed by the QDDP and RC.  See attached in service record

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I 135	<p><b>3505.5 FIRE SAFETY</b></p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group for persons with intellectual disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6)</p> <p>The finding includes:</p> <p>The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On May 18, 2011, at 11:23 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three designated shifts (8:00 AM - 4:00 PM; 4:00 PM -12:00 AM and 12:00 AM - 8:00 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (8:00 AM - 8:00 PM and 8:00 PM - 8:00 AM) for the weekend (Saturday/Sunday).</p> <p>Review of the facility's fire drill log records on May 18, 2011, beginning at 11:27 a.m., revealed that no drills were held during the weekday morning shift from September 2010 through November 2010. In addition, there were no fire drills held during the weekend evening shifts from September 2010 through November 2010. This was acknowledged by the facility's QIDP and the house manager on May 18, 2011, at 12:05 p.m.</p>	I 135	<p>I 135</p> <p>The RC, QDDP and staff were in serviced on Fire safety/ Drill and Evacuation procedures. 5/13/11</p> <p>In the future the RC will ensure that all fire drills are completed as scheduled and that proper procedures for egress use and timing are followed as per policy and procedures.</p> <p>See attached in service record</p>

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<p>I 379 Continued From page 5</p> <p>I 379 3519.10 EMERGENCIES</p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that all incidents that present a risk to resident's health and well-being were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HLRA), for one of three residents of the GHPID. (Resident #1)</p> <p>The finding includes:</p> <p>On May 17, 2011, beginning at 10:21 a.m., review of incident/investigation reports revealed that on April 14, 2011, Client #1 was transported to the emergency room for treatment of a laceration to the scalp. According the incident/investigation, Client #1 also required sutures. Interview with the qualified intellectual disabilities professional (QIDP) on May 18, 2011, 2:45 p.m., revealed that the GHPID incident management coordinator (IMC) notified the department of health (DOH) of Client #1's injury to his head. Further interview with the QIDP revealed that the IMC faxed incident to DOH, however did not keep a copy of</p>	<p>I 379</p> <p>I 379</p>	<p>I 379</p> <p>In the future the IMC will ensure that all faxes sent to DOH will be attached to a fax receipt before being filed with the individual's incident report and investigation. See attached in service record – IMC and QDDP</p>	<p>(X5) COMPLETE DATE</p> <p>5/13/11</p>

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I 379	Continued From page 6  the facsimile. At the time of the survey, the GHPID failed to provide evidence that the aforementioned incident was reported to DOH as required.	I 379		