

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

PRINTED: 09/2 /2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G179</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5701 13TH STREET, NW WASHINGTON, DC 20011</b>
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(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 September 8, 2011 through September 9, 2011. A sampling of three clients was selected from a population of six females with various cognitive and intellectual disabilities. A focused review was conducted of Client #4, due to a concern identified during meal observations. This survey was conducted utilizing the fundamental survey process.  The findings of the survey were based on observations and interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident and investigation reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the six clients in the facility. (Client #2)  The finding includes:  On September 8, 2011, at 5:30 p.m., Client #2 was observed standing in her bedroom in front of her door. At the same time, the licensed practical nurse (LPN) asked the client to raise her shirt. As	W 130	W130 In the future the QIDP will ensure that all staff respect the individuals' privacy. The RN/QIDP will make sure staff are observed periodically esp. during medication administration. All staff were in serviced on Individual's rights and Privacy rights See attached - in service record on <u>Individual rights and Privacy</u>	9/30/11

*Received 10/12/11*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Guan J. Shan</i>	TITLE <i>VP Operations</i>	(X5) DATE <i>9/30/11</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 130	Continued From page 1 the client raised her shirt, her stomach and the lower part of her bra were exposed. The LPN then injected insulin into her stomach. During this time, several clients and staff were observed in the hall and in the room across from the client's bedroom, which were in clear view of the medication administration.  Interview with the LPN at approximately 7:30 p.m., revealed that Client #2 should have received her insulin in a private area, or with the bedroom door closed.	W 130		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN  The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the individual program plan (IPP) stated a specific objective to meet client needs identified by the comprehensive assessment, for one of three clients in the sample. (Client #1)  The finding includes:  The facility failed to implement a training objective recommended to increase Client #1's independence in personal hygiene. (closing and wiping mouth).	W 227	W227 The QIDP and the IDT recommended that the IPP for personal hygiene be reinstated. All staff were in serviced on the new IPP with the new objective. The QIDP will ensure that the program is implemented and the individual's hygienic care and comfort are met. See attached – in service record on new IPP for drooling and personal hygiene and new WTP	9/31/11

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W 227	<p>Continued From page 2</p> <p>On September 8, 2011, beginning at 3:54 p.m., Client #1 was observed drooling with her mouth opened as she walked around. During the medication administration at 5:54 p.m., the Licensed Practical Nurse asked the direct support staff to give Client #1 a paper towel to wipe her mouth. Further observation revealed the client continued to drool, however, the direct support staff did not prompt the client to wipe her mouth.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on September 9, 2011, at 11:11 a.m., revealed that Client #1 had an informal program to wipe her mouth.</p> <p>Review of the Speech and Language Assessment dated August 21, 2010 on September 9, 2011, revealed to "provide verbal prompts by program staff to maintain a dry mouth through request to close her mouth and swallow, as well as wipe her mouth."</p> <p>At the time of the survey, however, there was no evidence that the IPP included a specific objective to address the aforementioned training need.</p>	W 227		
W 242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p>	W 242		

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W 242	Continued From page 3  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to train each client in personal skills essential for independence, for one of the three clients in the sample. (Client #1)  The finding includes:  [Cross refer to W227]. The facility failed to ensure Client #1 was provided training to increase her independence in personal hygiene (closing and wiping mouth).	W 242	W242 Cross refer W227	9/3/11
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, interview, and record review, 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 September 9, 2011, at 3:37 p.m., the surveyor noted that the hot water temperature felt very warm to touch in bathrooms #1 and #2. The surveyor and the facility coordinator (FC) then measured the hot water temperatures, and determined that they read 120 degrees	W 426	W426 The water temperature thermostat was adjusted and the water temperature was checked hourly for 24hrs. The water temperature is stabilized to be between 100-110 degrees currently. All staff have been in serviced on accurate procedure to be followed in taking water temperature and in individuals safety and protection. See attached in service record - Safety of individuals, hourly temperature log	9/3/11

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W 426	<p>Continued From page 4</p> <p>Fahrenheit in bathroom #1, and 118 degrees Fahrenheit in bathroom #2. The surveyor notified the qualified intellectual disabilities professional (QIDP), who immediately contacted the maintenance staff. At 4:10 p.m., a maintenance staff arrived at the facility to check the water temperature.</p> <p>On September 9, 2011, at 4:15 p.m., interview with the maintenance staff confirmed that the hot water temperature exceeded 110 degrees Fahrenheit in the clients' bathrooms. According to the maintenance staff, he adjusted the temperature setting on the hot water heater and the temperature should soon decrease to 110 degrees Fahrenheit. Further discussion with the maintenance staff revealed that he would monitor the hot water temperature during the evening to ensure that it did not exceed 110 Fahrenheit.</p> <p>On September 9, 2011, at 5:10 p.m., the surveyor and the FC observed that the hot water temperatures read 119 degrees Fahrenheit (bathroom #1) and 117 degrees Fahrenheit (bathroom #2).</p> <p>On September 9, 2011, at 5:15 p.m., interview with the FC revealed that the policy was to monitor hot water temperature during each shift. Further discussion with the FC indicated that staff would be requested to monitor the hot water temperature hourly until the temperature decreased to 110 degrees Fahrenheit. The maintenance staff and the QIDP confirmed that if the water temperature exceeded 110 degrees, maintenance should always be immediately notified.</p>	W 426		
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W 426	Continued From page 5 At the time of the survey, however, there was no evidence that the facility ensured that the temperature of the water did not exceed 110 degrees Fahrenheit.	W 426		
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 observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency prescribed for one of six clients residing in the facility. (Client #4)  The finding includes:  Observation on the evening of September 8, 2011, at 7:07 p.m., revealed Client #4's one-on-one staff monitoring and assisting her as she ate her meal. The staff finely chopped canned sliced peaches, then assisted the client to eat them.  On September 8, 2011, at 7:18 p.m., interview with the staff monitoring Client #4 revealed that she was prescribed a pureed texture diet. Staff, however, indicated that the canned peaches were very soft and she was able to smash them finely. Interview with the residential director on September 9, 2011 at 3:12 p.m. revealed the client was edentulous and should receive pureed foods.  Review of Client #4's mealtime protocol dated May 11, 2011, on September 9, 2011 at 10:37	W 474	W474 All staff have been in serviced on the mealtime protocol and individuals' dietary needs. In the future the QIDP, RN and RC will ensure that there is weekly staff observation and documentation of mealtimes. See attached in service record for mealtime protocol	9/30/11

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W 474	Continued From page 6 a.m., revealed the client's food was to be pureed in a blender and that the food should be pudding-like, smooth, and lump free. On September 9, 2011, at 10:47 a.m., review of the physician's orders for September 2011, revealed the client was prescribed an 1800 kcal diabetic, high fiber (pureed texture diet). At the time of the survey, there was no evidence the facility ensured that Client #4 received her food in a pureed texture at all times, as prescribed.	W 474		
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Health Regulation & Licensing Administration

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1000	<p><b>INITIAL COMMENTS</b></p> <p>A relicensure survey was conducted from September 8, 2011 through September 9, 2011. A sampling of three clients was selected from a population of six females with cognitive and intellectual disabilities. A focused review was conducted of Client #4, due to a concern identified during meal observations.</p> <p>The findings of the survey were based on observations and interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident and investigation reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1000		
1056	<p><b>3502.14 MEAL SERVICE / DINING AREAS</b></p> <p>Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure effective training on sanitary food handling and storage practices to meet the needs of six of six residents in the facility. (Residents #1, #2, #3, #4 #5 and #6)</p> <p>The finding includes:</p> <p>On September 8, 2011, at 3:09 p.m., two packages of steaks and three bags of collard greens were observed on the kitchen counter thawing.</p>	1056	<p><b>1056</b></p> <p>All staff were in serviced on Safe Food handling practices and preparation. The QIDP will ensure that food preparation is only handled by staff who have a food handler certification.</p> <p>See attached in service record on – food handling and preparation</p>	<p>9/30/11</p>

Health Regulation & Licensing Administration  
*Guan J. Swan*  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
 STATE FORM 6889

*VP* TITLE  
*Operations*  
 (X6) DATE  
**9/30/11**  
 If continuation sheet 1 of 8

Health Regulation & Licensing Administration

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1056 Continued From page 1

On September 9, 2011, at approximately 3:00 p.m., the direct support staff revealed she had placed the steaks and greens on the kitchen counter at approximately 1:00 p.m. to begin thawing for the dinner meal. Further discussion with the support staff revealed that the collard greens observed on the counter at approximately 1:00 p.m. were cooked for the dinner meal, which was served at 6:35 p.m.

Record review on September 9, 2011, at approximately 12:30 p.m., revealed that the aforementioned direct support staff did not have a food handler's certificate. Interview with the QIDP, however, revealed that the staff was to be supervised by staff in the home who were certified food handlers. At the time of the survey, there was no evidence that the GHPID ensured that each staff was trained to implement safe food handling practices at all times.

1056

1090 3504.1 HOUSEKEEPING

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by:  
Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure the interior of the facility was maintained in a safe and sanitary manner to meet the needs of six of six residents in the facility (Residents #1, #2, #3, #4, #5, and #6)

The findings include:

1090

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1090	<p>Continued From page 2</p> <p>A. On September 9, 2011, beginning at 3:18 p.m., the facility coordinator (FC) and the qualified intellectual disabilities professional (QIDP) accompanied the surveyor during observations of the environment. The following concerns were identified:</p> <p>1. Several tiles on the basement floor (behind the refrigerator and on the right side of the entrance door to the laundry room) were no longer attached.</p> <p>2. Spaces were observed at the floor to wall junction in the laundry/utility room. Interview with the QIDP revealed the coving had been removed, causing the spaces to be visible.</p> <p>3. A tile covered area of the floor in bathroom #1 (near the doorway), was noted to go downward when stepped upon. Further observation revealed several pieces of the hardwood flooring in the hallway (adjacent to the bathroom door), were chipped around the edges. The QIDP indicated that the flooring chipped due to water leaking in bathroom #1. Further discussion with the QIDP revealed the leak in the bathroom #1 had been repaired.</p> <p>4. Uncaulked space was observed where the countertop joined the molding along the wall, on the left side of the range.</p> <p>5. The kitchen drawers were covered with vinyl, adhesive-backed shelf paper. The corners of the shelf paper were unsecured, causing it to be difficult to thoroughly clean the drawers.</p> <p>6. Protective plastic seat covers placed on top of the upholstered living room couches, were torn.</p>	1090	<p>1090A.</p> <ol style="list-style-type: none"> <li>1. Tiles were replaced</li> <li>2. All spaces have been concealed</li> <li>3. The tile has been replaced correctly and the wood flooring has been replaced</li> <li>4. The molding was redone and there are no open spaces</li> <li>5. The kitchen drawers have new vinyl covering</li> <li>6. Plastic upholstery cover has been replaced</li> <li>7. The door knob has been tightened</li> <li>8. The molding has been replaced</li> <li>9. The strip underneath the door has been fixed</li> <li>10. The linoleum has been fixed</li> <li>11. The shower chair has been fixed</li> </ol> <p>1090B The water temperature thermostat was adjusted and the water temperature was checked hourly for 24hrs. The water temperature is stabilized to be between 100-110 degrees currently. All staff have been in serviced on accurate procedure to be followed in taking water temperature and in individuals safety and protection. In the future the QIDP and the Maintenance Manager will ensure that a monthly environmental QA is completed accurately. See attached in service record – Safety of individuals, hourly temperature log</p>	9/10/11
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1090	<p>Continued From page 3</p> <p>7. The door knob was loose on the front entrance door. This created a potential for pinching of the hand when opening and closing the door.</p> <p>8. The molding was broken underneath the door exiting to the exterior of the facility, from the bedroom of Residents #1 and #3.</p> <p>9. The strip underneath the door was partially detached from the door exiting to the exterior of the facility, from the bedroom of Residents #2 and #5.</p> <p>10. Near the exit door from the bedroom of Residents #2 and #5, the edge of the linoleum was observed to be rolled upward where it met the hardwood flooring.</p> <p>11. The screw was missing from the back of the shower chair on the left side, causing the back to be slightly loose.</p> <p>During the environmental observations, the FC and the QIDP acknowledged aforementioned findings.</p> <p>B. The facility failed to ensure that the temperature of the water did not exceed 110 degrees Fahrenheit for six of six residents residing in the facility. (Residents #1, #2, #3, #4, 5, and #6)</p> <p>On September 9, 2011, at 3:37 p.m., the surveyor noted that the hot water temperature felt very warm to touch in bathrooms #1 and #2. The surveyor and the facility coordinator (FC) then measured the hot water temperatures, and determined that they read 120 degrees Fahrenheit in bathroom #1, and 118 degrees</p>	1090		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/09/2011
NAME OF PROVIDER OR SUPPLIER  METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(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
1090	<p>Continued From page 4</p> <p>Fahrenheit in bathroom #2. The surveyor notified the qualified intellectual disabilities professional (QIDP), who immediately contacted the maintenance staff. At 4:10 p.m., a maintenance staff arrived at the facility to check the water temperature.</p> <p>On September 9, 2011, at 4:15 p.m., interview with the maintenance staff confirmed that the hot water temperature exceeded 110 degrees Fahrenheit in the residents' bathrooms. According to the maintenance staff, he adjusted the temperature setting on the hot water heater and the temperature should soon decrease to 110 degrees Fahrenheit. Further discussion with the maintenance staff revealed that he would monitor the hot water temperature during the evening to ensure that it did not exceed 110 Fahrenheit.</p> <p>On September 9, 2011, at 5:10 p.m., the surveyor and the FC observed that the hot water temperatures read 119 degrees Fahrenheit (bathroom #1) and 117 degrees Fahrenheit (bathroom #2).</p> <p>On September 9, 2011, at 5:15 p.m., interview with the FC revealed that the policy was to monitor hot water temperature during each shift. Further discussion with the FC indicated that staff would be requested to monitor the hot water temperature hourly until the temperature decreased to 110 degrees Fahrenheit. The maintenance staff and the QIDP confirmed that if the water temperature exceeded 110 degrees, maintenance should always be immediately notified.</p> <p>At the time of the survey, however, there was no evidence that the GHPID ensured that the</p>	1090		

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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5701 13TH STREET, NW WASHINGTON, DC 20011</b>		
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I 090	Continued From page 5  temperature of the water did not exceed 110 degrees Fahrenheit.	I 090		
I 206	<b>3509.6 PERSONNEL POLICIES</b>  Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that one of the twelve direct care staff (Staff#1) and one of the thirteen consultants (pharmacist) had current health certificates.  The findings include:  On September 9, 2011, beginning at 1:30 p.m., review of the personnel records revealed the GHPID failed to provide evidence of current health certificate for Staff #1 and the consultant pharmacist.  Interview with the facility's qualified intellectual disabilities professional (QIDP) on September 9, 2011, at 1:42 p.m., confirmed that the aforementioned direct care staff and the pharmacist did not have current health certificates in their personnel files.	I 206	<b>I206</b> See attached health certificates for staff#1 and the consultant pharmacist is no longer contracted with Metro Homes, Inc. The HR Dept. has developed an audit system and is currently in the process of developing a 'tickler or reminder system' which will notify HR of expirations and renewals of certifications and licenses.	9/10/11

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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5701 13TH STREET, NW WASHINGTON, DC 20011</b>
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I 420	Continued From page 6	I 420		
I 420	<p><b>3521.1 HABILITATION AND TRAINING</b></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 of physical, mental and social functioning.</p> <p>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 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 of physical, mental and social functioning, for one of three residents in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>The group home for persons with intellectual disabilities failed to implement a training objective recommended to increase Resident #1's independence in personal hygiene. (closing and wiping mouth).</p> <p>On September 8, 2011, beginning at 3:54 p.m., Resident #1 was observed drooling with her mouth opened as she walked around. During the medication administration at 5:54 p.m., the licensed practical nurse asked the direct support staff to give Resident #1 a paper towel to wipe her mouth. Further observation revealed the resident continued to drool, however, the direct support staff did not prompt the resident to wipe her mouth.</p>	I 420	<p><b>I420</b></p> <p>The QIDP and the IDT recommended that the IPP for personal hygiene be reinstated. All staff were in serviced on the new IPP with the new objective. The QIDP will ensure that the program is implemented and the individual's hygienic care and comfort are met.</p> <p>See attached – in service record on new IPP for drooling and personal hygiene and new WTP</p>	9/31/11

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NAME OF PROVIDER OR SUPPLIER  METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
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I 420	Continued From page 7  Interview with the qualified intellectual disabilities professional (QIDP) on September 9, 2011, at 11:11 a.m., revealed that Resident #1 had an informal program to wipe her mouth.  Review of the Speech and Language Assessment dated August 21, 2010 on September 9, 2011, revealed to "Provide verbal prompts by program staff to maintain a dry mouth through request to close her mouth and swallow, as well as wipe her mouth."  At the time of the survey, however, there was no evidence that the individual program plan included a specific objective to address the aforementioned training need.	I 420			