

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

PRINTED: 03/17/2010
FORM APPROVED
OMB NO. 0938-0391

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 02/25/2010
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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 February 23, 2010 through February 25, 2010. The survey was initiated using the fundamental survey process. A sample of three clients was selected from a resident population of two men and three women with various degrees of cognitive and intellectual disabilities. In addition, the mealtime adaptive equipment that was prescribed for one additional client (#4) was reviewed.</p>	W 000		
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The findings of the survey were based on observations, 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 reports.</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services met the needs of one of the three sampled clients. [Client #3]</p> <p>The finding includes:</p>	W 120	<p>W 120</p> <p>The QMRP has requested the PT to complete the in service for the gait belt, at the day program. In the future the QMRP will ensure that during the monthly day program visits she will monitor and document the use of all adaptive equipment used by the individual.</p> <p>The QMRP will make sure that all individuals residing at this facility will be visited at their day programs, on a monthly basis. The QMRP will also ensure that a monthly monitoring of the use of adaptive equipment is documented on the Day Program Observation Record.</p>	3/26/10
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Cross-refer to W159. The facility failed to ensure that staff at Client #3's day program used his gait belt while ambulating, as prescribed.</p> <p>Each client's active treatment program must be</p>	W 159	<p>See attached - in service record - day program</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Susan J. Sloan* TITLE: *VP - Operations* (X8) DATE: *3/26/10*

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 159	<p>Continued From page 1</p> <p>integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: . Based on observation, client and staff interview, and record review, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated and monitored services, for two of the three clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. The facility's QMRP failed to ensure the coordination of services to ensure that staff at Client #3's day program used his gait belt while ambulating, as follows:</p> <p>On February 23, 2010, at 8:40 a.m., direct support staff held Client #3 by a gait belt as he ambulated out of the facility, using a rolling walker. At 12:57 p.m., he was observed ambulating at his day program without the gait belt. When asked, the client said the gait belt was kept in the facility van. Residential staff routinely removed it once he was seated at day program. Residential staff then put it back on him when they returned for his afternoon trip home. At 1:08 p.m., staff in his treatment room confirmed that the gait belt always remained with residential staff. At 1:34 p.m., Client #3's day program coordinator presented documentation of an in-service training by the physical therapist (PT) on January 13, 2009. Use of a gait belt was not indicated in January 2009. At 1:57 p.m., the day program IPP coordinator presented Client #3's PT assessment, dated September 22, 2009; it recommended using both a gait belt and a</p>	W 159	<p>W 159</p> <p>1. CROSS REFER W 120</p> <p>2. A new walker was obtained and is currently being used by the individual.</p> <p>3. In the future the QMRP will ensure that all incidents of falls and issues are discussed and reassessed by the physical therapist.</p> <p>In the future the QMRP will ensure that all assessments are reviewed for accuracy and all recommendations are completed and the report is then filed in the individual's record.</p> <p>See attached – receipt for new walker</p>	3/24/10

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W 159	<p>Continued From page 2</p> <p>standard rolling walker while ambulating. The IPP coordinator said he had never seen Client #3 with a gait belt at day program.</p> <p>Later that day, at 3:01 p.m., interview with the QMRP revealed that Client #3 had two gait belts; one was kept by residential staff. The QMRP stated that she had delivered another gait belt to the day program "as soon as it arrived... around May or June" 2009. The day program reportedly told her that the PT must provide in-service training before they would ask their (day program) staff to use the gait belt. The QMRP reported having asked the PT to provide staff training at the day program. However, she acknowledged that she had not asked the PT about it since she made the request, and had not asked about the gait belt when she visited the day program on August 12, 2009, September 7, 2009, October, 12, 2009, November 25, 2009, December 30, 2009, and January 28, 2010.</p> <p>On February 25, 2010, at 12:25 p.m., review of Client #3's Health Management Care Plan (HMCP), dated September 22, 2009, revealed the following: "... unsteady gait...use gait belt during ambulation. Encourage to use walker as recommended by the PT..." It should be noted that the HMCP reflected that he received Fosamax 70 mg weekly, and Calcium with Vitamin D 600 mg/400 IU twice daily, to address a diagnosis of osteoporosis.</p> <p>2. Cross-refer to W436.2. The facility's QMRP failed to verify the safety and/or suitability of Client #3's existing walker since the PT recommended that he receive a new walker in his annual assessment, dated September 22, 2009. The PT's quarterly report dated December 30, 2009,</p>	W 159			

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W 159	Continued From page 3 indicated that the existing walker was "in disrepair and should be replaced as soon as possible." 3. On February 23, 2010, at 10:36 a.m., review of incident reports revealed that Client #1 fell while leaving her day program on September 3, 2009. She sustained a bruise on her right cheek and lip. On February 25, 2010, at 10:40 a.m., review of the client's physical therapy assessment, dated December 30, 2009, revealed that the physical therapist had written "no reports of falls." The assessment, however, had been performed 6 weeks after the client's fall. Interview with the QMRP on February 25, 2010, at 10:49 a.m., confirmed that the facility had not informed the physical therapist of Client #1's fall. The QMRP explained that she "did not see it as a physical therapist or occupational therapist problem." She later, however, acknowledged that the PT might have provided further assessment and/or made relevant recommendations to reduce the likelihood of similar falls in the future. There was no evidence that the QMRP ensured the accuracy of Client #1's physical therapy assessment.	W 159			
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.	W 249			

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W 249	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to implement a client's Individual Support Plan (IPP), for one of the three clients included in the sample. (Client #2)</p> <p>The findings include:</p> <p>Observation at the day program on February 23, 2010, at 12:14 p.m., revealed Client #2's 1:1 direct support staff telling him to go into the bathroom to wash his hands. After the client came out of the bathroom, he went into the cafeteria and washed his hands again. At 12:16 p.m., the client was observed retrieving water from the cooler. At 5:45 p.m., another 1:1 direct support staff (next shift) told the client to get his coat to go on a community walk.</p> <p>Review of Client #2's IPP dated September 23, 2009, on February 24, 2010, at approximately 3:00 p.m., revealed an objective for Client #2 to "independently sign money, wash hands, walk and water." On February 24, 2010, at 11:00 a.m., review of the client's speech and language evaluation dated September 3, 2008, revealed a recommendation for the "direct care program staff in the residence to provide the client with a language rich environment during daily living activities by employing manual signs and approximations paired with verbal speech to label actions, items and objects used during personal hygiene, grooming, leisure recreation activities, etc." At no time during the survey were any of the 1:1 staff observed using signs while communicating with Client #2.</p>	W 249	<p>W 249</p> <p>All staff were in serviced to pair manual signs and verbal speech when communicating with the individual. The individual has a communication program and all staff were in serviced on the program.</p> <p>See attached – in service record on communication WTP and in service record for manual sign usage as per the communication WTP.</p>	3/25/10	

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W 249	Continued From page 5 Interview with the 1:1 support staff on February 25, 2010, at approximately 3:30 p.m., stated that he always used manual signs with the client. There was no evidence that the facility implemented Client #2's communication program as recommended in the IPP.	W 249			
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with physician's orders, for one of the three clients in the sample. (Client #1) The finding includes: On February 23, 2010, Client #1 was administered a stool softener (Docusate) and multi-vitamin supplement at approximately 8:08 a.m. The trained medication employee (TME) ended the morning medication administration at approximately 8:35 a.m. Later that day, at 4:20 p.m., review of Client #1's physician's orders dated February 1, 2010, revealed that the client should have also received Tobradex eye drops in both eyes that morning. The Tobradex was prescribed twice daily for 10 days to treat conjunctivitis. The following day, at 9:45 a.m., review of the client's medication administration record (MAR) revealed that the TME had left blank the spaces designated for 7 a.m. administration of Tobradex drops on the previous morning (as observed) and that morning. A moment later, the facility's LPN examined the	W 369	W 369 The TME was in serviced on Medication Policy and Procedure. In the future the RN will continue to complete quarterly TME observation audits and revise monitoring needs as they arise. See attached – in service record and TME observation record	3/25/10	

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W 369	Continued From page 6 MAR, confirmed the spaces had been left blank and acknowledged that the client had not received her eye drops as ordered.	W 369		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client was taught to administer their own medications, for two of the three clients in the sample. (Client #2 and #3) The findings include: 1. During the medication administration on February 23, 2010, at 8:04 a.m., the trained medication employee (TME) was observed punching Client #1's medications from the bubble pack into a medication cup and handing it to him. Interview with the registered nurse on February 25, 2010, at approximately 9:45 a.m., revealed that Client #1 had a self-medication program. Review of Client #1's record on February 25, 2010, at approximately 10:00 a.m., revealed a self-medication administration assessment dated September 22, 2009. According to the assessment, a recommendation was made for the client to participate in a program that required him to increase his self esteem by self-administering his medication. Review of	W 371	W 371 1. & 2. All TMEs were in serviced on each individual's self medication program. In the future the RN Supervisor and the QMRP will ensure that the TMEs are monitored /documentation completed at least quarterly to ensure that the WTP and medication administration process is being followed. The self medication program documentation will be tabulated for efficacy on a monthly basis and documentation will be made in the QMRP and RN/LPN monthly notes. Changes to the WTP will be made accordingly. See attached in service record for IPP, TME observation record	3/26/10

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W 371	Continued From page 7. Client #1's record on February 25, 2010, revealed an individual program plan (IPP) dated September 23, 2009, that further documented a program requiring Client #1 to punch his medication out of the blister pack. 2. Similarly, Client #3 had a self-medication training program. Two of the tasks outlined in the program were for the TME or nurse to ask the client to "verbalize the purpose of seizure medication" and to "identify name on the medication card." The morning TME, however, had not been observed asking the client about the medication or the name on the card. The morning TME was interviewed on February 25, 2010, at approximately 10:20 a.m. She stated that she asked clients to bring their glass of water in the morning. She acknowledged that she did not implement other aspects of their self-medication programs in the morning, due to time constraints. She explained that she did not want to delay the clients' departure for day programs. At the time of the survey, the facility failed to ensure that clients were consistently given the opportunity to participate in self-administration of their medications.	W 371			
W 390	483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation and record review, the facility's nurses failed to remove from use, outdated drugs, for one of three clients in the sample. (Client #3)	W 390			

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W 390	Continued From page 8 The finding includes: On February 24, 2010, at 9:51 a.m., during an inspection of the medication cabinet, a blister pack of Acetaminophen 325 mg tablets was observed in Client #3's basket of medications. The Acetaminophen was prescribed for use "as needed," in accordance with the client's physician's orders. The manufacturer's label on the back of the blister pack indicated an expiration date of November 30, 2009. The Licensed Practical Nurse (LPN) on duty at that time examined the label and confirmed that the medication had expired. Moments later, however, it was observed that the label prepared by the pharmacist indicated an expiration date of March 17, 2010. The LPN confirmed this and suggested that was why the medication remained in the basket beyond the manufacturer's expiration date. Further examination of the pharmacy label revealed that the Acetaminophen had been filled on March 17, 2009.	W 390	W 390 The RN/LPN will ensure that monthly medication room QA is completed which includes a check for checking current medications for labels. See attached – Monthly QA record	3/26/10
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to establish a system that ensured consistent use of, and the timely	W 436		

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W 436	<p>Continued From page 9</p> <p>maintenance of, clients' adaptive and assistive devices, for two of the three clients in the sample. (Clients #3 and #4)</p> <p>The findings include:</p> <p>1. Facility staff failed to ensure consistent use of Client #4's spout cup, as follows:</p> <p>On February 23, 2010, at 7:46 a.m., Client #4 was observed drinking from a double-handled drink cup at the breakfast table. There was a pronounced slurping and some spillage as she drank. When asked about her cup during the Entrance Conference, at approximately 8:56 a.m., the residential coordinator stated that Client #4's double-handled cup came with a spouted lid. The Trained Medication Employee (TME), who had administered medications earlier that morning, overheard the interview. When informed that the client was observed at breakfast using a cup without a lid, the TME retrieved a double-handled cup from a kitchen cabinet with a spouted lid. The TME and residential coordinator both stated that the lid should be used at all times.</p> <p>On February 25, 2010, at approximately 10:15 a.m., review of Client #4's occupational therapy assessment, dated January 18, 2010, revealed that a "spouted cup with lid was recommended to reduce spillage when drinking." The spouted cup with lid also was reflected in her mealtime protocol, dated January 19, 2010.</p> <p>2. The facility failed to obtain a replacement standard rolling walker for Client #3, as follows:</p> <p>During observations at Client #3's day program on February 23, 2010, his direct support staff and</p>	W 436	<p>W 436</p> <p>1. All staff were in serviced on use of adaptive eating utensils. In the future the QMRP and RN will ensure the appropriate eating utensil is being used by monitoring meal intake at least weekly.</p> <p>2. The individual has a new walker and is using it. See attached walker receipt. In the future the QMRP will ensure that during the monthly day program visits she will monitor and document the use of all adaptive equipment used by the individual.</p>	<p>3/24/10</p> <p>3/26/10</p>

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W 436	<p>Continued From page 10</p> <p>the Individual Program Plan (IPP) coordinator both reported that the client had received a new walker in mid-2009. The client, however, expressed fear of falling and, therefore, stopped using the new walker. He had resumed using his older walker ever since. The new walker reportedly had larger wheels than his previous walker. Later that day, at 3:13 p.m., the qualified mental retardation professional (QMRP) confirmed that Client #3 became frightened of falling and refused to use the new walker. The Physical Therapist (PT) reportedly discontinued his recommendation for the new walker, after two training sessions with the client.</p> <p>On February 25, 2010, at approximately 12:10 p.m., review of Client #3's PT assessment, dated September 22, 2009, revealed the following: he "received a new Rolator style walker, which he refuses to use... will be fitted for another standard rolling walker." Then, in a quarterly report dated December 30, 2009, the PT wrote: "His current walker is in disrepair and should be replaced as soon as possible." At 12:20 p.m., the QMRP stated that the PT had not told her why he recommended a different walker. She then stated that the client's insurance plan (Medicaid) would not pay for a new walker, since Medicaid had paid for the Rolator walker less than one year before. Upon further interview, the QMRP stated that the PT had reportedly told her that the existing walker was safe, "it's ok to use." After looking at the client's PT records, however, the QMRP acknowledged that she had not documented those conversations. The safety and/or suitability of Client #3's current walker could not be verified in the record.</p> <p>3. Cross-refer to W159.1. There was no</p>	W 436	3. cross refer W 159 1.	3/26/10	

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

PRINTED: 03/17/2010
FORM APPROVED
OMB NO. 0938-0391

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 02/25/2010
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 436	Continued From page 11 evidence that Client #3 and his support staff at the day program received training on the proper use of his prescribed gait belt during his day program hours.	W 436		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that problems with evacuation drills were investigated and addressed. The findings include: Evacuation drills from the period February 7, 2009 - February 24, 2010 were reviewed on February 24, 2010, beginning at 11:04 a.m. The facility had documented 42 evacuation drills conducted during the 12-month period. While most were achieved within 10 minutes or less, 7 of the 42 drills took significantly more time to complete, as follows: - a drill February 7, 2009, reportedly took 45 minutes to complete; - a March 9, 2009, drill took 15 minutes; - April 28, 2009, 22 minutes; - drills October 29, 2009, and October 31, 2009, took 45 minutes; - January 9, 2010, 15 minutes; and, - January 19, 2010, 20 minutes. The qualified mental retardation professional (QMRP) and two direct support staff were interviewed on February 24, 2010, beginning at 12:43 p.m. They reported that their fire safety	W 448	W 448 All staff were in serviced on fire safety, drills and documentation. In the future the QMRP will ensure that the monthly QA will be completed so that fire drills are conducted efficiently and documentation will be checked for accuracy on a monthly basis. See attached -- monthly QA record, in service record, Firemak and Guardian records	3/26/10

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W 448	Continued From page 12 expert had stated during staff in-service training, that drills should be achieved within 10 minutes. When asked about drills taking 15 or 20 minutes (or longer) to complete, the QMRP indicated that would be problematic. The direct support staff indicated that sometimes the alarm continued ringing after the drill ended. In such instances, staff and clients were to remain out of the facility until the alarm stopped. The QMRP concurred, adding that such a delay/problem would be noted on the drill report form. However, report forms for the aforementioned drills did not reflect any documented problems with alarms. The QMRP further indicated that the above-cited evacuations had not been investigated by facility management.	W 448			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper infection control procedures, for two of the three clients in the sample. (Clients #2 and #3) The findings include: 1. On February 23, 2010, at 8:15 a.m., staff was observed standing in the hallway outside of a bathroom while Client #3 used the toilet. At 8:17 a.m., the client reached for his walker and staff provided physical support. The client left the bathroom without washing his hands, and staff did not remind him to do so. Client #3 went into his bedroom and sat on his bed. The trained	W 455	W 455 1. & 2. In the future staff will ensure that all individuals wash their hands after using the bathroom and document on the WTP. 2. All staff were in serviced on infection control and hand washing and table etiquette procedures. See attached – in service records	3/27/10	

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W 455	<p>Continued From page 13</p> <p>medication employee followed him into the bedroom and administered his morning medications. During the Exit conference on February 25, 2010, the residential coordinator indicated that he recalled the event described above, and acknowledged that Client #3 should have been reminded to wash his hands before leaving the bathroom.</p> <p>2. Evening observation on February 23, 2010, at 6:21 p.m., revealed Client #2 eating dinner. While the client was eating, a spoonful of Sloppy Joe fell between the table and his shirt. The client then proceeded to pick up the Sloppy Joe and ate it. (The one to one direct support staff did not attempt to redirect the client.)</p> <p>Review of the training records on February 25, 2010, at approximately 2:00 p.m., revealed that staff was trained on infection control on October 16, 2009.</p> <p>There was no evidence that proper infection control procedures were implemented consistently by all staff.</p>	W 455		
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Health Regulation Administration

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R 000	INITIAL COMMENTS A licensure survey was conducted from February 23, 2010 through February 25, 2010. A sample of three residents was selected from a population of two men and three women with various degrees of cognitive and intellectual disabilities. In addition, the mealtime adaptive equipment that was prescribed for one additional resident (#4) was reviewed. The findings of the survey were based on observations, 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 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 interview and review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 3 out of 13 direct support staff whose background check documentation was made available for review. (S2, S6 and S8) The findings include: On February 23, 2010, at approximately 9:40 a.m., the residential coordinator agreed to make	R 125	R 125 Background checks for S2, S6 and S8 are attached. The Agency has contracted with Global Investigative Services and now conduct national background checks for all individuals being hired.	3/26/20

Health Regulation Administration

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

Gwan J. Gwan

TITLE

VP Operations

(X8) DATE

3/26/10

Health Regulation Administration

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R 125	Continued From page 1 available for review the personnel records for all employees and consultants, including evidence of criminal background checks for all staff employed in the facility. Review of the personnel records on February 24, 2010, beginning at 1:10 p.m., revealed no evidence that a comprehensive background check had been obtained prior to employment for 2 of the 13 direct support staff (S2 and S8). Additional information forwarded post-survey revealed a third staff person (S6) whose background check was not comprehensive, as follows: 1. A District of Columbia background check had been documented for S2. However, his application form indicated that he had been employed in Pittsburgh, PA between December 2005 - April 2006. There was no evidence that a background check had been obtained in that jurisdiction. 2. A District of Columbia background check had been documented on September 22, 2008 for S8. However, her personnel record indicated that she had been employed in Silver Spring, MD from January 2006 - May 2007, and worked another job in Forestville, MD beginning on February 7, 2008. There was no evidence that background checks had been obtained in those Maryland jurisdictions. 3. The facility had documented background checks for S6 in the District of Columbia and Maryland. However, on February 26, 2010 (post-survey), the facility forwarded her June 4, 2008 application form on which she indicated that she had been employed in New York, NY from March 2007 - July 2007. There was no evidence that a background check had been obtained in that jurisdiction.	R 125		

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R 125	Continued From page 2 This is a repeat deficiency. Please see licensure deficiency reports dated January 7, 2009 and February 1, 2008.	R 125			

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1000	INITIAL COMMENTS A licensure survey was conducted from February 23, 2010 through February 25, 2010. A sample of three residents was selected from a population of two men and three women with various degrees of cognitive and intellectual disabilities. In addition, the mealtime adaptive equipment that was prescribed for a fourth resident (#4) was reviewed. The findings of the survey were based on observations, 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 reports.	1000		
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 GHMRP failed to ensure the interior and exterior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner, for five of the five residents in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: 1. On February 24, 2010, at 4:50 p.m., an electrical outlet located in the basement was observed to be in disrepair. The plate surrounding the double outlet was not flush with the surrounding wall. The plate was loose to the	1090		

Health Regulation Administration

Swan L. Sloan

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

VP Operations

TITLE

(X6) DATE

3/26/10

STATE FORM

6800

S9H711

If continuation sheet 1 of 9

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I 090	<p>Continued From page 1</p> <p>touch and laid approximately 1/3 inch away from the wall. The outlet was immediately brought to the attention of the facility's Residential Coordinator (RC) and qualified mental retardation professional (QMRP). A maintenance man came to the GHMRP and determined that the outlet had not been secured properly by screw. He fixed the outlet within the next 30 minutes; therefore, the deficiency was abated during the survey.</p> <p>2. On February 25, 2010, at 3:20 p.m., the safety alarm installed on an exterior door leading from Resident #2's bedroom failed to sound when it was opened by the RC. Earlier in the survey, the RC and QMRP had stated that the alarm was needed to alert staff in the event that Resident #2 exited the facility without a staff escort. [Note: Resident #2 received one-to-one staffing support 24 hours/day, 7 days/week to ensure his behavioral health and safety. The alarm was approved by the client's interdisciplinary team after he left the facility in May 2009 without a staff.] At 3:23 p.m., interview with the RC and QMRP revealed the alarm was to remain activated at all times. Further interview revealed that it had been "a long time" since the alarm had been tested. They summoned a maintenance man to the GHMRP. The alarm sounded at 4:55 p.m.; therefore, the deficiency was abated during the survey.</p> <p>3. On February 25, 2010, at 3:40 p.m., a burgundy Ford station wagon was observed in the facility's back yard. Two of its tires were flat and the inspection sticker on the windshield showed an expiration date of June 5, 2007. The RC indicated that he had previously asked an employee (the car's owner) to remove the vehicle.</p>	I 090	<p>I 090 In the future the QMRP and the Residential Coordinator will continue to complete monthly Environmental QA -- which includes alarms, electrical sockets. The Agency has also developed an environmental QA dept. of 3 personnel to ensure that our individuals reside in a safe and homey environment.</p> <p>See attached -- environmental QA</p>	3/27/10

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I 187	Continued From page 3 On February 24, 2010, at 10:20 a.m., interview with the RN confirmed that the LPN reported to her and she reported to the DON. She also confirmed that the TMEs reported to her directly, and not to the RC. At 11:34 a.m., the DON telephoned this surveyor. The DON affirmed that that the TMEs reported directly to the RN, in accordance with 22 DCMR, Chapter 61 (Trained Medication Employees). She further indicated that there was another organizational chart available at the main office. 2. On February 25, 2010, the QMRP presented a revised Organizational Chart that she received from their corporate office (fax cover sheet dated February 24, 2010). Review of the form, however, revealed a line drawn from the RN to the QMRP. A short time later, the RN examined the chart and stated that she did not report to the QMRP. She indicated the chart should be amended to reflect that she reported directly to the DON.	I 187		
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. 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,	I 206		

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I 206	<p>Continued From page 4</p> <p>provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for 5 out of 15 employees.</p> <p>The findings include:</p> <p>On February 23, 2009, at approximately 9:40 a.m., the residential coordinator agreed to make available for review the personnel records for all employees and consultants, including evidence of current health inventories/certificates. On February 24, 2010, beginning at 1:10 p.m., review of personnel records revealed no evidence of current health certificates for the house manager and 4 of the 13 direct support staff (S1, S3, S5 and S6). At 4:10 p.m., the qualified mental retardation professional (QMRP) confirmed the missing health certificates were not available.</p> <p>On February 25, 2010, at 2:28 p.m., the QMRP presented new information, including the following:</p> <ul style="list-style-type: none"> - the house manager showed documentation of a PPD performed on February 23, 2010, which was read on February 25, 2010 (results negative). His previous comprehensive health inventory had expired on February 5, 2010; - receipts dated February 25, 2010 showed that S1 and S3 had visited a clinic that day and requested a "physical and PPD." Results of the PPDs, however, would not be known until after the survey ended. It should be noted that S1's and S3's previous health certificates had expired on January 21, 2010 and August 2, 2009, respectively; 	I 206	<p>I 206 See attached annual physical exams for S1, S3, S4 and S6. 3/26/10</p> <p>The Agency has hired a new Director of HR effective from April 1, 2010. The Agency has developed a database with a reminder email system – to ensure all renewals are alerted to the HR dept. and subsequently the staff – at least 30 days prior to expiration.</p>	3/26/10

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I 206	<p>Continued From page 5</p> <p>- S5 had documented a PPD on January 22, 2010 (results negative); however, there was no evidence of a physician's certification of a comprehensive health inventory; and,</p> <p>- S6 had obtained a health inventory/certificate on February 25, 2010. Her previous health inventory had expired on September 5, 2009.</p> <p>This is a repeat deficiency.</p> <hr/> <p>Previously, the licensure deficiency report dated January 7, 2009 included the following:</p> <p>"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."</p> <hr/> <p>Previously, the licensure deficiency report dated February 1, 2008 included the following:</p> <ol style="list-style-type: none"> 1. Review of the personnel files conducted on 1/31/08 at approximately 3:36 PM revealed the GHMRP failed to provide evidence of current current health certificates for two staff. (S1 and S10) 2. Review of the personnel files conducted on 1/31/08 at approximately 3:36 PM revealed the GHMRP failed to provide evidence of current current health certificates for one consultant. (C7) 	I 206		

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I 436	<p>3521.7(f) 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>(f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each resident was taught to administer their own medications, for two of the three residents in the sample. (Resident #2 and #3)</p> <p>The findings include:</p> <p>1. During the medication administration on February 23, 2010 at 8:04 a.m., the trained medication employee (TME) was observed punching Resident #1's medications from the bubble pack into a medication cup and handed it to him.</p> <p>Interview with the registered nurse on February 25, 2010, at approximately 9:45 a.m., revealed that Resident #1 had a self-medication program. Review of Resident #1's record on February 25, 2010, at approximately 10:00 a.m., revealed a self-medication administration assessment dated September 22, 2009. According to the assessment, a recommendation was made for the resident to participate in a program that required him to increase his self esteem by self-administering his medication. Review of Resident #1's record on February 25, 2010, revealed an individual program plan (IPP) dated September 23, 2009, that further documented a</p>	I 436	<p>I 436 Cross refer to W 371</p>	

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I 436	Continued From page 7 program requiring Resident #1 to punch his medication out of the blister pack. 2. Similarly, Resident #3 had a self-medication training program. Two of the tasks outlined in the program were for the TME or nurse to ask the resident to "verbalize the purpose of seizure medication" and to "identify name on the medication card." The morning TME, however, had not been observed asking the resident about the medication or the name on the card. The morning TME was interviewed on February 25, 2010, at approximately 10:20 a.m. She stated that she asked residents to bring their glass of water in the morning. She acknowledged that she did not implement other aspects of their self-medication programs in the morning, due to time constraints. She explained that she did not want to delay the residents' departure for day programs. At the time of the survey, the facility failed to ensure that residents were consistently given the opportunity to participate in self-administration of their medications.	I 436			
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation and record review, the facility's nurses failed to remove from use, outdated drugs, for one of three residents in the sample. (Resident #3) The finding includes:	I 484	I 484 Cross refer W 390		

Health Regulation Administration

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 02/25/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 4424 20TH STREET, NE WASHINGTON, DC 20019		
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I 484	Continued From page 8 On February 24, 2010, at 9:51 a.m., during an inspection of the medication cabinet, a blister pack of Acetaminophen 325 mg tablets was observed in Resident #3's basket of medications. The Acetaminophen was prescribed for use "as needed," in accordance with the resident's physician's orders. The manufacturer's label on the back of the blister pack indicated an expiration date of November 30, 2009. The Licensed Practical Nurse (LPN) on duty at that time examined the label and confirmed that the medication had expired. Moments later, however, it was observed that the label prepared by the pharmacist indicated an expiration date of March 17, 2010. The LPN confirmed this and suggested that was why the medication remained in the basket beyond the manufacturer's expiration date. Further examination of the pharmacy label revealed that the Acetaminophen had been filled on March 17, 2009.	I 484			