

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

PRINTED: 05/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</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	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from April 20, 2011 through April 21, 2011. A sample of three clients was selected from a population of two men and three women with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations and 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.</p>	W 000	<p><i>Received 5/20/11</i></p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 800 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 125	<p><b>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, for four of five clients residing in the facility. (Clients #2, #3, #4, and #5)</p> <p>The findings include:</p> <p>1. The facility failed to ensure clients' rights were protected by making certain each client involved family members and/or legally sanctioned</p>	W 125	<p><b>W 125</b></p> <p>1. An emergency HRC meeting was scheduled and approvals for the door bell were obtained. All individuals' guardians have given their consent for the usage of the doorbell. In the future the QDDP will ensure that each individual's rights are protected. QDDP has been in serviced on HRC / restriction of rights etc. policy and procedures. See attached – consents – HRC and guardian</p> <p>2. The staff person has been disciplined and has been in serviced on the individual's diet and mealtime protocol as well as rights and client protection. See attached – in service record</p>	5/16/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan Sloan</i>	TITLE <i>V Operations</i>	(X6) DATE <i>5/16/11</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 125	<p>Continued From page 1</p> <p>medical guardian representative assisted them with making decisions, as evidenced below:</p> <p>On April 20, 2011, at 9:29 a.m., review of an internal investigation report dated April 9, 2010, revealed that on April 7, 2010, Client #1's one to one staff reported that the client had left the facility without a staff escort while the staff person went to the kitchen. The police was notified and a missing person's report was filed. Further review of the investigative findings revealed that due to Client #1's history of leaving the home without staff, it was recommended that the facility's management team consider placing an alarm on the side door upstairs.</p> <p>On April 20, 2011, at 10:00 a.m., interview with the qualified intellectual disabilities professional (QIDP) (who had conducted the investigation) revealed that a door alarm was placed on the side door in the dining room. Further interview revealed that the door alarm was off during the day time because it was "too loud". The QIDP also added that the human rights committee (HRC) had approved the use of the alarm. The QIDP's interview was confirmed through review of the facility's HRC minutes dated April 28, 2010, on April 21, 2011, at approximately 11:05 a.m.</p> <p>On April 21, 2011, at approximately 11:20 a.m., continued interview with the QIDP revealed that Client #1's housemates' had involved family members and/or court appointed legal guardians to assist them with decision making. Further interview with the QIDP revealed that Clients #1's housemates were informed verbally of the new alarm that was placed on the side door. When</p>	W 125		
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W 125 Continued From page 2  
asked whether Client #1's housemates' legal guardians and/or involved family members were involved in the decision making process regarding the door alarm, the QIDP replied that she believed they were. She then acknowledged that their was no written documentation available for review to verify that they had been involved.

Note: It should be noted that on April 20, 2011, at approximately 1:30 p.m., direct care staff was observed to open the side door. The alarm was extremely loud.

2. The facility failed to ensure Client #1's right to receive a full meal as prescribed, as evidenced below:

On April 27, 2011, Client #2 was observed eating lunch, beginning at 12:32 p.m. The meal ended with fruit cocktail. At 12:43 p.m., the direct support staff person (DPS1), who had been with the client throughout the meal, was observed spoon feeding Client #2 fruit cocktail. [Note: The client had been observed feeding herself independently earlier.] At 12:44 p.m., DPS1 walked away from the table holding the cup of fruit cocktail, which remained approximately half full, and threw the rest of the fruit cocktail into a trash receptacle. The client had not been observed refusing to eat the dessert before it was discarded. At 1:00 p.m., the day program's director and their nurse expressed dismay that the client was not allowed to complete her meal.

W 125

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

W 249

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W 249	<p>Continued From page 3</p> <p>treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to implement effective intervention techniques as prescribed in clients' behavior support plans, for one of the three clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>On April 20, 2011, beginning at 7:22 a.m., Client #2 was observed vocalizing an "Aiy yi yi yi" sound while seated at the breakfast table. She repeated the sound continuously, stopping only when she placed food or drink in her mouth. The observed response from the direct support staff was to say her name and rub her shoulder. After breakfast, she made the "Aiy yi yi yi" sound and moved her hands continuously until she and her peers left the facility, at approximately 8:50 a.m.</p> <p>Client #2 was observed at her day program on April 20, 2011. While seated in an exercise room, from 11:35 a.m. until 11:44 a.m., she rocked her upper body, made the "Aiy yi yi yi" sound and moved her arms and hands continuously. The day program director, who was present at the time, stated that two target behaviors (screaming and flailing her hands in an agitated state) had increased significantly after a medication was discontinued. The client was not</p>	W 249	<p>W 249</p> <p>All staff and HM / QDDP have been in serviced on the individual's BSP and use of communication book.</p> <p>In the future the QDDP and HM will ensure that all staff at the residential and day program follow the BSP and utilize the communication book as recommended in the BSP.</p> <p>See attached – in service record</p>	5/16/11

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W 249 Continued From page 4

as agitated while dancing with an instructor for approximately 10 minutes, beginning at 11:44 a.m. At approximately 11:55 a.m., the instructor stated that Client #2 "screams a lot." More screaming was observed while Client #2 sat in the lunch room between 12:02 p.m. - 12:32 p.m. The vocalizations were less intense after her lunch was presented at 12:32 p.m.

Observations resumed in the facility later that day (April 20, 2011), at 3:53 p.m., when Client #2 returned from day program. Her vocalizations were louder than earlier that day. She sat down at the dining room table at 4:06 p.m., flailed her hands, continued making the loud "Aiy yi yi yi" vocalizations and let out two shrieks. At 4:07 p.m., the qualified intellectual disabilities professional (QIDP) presented a spout cup with apple juice. The client immediately grabbed the cup and drank. The QIDP offered her verbal praise. Client #2 resumed the vocalizations but they were not as loud as before. At 4:10 p.m., staff presented a bowl of various snack items. The client calmed a bit and selected a fresh apple. She remained relatively calm while the staff diced her apple in the kitchen.

Client #2 resumed her loud vocalizations when she finished her snack at 4:22 p.m. The QIDP escorted her to the living room where she sat in her "favorite chair." She continued making the "Aiy yi yi yi" sound, interspersed with an occasional louder shriek, and flailed her hands. The QIDP spoke to her then left the room.

At 4:27 p.m., the house manager (HM) came into the living room, placed his hand on the client's right shoulder and spoke to her. She continued

W 249

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W 249 Continued From page 5

her vocalizations and hand-flailing but at a slightly lower tone. At 4:28 p.m., the HM said "it's ok, it's ok... I'm going" and then left the room. The client remained seated in her "favorite chair" in the living room, appearing very agitated. Her screaming and hand flailing was incessant. A direct support staff person came over to Client #2, spoke briefly and when she continued shrieking, the staff said the client's name then walked away.

At 4:30 p.m., the QIDP came back to the client and asked if she would like to go for a walk. The client stood up and they walked to the client's bedroom. Loud screams and the sound of foot stomping could be heard coming from her bedroom. At 4:33 p.m., the client entered the dining room and sat at the table to receive medications. She loudly shrieked "Aiy yi yi yi" and flailed her hands continuously while seated.

The HM joined Client #2 at the dining table at 5:00 p.m. He presented a See 'n Say Rhyme Maker and demonstrated how it worked. She pushed it away, pushed away a wooden puzzle board and continued screaming. At 5:02 p.m., staff presented a cup of apple juice which she readily took in hand and drank. When the staff asked if she was "ok," the client's vocalizations grew sharply louder. The HM persisted with trying to engage her in table top activities. At 5:06 p.m., the client responded appropriately to his request that she push a button on the Rhyme Maker. He praised her after she pushed the button. She pushed the button again a few more times at his request; however, the vocalizations continued non-stop. At 5:08 p.m., Client #2 and the HM left the facility for a walk. At 5:10 p.m.,

W 249

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W 249 Continued From page 6  
she was observed walking next to the HM on a sidewalk a block away; she was continuously screaming and flailing her hands.

Client #2 and the HM re-entered the facility at 5:17 p.m. The client screamed and flailed her hands incessantly until approximately 5:35 p.m., when a different staff came to her, gave her a cup of apple juice and told her she loved her. The client remained relatively calm through the remainder of the observation period (end 6:10 p.m.).

Client #2's Psychological Evaluation, dated January 11, 2011, and Behavior Support Plan (BSP), dated January 18, 2011, were reviewed on April 21, 2011, beginning at 9:14 a.m. The psychologist documented a "history of... hollering and stomping of her feet." The psychologist also wrote: "It is also important to note that the increase in <client's name> behavior have been correlated directly to the discontinuation of Moban...agitation in terms of of frequency, intensity and duration increased exponentially...other trials of medication have yet to be successful in managing her agitated symptoms.

At 9:50 a.m., continued review of Client #2's BSP revealed that staff had been observed on the day before implementing some of the interventions outlined in the plan (i.e. inform her of changes in schedule, prompt her to take a walk, rub her shoulders gently, have her sit in her favorite chair, and call her name in a firm voice and redirect her if she becomes agitated). However, there were other interventions that were prescribed but were not observed being used. Specifically, the BSP

W 249

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W 249	<p>Continued From page 7</p> <p>said staff should prompt the client "to use signs and/or picture book to express herself" because she had "limited communication skills." The BSP also said the client should "practice self-soothing/ calming activities to reinforce her ability to calm himself &lt;sic&gt; down." At no time on April 20, 2011 were staff (in the home or at day program) observed encouraging Client #2 to use signs or a picture book to express herself.</p> <p>On April 21, 2011, at 2:23 p.m., interview with the HM revealed that the psychologist had trained staff on Client #2's BSP within the past two or three months. When asked what intervention techniques should staff use, he outlined the techniques that were observed being implemented on the day before. At 2:28 p.m., the QIDP indicated that Client #2 would sometimes "go days without any sign of agitation." She further stated that the prolonged behavioral outbursts observed on April 20, 2011 had been more intense than usual.</p> <p>At 4:40 p.m., the QIDP was asked about Client #2 signing and/or using a picture book. She said she did not think the client would have cooperated had staff asked her to sign or use a picture book. She said the picture book that was kept stored "in a cabinet." She acknowledged that the picture book had not been presented to her on the day before. When asked about "self-soothing techniques," the QIDP described techniques staff used to help soothe the client. When asked again whether Client #2 had programming opportunities to practice self-soothing/ calming activities to reinforce her ability to remain calm, the QIDP replied "no."</p>	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION	W 252		

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W 252 Continued From page 8

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, facility staff failed to document all behavior data in accordance with the behavior support plan (BSP), for one of the three clients in the sample. (Client #2)

The finding includes:

[Cross-refer to W249] Client #2 was observed in her home on April 20, 2011. The client displayed one of her targeted maladaptive behaviors (screaming) almost continuously from 7:22 a.m. - 8:50 a.m. After she returned from day program that day, the client displayed two of her targeted maladaptive behaviors (screaming and/or stomping her feet) continuously from 3:53 p.m. - 4:07 p.m. and from 4:22 p.m. - 5:35 p.m.

Client #2's Behavior Support Plan (BSP), dated January 18, 2011, was reviewed on April 21, 2011, beginning at 9:30 a.m. The psychologist documented a "history of... hollering and stomping of her feet." The psychologist also wrote: "the frequency of <client's name> target behaviors will be recorded as they occur...The data will be used to make modifications to the BSP, medication consideration, and changing or adding additional support procedures/needs."

W 252

W 252  
All staff and HM / QDDP have been in serviced on the individual's BSP and use of communication book.  
In the future the QDDP and HM will ensure that all staff at the residential and day program follow the BSP and utilize the communication book as recommended in the BSP.  
See attached – in service record and data collection record

5/16/11

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W 252 Continued From page 9  
On April 21, 2011, at 1:52 p.m., review of the behavior data sheets in Client #2's program book for April 2011 revealed that staff had documented one behavioral incident on the previous day. Staff documented that at "4:15 p.m., after day program," the client was "stomping" and "hollering." The documentation further indicated that staff had "asked her to calm down" to which the client had "refused." The afternoon data did not reflect the continuing nature of the behavior (more than one occurrence) or that the client appeared to calm slightly when presented with food or drink or when a certain staff person spoke with her at 5:34 p.m. In addition, none of the client's screaming behavior during the morning of April 20, 2011 had been documented in accordance with the BSP.

W 252

It should be noted that review of the April 2011 data sheets revealed that staff consistently documented that the client had either "refused" to stop the behavior or that the behavior "continued" after staff intervened at a particular time recorded. The same data sheets never showed more than one occurrence of targeted behaviors, even though staff documented that the behavior had "continued." Neither the BSP nor the behavior data collection sheets provided clear instructions to staff regarding how they should record behavioral incidents that last for prolonged periods of time (and/or beyond a one-time intervention).

W 369 483.460(k)(2) DRUG ADMINISTRATION

W 369

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

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W 369 Continued From page 10

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 without error, for one of the five clients residing in the facility. (Client #1)

The finding includes:

The morning medication administration pass was observed on April 20, 2011, beginning at 7:44 a.m. At 8:15 a.m., the trained medication employee (TME) held a clear plastic medicine cup in her left hand while she poured Enulose stool softener from a bottle in her right hand. She placed the cup on the table in front of Client #1 and indicated that she was ready to begin administering his medications. Observation of the medicine cup (while placed on the table top) revealed that there were 18 ml of liquid poured. According to the TME (and the label on the prescription bottle) Client #1's physician had ordered 15 ml.

After she was informed that there was too much Enulose in the cup, the TME raised the cup to eye level again, examined it and stated that it was "ok" and returned the cup to the table. Before she began the administration process, she was asked to examine it while placed on a level surface. She leaned over, hesitated, then stated it was "difficult to see." After a brief pause, it was suggested that perhaps there was another level surface available. She paused.

This surveyor then determined there was a shelf in the medicine closet that was at eye level and had brighter lighting than at the dining room table.

W 369

W 369

The TME was in serviced on Policy and Procedure – Medication Administration

In the future the RN and LPN will ensure that there is adequate and appropriate monitoring of the TMEs administering medications as per Metro Homes P&P and QA requirements.

See attached – TME – QA record and in service – Medication P&P

5/16/11

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
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W 369 Continued From page 11  
The TME placed the cup on the shelf, examined it again and acknowledged that there was more than 15 ml. She removed 3 ml, said "thank you" and then administered Client #1 his medications.

W 369

At 9:39 a.m., interview with the registered nurse revealed that she had observed the same TME two days earlier at which time she had not identified any deficient practices.

This is a repeat deficiency.

Previously, in a Federal Deficiency Report dated February 20, 2010, the facility's TME was cited for failing to administer eye drops to one client in accordance with physician's orders.

W 426 483.470(d)(3) CLIENT BATHROOMS

W 426

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 staff interview, the facility failed to ensure the facility's water temperature remained below 110 degrees Fahrenheit to ensure the health and safety of five of five clients residing in the facility. (Clients #1, #2, #3, #4 and #5)

The finding includes:

Observation on April 20, 2011 at 10:25 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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W 426	Continued From page 12  revealed the temperature in the Bath #1 in the main hallway, Bath #2 in Client #3 's bedroom and the kitchen all were measured to 120 degrees Fahrenheit. Interview with the qualified intellectual disability professional (QIDP) on the same day and the same time confirmed the high water temperature. The QIDP indicated she would have the maintenance staff adjust the temperature before the end of survey. Later confirmation on April 21, 2011 at approximately 4:35 p.m. revealed the water temperature was adjusted and corrected to 110 degrees Fahrenheit.  The facility failed to implement an effective system of monitoring and maintaining the water temperature to protect the health and safety of its clients.	W 426	W 426  The water temperature has been adjusted and regulated to 110 degrees. All staff were in serviced on safety and taking/reporting of abnormal water temperatures.  In the future the QDDP / HM will ensure that staff report abnormal water temperatures promptly and this is corrected expeditiously to avoid injuries.  QDDP/HM will continue to complete environmental QA audits as per Metro Homes P&P.  See attached – in service record	5/16/11
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 interviews and record review, the facility failed to ensure that staff consistently used prescribed adaptive equipment, for one of the three clients in the sample. (Client #2)  The finding includes:	W 436		

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W 436 Continued From page 13

On April 20, 2011, at 7:35 a.m., Client #2 was observed in her home drinking water from a double-handled spout cup with lid. She was observed later that morning at the day program. At 11:57 a.m., a direct support staff person (DPS1) offered the client water in a Styrofoam cup. Another day program staff (DPS2), who was standing nearby, walked over to them, took the cup in hand and began demonstrating to the other staff how to squeeze the upper edge of the Styrofoam cup when assisting the client. The client was not observed to be in distress.

When asked if this was how the client always drank her fluids, DPS2 replied no, adding that there was a spout cup available in another room. She then turned to DPS1 and instructed her to retrieve the spout cup. When asked about the squeezing technique, DPS2 said this was a way to reduce the amount of water. When queried further, she indicated that the spout cup was prescribed to reduce spillage and it reduced the amount of water "so she won't choke." The other staff returned, carrying a spout cup with the client's name written on it.

On April 20, 2011, beginning at 12:57 p.m., interview with the day program's director and their nurse confirmed that Client #2 was prescribed a spout cup with lid to reduce the flow rate and, thereby, reduce her chance of aspirating fluids.

On April 21, 2011, at approximately 4:40 p.m., interview in the home with the qualified intellectual disabilities professional revealed that she had observed day program staff using Client #2's spout cup with lid whenever she visited the day program. She indicated that she would

W 436

W 436  
Staff were in serviced on use of adaptive eating utensil.  
In the future the residential and day program QDDPs will ensure that there is adequate and appropriate monitoring of staff during mealtimes as per Metro Homes P&P.  
See attached in service record and mealtime observation record

5/16/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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W 436 Continued From page 14 follow-up.

W 436

W 440 483.470(i)(1) EVACUATION DRILLS

W 440

The facility must hold evacuation drills at least quarterly for each shift of personnel.

W 440

All staff were in serviced on Fire Drill and new schedule.

5/16/11

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 five of five clients residing in the facility. (Clients #1, #2, #3, #4, and #5)

In the future the QDDP and HM will ensure that fire drills are conducted at least quarterly on every shift. The QDDP/HM will ensure that this is done as part of the monthly QA audit system at Metro Homes.

The finding includes:

See attached in service record and fire drill schedule

The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:

On April 20, 2011, at 12:29 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three designated shifts 8:00 a.m. - 4:00 p.m.; 4:00 p.m. -12:00 a.m. and 12:00 a.m. - 8:00 a.m. (Monday through Friday). Further interview revealed that there were two designated shifts 8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m. for the weekend (Saturday/Sunday).

Review of the facility's fire drill log records on April 20, 2011, at approximately 12:32 p.m. revealed no documented drills were held during the weekday morning shift (8:00 a.m. - 4:00 p.m.; ) from March 2010 through May 2010. In addition, there were no documented fire drills held during the weekday overnight shift (12:00 a.m. - 8:00 a.m.) from June 2010 through November 2010. This was acknowledged by the

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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W 440 Continued From page 15 facility's QIDP and HM on April 21, 2011, at approximately, at 12:30 p.m.

W 440

W 455 483.470(l)(1) INFECTION CONTROL

W 455

There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

W 455  
All staff were in serviced on Infection Control and sanitation practices. In the future the QDDP at the day program will ensure that there is daily supervision of staff during mealtimes.

5/16/11

This STANDARD is not met as evidenced by:  
Based on observation and interview, the facility failed to ensure that all staff were effectively trained on sanitation and infection control practices, for one of the three clients in the sample. (Client #2)

See attached – in service record

The finding includes:

On April 20, 2011, Client #2 was observed at her day program, beginning at 11:35 a.m. At 12:45 p.m., the direct support staff person (DPS1), who had assisted the client with her lunch, was observed using a paper towel to wipe food from Client #2's shirt after she finished the meal. DPS1 used the same paper towel to wipe the table top where the client and a peer had just finished eating. Still using the same paper towel, DPS1 wiped Client #2's right and left hands, wrist and forearms. [Note: Prior to the lunch, Client #2 had been observed placing her right and left hands up to her mouth on numerous occasions that morning, both in the home and at the day program.]

Beginning at 12:57 p.m., interview with the day program's director and their nurse confirmed that Client #2 was known to put her hands up to her mouth. They further indicated that day program

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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W 455 Continued From page 16  
staff had received in-service training on infection control.

W 455

On April 21, 2011, at approximately 4:40 p.m., interview in the home with the qualified intellectual disabilities professional revealed that she had observed day program staff receiving in-service training when she visited there on Monday, April 18, 2011. She did not, however, know what subject matter had been covered on the day program staff training agenda. When queried further, she acknowledged that she had not determined whether all staff had received training on sanitary practices and infection control.

W 460 483.480(a)(1) FOOD AND NUTRITION SERVICES

W 460

Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

W 460

1. Staff were in serviced on individual's diet and following the menu for food type and amount.  
2. Staff were in serviced on diet and menu management. The nutritionist re-evaluated the individual's diet. The RN completed a weight assessment. In the future the Nutritionist, QDDP and RN will ensure that there is a mealtime observation at least 2x/week and there is a quarterly assessment completed on individuals who are on a special diet.

5/16/11

This STANDARD is not met as evidenced by:  
Based on observation, interview, and record review, the facility failed to ensure therapeutic diets were provided as prescribed, for two of the three clients in the sample. (Clients #1 and #3)

The findings include:

1. The facility failed to ensure that Client #1's therapeutic diet was implemented as prescribed to promote weight loss, as evidenced below:

On April 20, 2011, at approximately 5:56 p.m., observation conducted during the dinner meal revealed the direct care staff measured one cup

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W 460	<p>Continued From page 17</p> <p>of noodles and placed the noodles on Client #1's plate. At 6:08 p.m., Client #1 was observed to pour approximately 16 ounces of 2% milk into a cup and drank it. Interview with the direct care staff who prepared Client #1's dinner on April 20, 2011, at 5:58 p.m., revealed that the client was prescribed an 1800 calorie diet. Further interview revealed that she measured one cup of noodles using a measuring cup in accordance with the facility's menu.</p> <p>Review of Client #1's physician's order dated April 21, 2011, at approximately 3:26 p.m., revealed that the client was prescribed a 1800 calorie low fat, low cholesterol, high fiber, low starch, low trans fat diet. A few minutes later, review of the facility's menu revealed that, Client #1 should have received a 1/2 cup of noodles and a cup of skim milk. Review of the client's nutritional assessment dated March 20, 2011, at approximately 3:30 p.m., revealed that his desirable body weight was (DBW) of 150 -192 lbs. Further review revealed the client's current weight was 210 lbs.</p> <p>Observations on April 20, 2011, revealed that facility staff served the client twice the amount of noodles that were prescribed and failed to ensure he received fat free milk.</p> <p>2. Observation on April 20, 2011 at 11:35 a.m. revealed Client #3 was holding a can of Coke Classic as she walked around the day program. Interview with the day program staff on the same day at approximately 12:27 p.m. revealed she has worked with Client #3 for about ten years. This same staff also indicated Client #3 was allowed to</p>	W 460	See attached – in service record, nutritionist record and nursing assessment	

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W 460 Continued From page 18

have soda at the day program from time to time. Although the staff could not provide the frequency to which this happened, the staff also added that sometimes they put water into the "soda can", in lieu of the soda, and allowed her to drink it.

Observation on April 20, 2011 at 4:19 p.m. revealed Client #3 was allowed to pour her own glass of apple juice to drink with her snack. She poured approximately sixteen ounces (16oz) of apple juice into her cup to drink. Additional observation on April 20, 2011 at 5:58 p.m. revealed Client #3 was also allowed to pour her own glass of milk during dinner. She poured approximately sixteen ounces (16oz) of 1% milk into her cup to drink.

Review of Client #3's Physician's Order Sheets (POS) on April 21, 2011 at 11:03 a.m. revealed she was prescribed a "1000 CAL - Low Fat and Low Cholesterol" diet and the current menu listed that she receives skim milk instead of 1% milk. Further record review on the same day at 11:16 a.m. revealed Client #3's weight dropped from 201 lbs in January 2007 to 176 lbs on August of 2009. Client #3's weight has remained in the 176 lbs range since that time despite her consistent exercise regimen and calorie restricted diet.

Further record review on April 21, 2011 at 11:32 a.m. revealed Client #3's October 16, 2010 Nutrition Assessment listed this client's Desired Body Weight (DBW) to be between 94 lbs - 124 lbs. As of the date of survey, Client #3 weighed 177.5 lbs.

Interview with the QDDP and the Supervisory RN on April 21, 2011 at 12:30pm revealed they have

W 460

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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W 460 Continued From page 19  
not done anything different since the current weight management plan was initiated in 2002. There was no evidence presented or on file during the survey that indicated how her additional caloric intake was being managed. There was also no evidence that the staff was accurately monitoring and documenting Client #3's caloric intake to ensure she only received her prescribed dietary restriction of a "1000 cal" per day.

W 460

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>	
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I 000	INITIAL COMMENTS  A licensure survey was conducted from April 20, 2011 through April 21, 2011. A sample of three residents was selected from a population of two men and three women with various cognitive and intellectual disabilities.  The findings of the survey were based on observations and interviews with staff and residents in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	I 000	
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE  Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.  This Statute is not met as evidenced by: Based on observation and staff interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure all blinds in all rooms were in good repair for one of three clients in the sample. (Client #3)  The findings include:  Observation on April 20, 2011 at approximately 10:40 a.m. revealed the blinds in Resident #3's bedroom were broken and in poor condition. Interview with the qualified intellectual disability professional (QIDP) on the same day at the same time confirmed the poor condition of the blinds. The QIDP indicated she would have the blinds replaced immediately to correct the oversight.  The facility failed to ensure all blinds in all rooms remained in good repair.	I 022	I 022 Blinds have been changed QDDP/HM will continue to complete environmental QA audits as per Metro Homes P&P. See attached -- in service record  5/16/11

Health Regulation Administration

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

STATE FORM

6899

8LW011

If continuation sheet 1 of 11

*Swan Sloan*

*VP Operations*

(X6) DATE  
*5/16/11*

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
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I 042	Continued From page 2  Resident #1 should have received a 1/2 cup of noodles and a cup of skim milk. Review of the resident's nutritional assessment dated March 20, 2011, at approximately 3:30 p.m., revealed that his desirable body weight was (DBW) of 150 -192 lbs. Further review revealed the resident's current weight was 210 lbs.  Observations on April 20, 2011, revealed that facility staff served the resident twice the amount of noodles that were prescribed and failed to ensure he received fat free milk.	I 042		
I 090	<b>3504.1 HOUSEKEEPING</b>  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 staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure the maintenance and upkeep of the facility ' s environment as required by this section.  The finding includes:  1. The facility failed to ensure all window screens were in place and in good condition. Two of the windows on the main level were without a window screen (dining room, Resident #3 ' s bedroom window). 2. The dryer vent was bent and vented improperly back into the basement at the time of the survey. During the survey, the maintenance staff repaired the dryer vent and resolved the	I 090	<b>I 1090</b> 1. – The window screens were replaced. 2. – The dryer vent was replaced. 3. – The headboard was fixed and is secure. 4. – The bathroom drain is fixed and the water is draining well.  <b>QDDP/HM will continue to complete environmental QA audits as per Metro Homes P&amp;P.</b>	<b>5/16/11</b>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>	
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I 090	Continued From page 3  venting problem. 3. Resident #4 ' s headboard was broken and could be moved from side to side. 4. The drain in Bathroom #1 did not drain properly and it pooled up whenever the faucet was turned on.  The GHPID failed to ensure an effective system of monitoring and maintenance of the physical environment.	I 090		
I 135	3505.5 FIRE SAFETY  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.  This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities professional (GHPID) failed to hold evacuation drills quarterly on all shifts, for five of five residents residing in the GHPID. (Residents #1, #2, #3, #4, and #5)  The finding includes:  The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:  On April 20, 2011, at 12:29 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three designated shifts 8:00 a.m. - 4:00 p.m.; 4:00 p.m. -12:00 a.m. and 12:00 a.m. - 8:00 a.m. (Monday through Friday). Further interview revealed that there were two designated shifts 8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m. for the weekend	I 135	I 135 All staff were in serviced on Fire Drill and new schedule. In the future the QDDP and HM will ensure that fire drills are conducted at least quarterly on every shift. The QDDP/HM will ensure that this is done as part of the monthly QA audit system at Metro Homes. See attached in service record and fire drill schedule	5/16/11

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
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I 135	Continued From page 4 (Saturday/Sunday).  Review of the GHPID's fire drill log records on April 20, 2011, at approximately 12:32 p.m. revealed no documented drills were held during the weekday morning shift (8:00 a.m. - 4:00 p.m.; ) from March 2010 through May 2010. In addition, there were no documented fire drills held during the weekday overnight shift (12:00 a.m. - 8:00 a.m.) from June 2010 through November 2010. This was acknowledged by the GHPID's QDDP (HM) on April 21, 2011, at approximately, at 12:30 p.m.	I 135		
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 staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that three of sixteen staff secured an annual health screening to ensure the health and safety of its residents. [Staff #5, #7 and #13]  The findings include:  1. Review of Staff #5 personnel record on April 21, 2011 at approximately 2:05 p.m. revealed there was no evidence that a communicable disease screening was completed over the past	I 206	<b>I 206</b> 1. – Physical exam had been completed but not filed. 2. - Physical exam had been completed but not filed 3. - Physical exam had been completed but not filed.  In the future, QDDP/HM will continue to complete HR QA audits as per Metro Homes P&P.	<b>5/16/11</b>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>	
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I 206	Continued From page 5  licensure year. 2. Review of Staff #7 personnel record on April 21, 2011 at approximately 2:15 p.m. revealed there was no evidence that a communicable disease screening was completed over the past licensure year. 3. Review of Staff #13 personnel record on April 21, 2011 at approximately 2:20 p.m. revealed there was no evidence that either a communicable disease or a health certification was completed over the past licensure year.  Interview with the facility 's qualified developmental disability professional (QDDP) on April 21, 2011 at approximately 2:10 p.m. confirmed the above findings. The QDDP indicated she would meet with the human resources department and resolve the discrepancies.	I 206		
I 229	3510.5(f) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;  This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that staff received training on all facets of behavior intervention, including crisis procedures (blocks and/or restraints), for one of the three residents in the sample. (Resident #2)  The finding includes:	I 229	I 229  All staff were scheduled for training in CPI on 5/16/11 for 3 days. They should complete certification by 5/31/11.  In the future the QDDP will ensure that all staff who are assigned to a home with individuals who have aggressive and self injurious behaviors -- be trained in CPI, so as to promote safety procedures during crisis prevention.  See attached -- list of employees being trained in CPI	5/31/11

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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I 229	Continued From page 6  On April 21, 2011, at 9:30 a.m., review of Resident #2's psychiatric and psychological records revealed that she had a Behavior Support Plan (BSP), dated January 18, 2011, to address target behaviors of aggression (hit, pinch and scratch others; push over or throw objects) and agitation (hollering, pacing, stomping her feet). The BSP included "Crisis Intervention - In the event that <client's name> has a behavioral crisis, staff must follow the crisis procedures as outlined in Metro Home's policy and procedures manual. Staff must be trained and prepared to use approved blocks and/or restraints to prevent injury, coupled with verbal and physical redirection... nonviolent crisis intervention should be used only as a last resort."  On April 21, 2011, at 2:47 p.m., the qualified intellectual disabilities professional (QIDP) stated that the agency used "CPI, Crisis Prevention Institute" for certifying staff training. She agreed to provide documentation of staff training in CPI. At 5:28 p.m., review of the documentation presented revealed that six (6) out of sixteen (16) employees had received CPI training. The house manager (HM) confirmed this, stating that "only the one-to-ones have been trained for CPI." At 5:33 p.m., the QIDP expanded on what the HM said, adding that the "one-to-one staff here do not take care of anyone" other than Client #1. If Client #2 were in crisis, the staff currently certified in CPI (and assigned to Client #1) would not be available to intervene. The QIDP stated her intention to have additional staff receive training in CPI.	I 229		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS	I 260		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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I 260	Continued From page 7  Each Residence Director shall maintain current and accurate records and reports as required by this section.  This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all staffs' personnel records remained updated and accurate.  The findings include:  The personnel records for Staff #5, #7, and #13 which were presented at the time of survey failed to reflect an accurate health screening history. Interview with the facility's qualified intellectual disability professional (QDIP) on April 21, 2011 at approximately 2:10 p.m. confirmed the above findings. The QDIP indicated she would meet with the human resources department and resolve the discrepancies.	I 260	I 260  1. - Physical exam had been completed but not filed. 2. - Physical exam had been completed but not filed 3. - Physical exam had been completed but not filed.  In the future, QDDP/HM will continue to complete HR QA audits as per Metro Homes P&P.	5/16/11
I 291	3514.2 RESIDENT RECORDS  Each record shall be kept current, dated, and signed by each individual who makes an entry.  This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) ensured that entries made in resident records included a signature and date, except in the case of psychotropic medication review forms, for four of the five residents of the facility. (Residents #1, #2, #3 and #4)  The finding includes:  During the Entrance conference on April 20,	I 291		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
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I 291	<p>Continued From page 8</p> <p>2011, at 9:15 a.m., the qualified intellectual disabilities professional (QIDP) and the registered nurse (RN) stated that Residents #1, #2, #3 and #4 routinely received psychotropic medications.</p> <p>On April 21, 2011, review of Resident #2's psychiatric record revealed that the facility's Psychotropic Medication Review (PMR) team had documented reviews of her behavioral status and medication regimen on a monthly basis throughout the preceding year. The most recent PMR forms were for meetings held on January 4, 2011, February 1, 2011, March 1, 2011 and April 5, 2011.</p> <p>On April 21, 2011, at 1:40 p.m., the RN stated that she had not been in attendance at the meetings held February 1, 2011 and March 1, 2011. When asked about her signatures that were on the forms dated February 1, 2011 and March 1, 2011, she explained that she had signed on a later date, to signify that she agreed with the decisions made by the others who were present. She acknowledged that she had not included a date at the time that she signed the form. She further indicated that she was not sure when she had reviewed the PMR form and signed it.</p> <p>At approximately 4:50 p.m., interview with the qualified intellectual disabilities professional (QIDP) confirmed that sometimes PMR team members were not present for the meeting/discussion but signed the PMR form on a later date to signify his/her approval. She further indicated that the primary care physician (PCP) routinely did not attend meetings but signed the PMR forms afterwards to document her approval. After reviewing the PMR forms, the QIDP acknowledged that they only reflected the</p>	I 291	<p>I 291 The RN was in serviced on appropriate documentation and the importance of a date accompanying every signed document or note. In the future the QA Dept. will ensure that all consult reviews are signed and dated by the PCP and the RN or LPN.</p>	5/16/11

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
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I 291	Continued From page 9  meeting date. She also acknowledged that the PCP's and RN's signatures did not also reflect the date on which they made their entries.	I 291		
I 422	<b>3521.3 HABILITATION AND TRAINING</b>  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with intellectual Disabilities (GHPID) failed to ensure that residents received training, habilitation and assistance as prescribed in their Individual Support Plan, for one of the three residents in the sample. (Resident #2)  The finding includes:  [Cross-refer to Federal Deficiency Report - Citation W249] Resident #2 was observed in her home on April 20, 2011. The resident displayed one of her targeted maladaptive behaviors (screaming) almost continuously from 7:22 a.m. - 8:50 a.m. After she returned from day program that day, the resident displayed two of her targeted maladaptive behaviors (screaming and/or stomping her feet) continuously from 3:53 p.m. - 4:07 p.m. and from 4:22 p.m. - 5:35 p.m.  Resident #2's Psychological Evaluation, dated January 11, 2011, and Behavior Support Plan (BSP), dated January 18, 2011, were reviewed on April 21, 2011, beginning at 9:14 a.m. The psychologist documented a "history of... hollering and stomping of her feet."  At 9:50 a.m., continued review of Resident #2's	I 422	<b>I 422</b> All staff and HM / QDDP have been in serviced on the individual's BSP and use of communication book. In the future the QDDP and HM will ensure that all staff at the residential and day program follow the BSP and utilize the communication book as recommended in the BSP. See attached – in service record and data collection record	5/16/11

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>	
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I 422	<p>Continued From page 10</p> <p>BSP revealed that staff had been observed on the day before implementing some of the interventions outlined in the plan (i.e. inform her of changes in schedule, prompt her to take a walk, rub her shoulders gently, have her sit in her favorite chair, and call her name in a firm voice and redirect her if she becomes agitated). However, there were other interventions that were prescribed but were not observed being used. Specifically, the BSP said staff should prompt the resident "to use signs and/or picture book to express herself" because she had "limited communication skills." The BSP also said the resident should "practice self-soothing/ calming activities to reinforce her ability to calm himself &lt;sic&gt; down." At no time on April 20, 2011 were staff (in the home or at day program) observed encouraging Resident #2 to use signs or a picture book to express herself.</p> <p>On April 21, 2011, at 2:23 p.m., interview with the HM revealed that the psychologist had trained staff on Resident #2's BSP within the past two or three months. When asked what intervention techniques should staff use, he outlined the techniques that were observed being implemented on the day before. At 2:28 p.m., the QIDP indicated that Resident #2 would sometimes "go days without any sign of agitation." She further stated that the prolonged behavioral outbursts observed on April 20, 2011 had been more intense than usual.</p> <p>At 4:40 p.m., the QIDP was asked about Resident #2 signing and/or using a picture book. She said she did not think the resident would have cooperated had staff asked her to sign or use a picture book. She said the picture book that was kept stored "in a cabinet." She acknowledged that the picture book had not been presented to</p>	I 422		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
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I 422	Continued From page 11  her on the day before. When asked about "self-soothing techniques," the QIDP described techniques staff used to help soothe the resident. When asked again whether Resident #2 had programming opportunities to practice self-soothing/ calming activities to reinforce her ability to remain calm, the QIDP replied "no."	I 422		
I 470	<b>3522.1 MEDICATIONS</b>  Drugs shall be administered as set forth in the User Of Trained Employees to Administer Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1994, D.C. Code, sec. 21-1201 et seq.  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 that all drugs, including prescribed topical ointments, were administered only by a Trained Medication Employee (TME) and/or a licensed nurse, for one of the five residents of the facility. (Resident #1)  The finding includes:  The morning medication pass was observed on April 20, 2011, beginning at 7:44 a.m. At 8:15 a.m., the trained medication employee (TME) held a clear plastic medicine cup in her left hand while she poured Enulose stool softener from a bottle in her right hand. She placed the cup on the table in front of Resident #1 and indicated that she was ready to begin administering his medications. Observation of the medicine cup (while placed on the table top) revealed that there were 18 ml of liquid poured. According to the TME (and the label on the prescription bottle)	I 470	<b>I 470</b> The TME was in serviced on Policy and Procedure – Medication Administration In the future the RN and LPN will ensure that there is adequate and appropriate monitoring of the TMEs administering medications as per Metro Homes P&P and QA requirements. See attached – TME – QA record and in service – Medication P&P	<b>5/16/11</b>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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I 470	Continued From page 12  Resident #1's physician had ordered 15 ml.  After she was informed that there was too much Enulose in the cup, the TME raised the cup to eye level again, examined it and stated that it was "ok" and returned the cup to the table. Before she began the administration process, she was asked to examine it while placed on a level surface. She leaned over, hesitated, then stated it was "difficult to see." After a brief pause, it was suggested that perhaps there was another level surface available. She paused.  This surveyor then determined there was a shelf in the medicine closet that was at eye level and had brighter lighting than at the dining room table. The TME placed the cup on the shelf, examined it again and acknowledged that there was more than 15 ml. She removed 3 ml, said "thank you" and then administered Resident #1 his medications.  At 9:39 a.m., interview with the registered nurse revealed that she had observed the same TME two days earlier at which time she had not identified any deficient practices.  This is a repeat deficiency.  _____  See Federal Deficiency Report, dated February 20, 2010 - Citation W369.	I 470			
I 500	3523.1 RESIDENT'S RIGHTS  Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal	I 500			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
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I 500	Continued From page 13  laws.  This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHPID failed to demonstrate how the rights of all residents were protected and failed to allow and encourage individual residents to exercise their rights as residents of the GHPID, and as citizens of the United States, for four of five residents residing in the GHPID. (Residents #2, #3, #3, and #4)  The finding includes:  1. The GHPID failed to ensure residents' rights were protected by making certain each resident involved family members and/or legally sanctioned medical guardian representative assisted them with making decisions, as evidenced below:  On April 20, 2011, at 9:29 a.m., review of an internal investigation report dated April 9, 2010, revealed that on April 7, 2010, Resident #1's one to one staff reported that the resident had left the GHPID without a staff escort while the staff person went to the kitchen. The police was notified and a missing person's report was filed. Further review of the investigative findings revealed that due to Resident #1's history of leaving the home without staff, it was recommended that the GHPID's management team consider placing alarms [back] on the doors upstairs.  On April 20, 2011, at 10:00 a.m., interview with the qualified intellectual disabilities professional (QIDP) (who had conducted the investigation)	I 500	<b>I 500</b>  An emergency HRC meeting was scheduled and approvals for the door bell were obtained. All individuals' guardians have given their consent for the usage of the doorbell. In the future the QDDP will ensure that each individual's rights are protected. QDDP has been in serviced on HRC / restriction of rights etc. policy and procedures. See attached – consents – HRC and guardian	5/16/11

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>	
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I 500	<p>Continued From page 14</p> <p>revealed that a door alarm was placed on the side door in the dining room. Further interview revealed that the door alarm was off during the day time because it was too loud. The QIDP also added that the human rights committee (HRC) had approved. The QIDP's interview was confirmed through review of the GHPID's HRC minutes dated April 28, 2010 on April 21, 2011, at approximately 11:05 a.m.</p> <p>On April 21, 2011, at approximately 11:20 a.m., continued interview with the QIDP revealed that Resident #1's housemates were informed verbally of the new alarm that was placed on the side door. When asked whether Resident #1's housemates' legal guardians and/or involved family members were involved in the decision making process regarding the door alarm, the QIDP replied that she believed they were. She then acknowledged that there was no written documentation available for review to verify that they had been involved.</p> <p>Note: It should be noted that on April 20, 2011, at approximately 1:30 p.m., direct care staff was observed to open the side door. The alarm was extremely loud.</p> <p>2. The facility failed to ensure residents' rights were protected by making certain each resident involved family members and/or legally sanctioned medical guardian representative assisted them with making decisions, as evidenced below:</p> <p>On April 20, 2011, at 9:29 a.m., review of an internal investigation report dated April 9, 2010,</p>	I 500		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
I 500	<p>Continued From page 15</p> <p>revealed that on April 7, 2010, Resident #1's one to one staff reported that the resident had left the facility without a staff escort while the staff person went to the kitchen. The police was notified and a missing person's report was filed. Further review of the investigative findings revealed that due to Resident #1's history of leaving the home without staff, it was recommended that the facility's management team consider placing an alarm on the side door upstairs.</p> <p>On April 20, 2011, at 10:00 a.m., interview with the qualified intellectual disabilities professional (QIDP) (who had conducted the investigation) revealed that a door alarm was placed on the side door in the dining room. Further interview revealed that the door alarm was off during the day time because it was "too loud". The QIDP also added that the human rights committee (HRC) had approved the use of the alarm. The QIDP's interview was confirmed through review of the facility's HRC minutes dated April 28, 2010, on April 21, 2011, at approximately 11:05 a.m.</p> <p>On April 21, 2011, at approximately 11:20 a.m., continued interview with the QIDP revealed that Resident1's housemates' had involved family members and/or court appointed legal guardians to assist them with decision making. Further interview with the QIDP revealed that Residents #1's housemates were informed verbally of the new alarm that was placed on the side door. When asked whether Resident #1's housemates' legal guardians and/or involved family members were involved in the decision making process regarding the door alarm, the QIDP replied that she believed they were. She then acknowledged that their was no written documentation available for review to verify that they had been involved.</p>	I 500	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	<p>Continued From page 16</p> <p>Note: It should be noted that on April 20, 2011, at approximately 1:30 p.m., direct care staff was observed to open the side door. The alarm was extremely loud.</p> <p>3. The facility failed to ensure Resident #1's right to receive a full meal as prescribed, as evidenced below:</p> <p>On April 27, 2011, Resident #2 was observed eating lunch, beginning at 12:32 p.m. The meal ended with fruit cocktail. At 12:43 p.m., the direct support staff person (DPS1), who had been with the resident throughout the meal, was observed spoon feeding Resident #2 fruit cocktail. [Note: The resident had been observed feeding herself independently earlier.] At 12:44 p.m., DPS1 walked away from the table holding the cup of fruit cocktail, which remained approximately half full, and threw the rest of the fruit cocktail into a trash receptacle. The resident had not been observed refusing to eat the dessert before it was discarded. At 1:00 p.m., the day program's director and their nurse expressed dismay that the resident was not allowed to complete her meal.</p>	I 500		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
R 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from April 20, 2011 through April 21, 2011. A sample of three residents was selected from a population of two men and three women with various cognitive and intellectual disabilities.</p> <p>The findings of the survey were based on observations and interviews with staff and residents in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.</p>	R 000	

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

*Shawn T. Sloan*

TITLE

*VP Operations*

(X6) DATE

*5/16/11*