

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from May 11, 2010 through May 14, 2010. A sample of three clients was selected from a population of two men and three women with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process; however, due to concerns in the areas of incident reporting, the process was extended on May 14, 2010, at 11:40 a.m., to review the facility's level of compliance in the Condition of Participation (CoP) for Client Protections.</p> <p>The findings of the survey were based on observations, interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports.</p>	W 000	<p><i>Received 6/5/10</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 120	<p><b>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</b></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 interview and record review, the facility failed to ensure that outside services met the needs of one of the three sampled clients. (Client #1)</p> <p>The finding includes:</p> <p>Client #1 was observed at his day program on May 12, 2010, beginning at 9:53 a.m. At 11:38 a.m., review of the client's day program active treatment program, dated August 14, 2009, revealed an objective for him to participate in one community outing per month. His record,</p>	W 120	<p>W 120</p> <p>In the future the day program will send a monthly recreation schedule to the QMRP. The QMRP will continue with her monthly day program visits, to ensure that recreational activities are completed as documented on the schedule. In addition, the QMRP will document the individual's outings at the day program – in her monthly QMRP progress note.</p>	6/5/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gwan D. Sloan</i>	TITLE <i>VP Operations</i>	(X6) DATE <i>6/5/10</i>
---	-------------------------------	----------------------------

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.

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 120	<p>Continued From page 1</p> <p>however, indicated that his most recent outing was in November 2009. At approximately 11:45 a.m., interview with the day program case manager and Client #1's direct support staff confirmed that he had not been on an outing in the past 5 months. The case manager cited inclement weather in February. The direct support staff did not offer an explanation. He and the case manager both indicated that transportation services were available.</p> <p>On May 14, 2010, at 10:20 a.m., the qualified mental retardation professional (QMRP) was asked if she knew whether Client #1 had been going on community outings in accordance with his day program IPP. She thought he had gone "mostly on rides in the van" since the February blizzards. When asked if day program outings were documented, she replied that they sent her quarterly reports. She then acknowledged, however, that the reports only provided generic statements regarding outings. Further interview revealed that the QMRP had visited Client #1's day program monthly, through March 2010.</p> <p>Moments later, at 10:27 a.m., review of the forms on which the QMRP had documented her day program visits, dated December 16, 2009, January 18, 2010, February 22, 2010 and March 26, 2010 revealed no problems were identified. On each form, the QMRP had placed a checkmark indicating that the "individual's needs were being met," even though interview with day program staff confirmed that he had not been on a community outing monthly, as prescribed in his August 14, 2009 treatment plan.</p> <p>There was no evidence that the facility had effectively monitored the services being provided</p>	W 120		
-------	--	-------	--	--

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
W 120	Continued From page 2 by Client #1's day program, to ensure that his programs were implemented as written.	W 120		
W 124	<p><b>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish a system to ensure that each client or his/her authorized surrogate healthcare decision-maker, was informed of the client's medical condition and proposed change in treatment plans, for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On May 11, 2010, at approximately 4:43 p.m., interview with the qualified mental retardation professional (QMRP), the registered nurse (RN) and the licensed practical nurse (LPN) coordinator revealed that Client #3 was receiving Paxil for treatment of obsessive compulsive disorder. She also received Zyprexa for schizophrenia. They stated that beginning in January 2010, her Zyprexa was titrated, as recommended by the psychiatrist and psychotropic medication review team. The client's mental and emotional status reportedly had shown improvement, with no behavioral incidents in several months. Further interview</p>	W 124	<p><b>W124</b></p> <p>In the future the QMRP, RN and LPN will ensure that family members are notified of all medication changes and due process is completed in compliance with HRC policy and procedures - protection of client's rights. They will ensure that medication changes will not be processed till proper consent and HRC procedures are followed.</p> <p>The QMRP, RN and LPN were in serviced on P&amp;P – HRC, Client abuse, client protection and client rights.</p>	6/5/10

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 124	<p>Continued From page 3</p> <p>revealed that approximately two weeks after Client #3 received her last dose of Zyprexa on April 6, 2010, she began hallucinating and making false accusations of abuse. In response, the psychiatrist wrote a new prescription for Zyprexa on April 26, 2010. They also stated that the client's father, her designated healthcare decision-maker, had agreed to her starting Zyprexa again on April 26, 2010.</p> <p>On May 11, 2010, at approximately 5:45 p.m., review of Client #3's individual Support Plan (ISP) and Psychological Evaluation, both dated November 30, 2009, revealed that her diagnoses included moderate mental retardation in adaptive skills, mild cognitive mental retardation and undifferentiated schizophrenia. The documents confirmed that Client #3's father was the designated healthcare decision-maker due to her impaired ability to process information. On May 13, 2010, beginning at 2:32 p.m., review of the client's Psychotropic Medication Review forms, Physician's Orders and Medication Administration Records from January 2010 - April 2010 verified the graduated titration of Zyprexa between January 13, 2010 - April 6, 2010 and re-introduction of Zyprexa, effective April 26, 2010. Review of consent forms verified that her father consented to increases and/or reintroduction of medications. Further review of the client's record, however, failed to show evidence that her father was consulted about his daughter's mental status in January 2010, before the medical team began titrating the Zyprexa.</p> <p>On May 13, 2010, beginning at 3:40 p.m., follow-up interview with the QMRP, RN and LPN Coordinator revealed that as a practice, the facility contacted Client #3's father (and other</p>	W 124		
-------	---	-------	--	--

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 124 Continued From page 4  
clients' surrogate healthcare decision-makers) only if/when a physician proposed introduction of a new medication, or if there was a recommendation to significantly increase the dosage of an existing medication. They acknowledged that the facility had not informed the father of Client #3's improved mental status in January 2010 or discussed with him the potential risks and benefits associated with proposed changes to her psychotropic medication regimen.

W 124

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by: Based on observation, interview and review of incident reports and investigations, the facility failed to ensure that all allegations of abuse or neglect and injuries of unknown origin were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA), for two of the five clients residing in the facility. (Clients #3 and #4)

The findings include:

1. During the Entrance Conference on May 11, 2010, at 4:38 p.m., the qualified mental retardation professional (QMRP) stated that Client #3 had been visibly upset upon her return home from day program on the afternoon of April

W 153

W153  
In the future the agency will ensure that P&P of Incident Management is followed.  
The QMRP, RC and 1 staff were re in-serviced on P&P of Incident Management reporting and documentation procedures.

6/5/10

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE	
W 153	<p>Continued From page 5</p> <p>21, 2010. When she asked if there was something wrong, the client alleged that a male staff at her day program "tried to touch" her vagina while she used a restroom earlier that day. The QMRP then telephoned the day program to report the client's allegation. A pre-survey review of incidents had revealed that the incident was first reported to the State agency on April 30, 2010, nine days after Client #3 made the allegation. At 4:51 p.m., the QMRP confirmed this, stating that the incident happened "at the day program... the day program would file the incident report... It's not our incident."</p> <p>2. A pre-survey review of incidents revealed that on Thursday, February 25, 2010, the facility reported an injury of unknown origin that was first discovered by staff on Monday, February 22, 2010. According to the incident report, a direct support staff reported for duty and shortly thereafter, at 8:15 a.m., she "discovered a black blister" on Client #4's "right finger." The staff notified her immediate supervisor, who then alerted a nurse. The incident report reflected that at 9:30 a.m., the nurse assessed her hand, provided first aid and notified the primary care physician. The cause of the injury was not indicated at the time. On May 11, 2010, beginning at 6:49 p.m., further review of the incident report and the corresponding investigation report, dated March 5, 2010, revealed the following deficient practices:</p> <p>a. The facility reported the injury of unknown origin to the State agency three days after the discovery.</p> <p>b. The facility's administrator was notified on February 24, 2010, two days after the injury was</p>	W 153			

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
W 153	<p>Continued From page 6 discovered.</p> <p>c. The facility's incident management coordinator (IMC) was notified of the injury on February 23, 2010, at 1:00 p.m., more than 24 hours after the staff person had discovered the "black blister."</p> <p>d. The QMRP documented having interviewed staff on February 24, 2010. Based on information obtained through those interviews, the facility changed its categorization of the incident to that of "neglect." The facility, however, failed to notify the State agency of the allegation of neglect.</p> <p>[Note: The internal investigation substantiated the allegation of neglect. As a result, the provider terminated the employment of one direct support staff person who had worked on February 21, 2010, and took disciplinary action against four additional employees for failing to report injuries/incidents timely.]</p>	W 153		
W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations of injuries of unknown origin to the administrator within five working days of the incident, for one of one client involved in such an incident. (Client #4)</p> <p>The finding includes:</p>	W 156	<p>W156</p> <p>In the future the agency will ensure that P&amp;P of Incident Management is followed. The QMRP, RC and 1 staff were re in-serviced on P&amp;P of Incident Management reporting and documentation procedures.</p>	6/5/10

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 156	Continued From page 7	W 156		
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on 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 #3 and #4)</p> <p>The findings include:</p> <p>1. The QMRP failed to ensure that Client #4's behavior support plan (BSP) and data collection was reflective of all known maladaptive behaviors, as follows:</p> <p>On May 12, 2010, at approximately 7:17 a.m., Client #4 reached towards Client #1, who was seated next to her in the living room, and stuck her fingers into Client #1's mouth. It was a quick poke into his mouth. The two staff who were</p>	W 159	<p>W159 All staff was in-serviced on BSP and documentation on data records. In the future the RC and the QMRP will ensure that a review of documentation on all IPP data sheets is done at least 3x/week.</p>	6/5/10

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
W 159	<p>Continued From page 8 present in the room did not respond.</p> <p>On May 14, 2010, at 2:23 p.m., the qualified mental retardation professional (QMRP) and the RN were asked whether Client #4's targeted maladaptive behaviors included poking her hand into other individuals' mouths or faces. They replied "yes." The further indicated that it was one of her known forms of physical aggression.</p> <p>A few minutes later, at 2:30 p.m., review of Client #4's behavior support plan (BSP), dated February 12, 2010, revealed that physical aggression was a targeted behavior. The BSP did not, however, define "physical aggression." Subsequent review of her behavior data sheets revealed that physical aggression was defined as "head butting, hitting others, pulling someone's nose, scratching someone." The BSP and data collection forms did not reflect the behavior observed (sticking her fingers or hand in another individual's mouth).</p> <p>Review of Client #4's behavior data sheets revealed that staff had not documented the incident of her poking Client #1 in the mouth that occurred on May 12, 2010. Follow-up interview with the QMRP revealed that she expected staff to document such behavior. There was no column designated for documenting sticking her fingers or hand in another individual's mouth.</p> <p>2. The QMRP failed to ensure that staff maintained accurate data regarding Client #3's sleeping pattern, as follows:</p> <p>Cross-refer to W124. Review of an incident report dated April 21, 2010, followed by interviews with staff in the home and at day program, revealed that Client #3's mental health status had</p>	W 159		

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 159	<p>Continued From page 9</p> <p>deteriorated in late-April. The client had received Zyprexa for the treatment of schizophrenia, until it was titrated and discontinued, effective April 6, 2010. The QMRP, RN and LPN Coordinator stated that the titration was based on the recommendation of the psychiatrist and psychotropic medication review team.</p> <p>On May 13, 2010, at approximately 3:00 p.m., review of Client #3's Psychotropic Medication Review (PMR) forms revealed that on March 2, 2010, the PMR team instructed the facility to maintain a "Sleep Chart." The PMR form dated April 6, 2010, included: "Sleep Chart, Accurate Data." The PMR form dated May 4, 2010 indicated "Sleep Chart needed."</p> <p>On May 14, 2010, at approximately 9:35 a.m., review of Client #3's records revealed that a sleep chart was initiated, beginning on March 3, 2010. Staff were to document her sleep/behavioral status every hour throughout the night. Review of the sleep charts, however, revealed that staff had not maintained consistent, accurate data, as follows: There was no sleep chart data available for March 15, 16, 22, 23, and 24, 2010. There was no sleep chart data recorded on April 3, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25 and 26, 2010. At approximately 9:58 a.m., the QMRP stated that she was unable to locate a sleep chart for May 2010. She confirmed that Client #3's PMR team still wanted hourly sleep data for monitoring her mental status.</p> <p>There was no evidence that the facility ensured that accurate data was documented consistently in measurable terms.</p>	W 159		
-------	---	-------	--	--

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 252	<p><b>483.440(e)(1) PROGRAM DOCUMENTATION</b></p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>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 three of the five clients residing in the facility. (Clients #1, #3 and #4)</p> <p>The finding includes:</p> <p>On May 12, 2010, at 8:18 a.m., Client #1 approached Client #5 from behind while Client #5 was dancing with a staff person in the living room. Client #1 slapped Client #5 on the back of his head. The staff person dancing with Client #5 immediately responded by telling Client #1 "Stop, don't do that. You don't hit people. Be nice!"</p> <p>On May 14, 2010, at 2:00 p.m., the QMRP indicated that physical aggression was one of Client #1's targeted maladaptive behaviors. She presented Client #1's behavior support plan (BSP), dated September 4, 2009, for verification. Subsequent review of his behavior data sheets revealed that staff had not documented the incident of Client #1 slapping Client #5 on the back of the head on May 12, 2010.</p> <p>On May 14, 2010, at 2:40 p.m., interview with the QMRP confirmed that staff were expected to record targeted behaviors "whenever they see it."</p>	W 252	<p><b>W252</b></p> <p>All staff was in-serviced on documentation of IPP data records.</p> <p>In the future the RC and the QMRP will ensure that a review of documentation on all IPP data sheets is done at least 3x/week.</p>	6/5/10
-------	---	-------	--	--------

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

PRINTED: 05/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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) COMPLETION DATE	
W 252	Continued From page 11 It should be noted that on May 14, 2010, beginning at 2:05 p.m., review of staff in-service training records revealed that the staff who were present/involved in the above-cited behavioral incidents had received training. Training on BSPs, including documentation, presented by either the psychologist or the QMRP had been documented on November 24, 2009, March 10, 2010 and March 12, 2010. However, inconsistent data collection indicated that the training had not been effective.	W 252			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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
1 000	<b>INITIAL COMMENTS</b>  A licensure survey was conducted from May 11, 2010 through May 14, 2010. A sample of three residents was selected from a population of two men and three women with varying degrees of intellectual disabilities.  The findings of the survey were based on observations, 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.	1 000		
1 090	<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 observation and interview, the GHMRP failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for five of five residents in the facility. (Residents #1, #2, #3, #4 and #5)  The findings include:  Observation and interview with the facility's residential coordinator (RC) on May 13, 2010, beginning at 2:00 p.m. revealed the following:  Exterior:  1. There were cracks in the cement front walkway which could become a trip hazard. It should be noted that one of the residents was blind.	1 090	<b>1090</b>  1. Cracks in the cement walkway were fixed. 2. Bricks were replaced. 3. Boards in the fence were replaced. 4. Broken bricks in the porch were fixed. 5. All overhead soffit boards were repainted. 6. Screen door was fixed. 7. Ceiling tiles were replaced. 8. Grease was cleaned from kitchen fan. 9. Dresser drawers – all knobs were replaced.  In the future the QMRP will ensure that a monthly environmental QA is completed with accuracy and maintenance notification and correction, is completed in a timely manner.	<b>6/5/10</b>

Health Regulation Administration

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

STATE FORM

*Gusman J. Sloan*

*VP Operations*

TITLE

(X6) DATE  
**6/5/10**

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>	
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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
1 090	<p>Continued From page 1</p> <p>2. Bricks in the front gate archway were crumbling.</p> <p>3. There were rotted boards along the top portion of the wooden fence that separated the side yard from that of their neighbors.</p> <p>4. There were broken bricks on the front porch landing.</p> <p>5. There was chipped and peeling paint on the front porch overhead soffit boards.</p> <p>Interior:</p> <p>6. A closure pump on the screen door leading from the basement to the side yard was not working properly. The door slammed each time that it was used.</p> <p>7. There were ceiling tiles missing in the room used for dry storage.</p> <p>8. There was an accumulation of grease on the ventilation fan in the kitchen.</p> <p>9. There were knobs missing from bedroom dresser drawers used by Residents #1, #2, and #3.</p> <p>The RC acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.</p>	1 090		
1 379	<p>3519.10 EMERGENCIES</p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other</p>	1 379		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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 379	<p>Continued From page 2</p> <p>unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interviews and review of incident reports and investigations, the facility failed to ensure that all allegations of abuse or neglect and other incidents that placed resident health and safety at risk were reported immediately to the Department of Health, Health Regulation and Licensing Administration (HRLA), for two of the five residents residing in the facility. (Residents #3 and #4)</p> <p>The findings include:</p> <p>1. During the Entrance Conference on May 11, 2010, at 4:38 p.m., the qualified mental retardation professional (QMRP) stated that Resident #3 had been visibly upset upon her return home from day program on the afternoon of April 21, 2010. When she asked if there was something wrong, the resident alleged that a male staff at her day program "tried to touch" her vagina while she used a restroom earlier that day. The QMRP then telephoned the day program to report the resident's allegation. A pre-survey review of incidents had revealed that the incident was first reported to the Department of Health on April 30, 2010, nine days after Resident #3 made the allegation. At 4:51 p.m., the QMRP confirmed this, stating that the incident happened "at the day program... the day program would file</p>	I 379	<p>I379 In the future the agency will ensure that P&amp;P of Incident Management is followed. The QMRP, RC and 1 staff were re in-serviced on P&amp;P of Incident Management reporting and documentation procedures.</p>	6/5/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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 379	<p>Continued From page 3</p> <p>the incident report... It's not our incident."</p> <p>2. On May 12, 2010, beginning at 2:22 p.m., interview with a nurse at Resident #3's day program revealed that on Friday, April 30, 2010, emergency 911 was called in response to the resident's behavior. The nurse and the day program's Senior Supervisory Behavior Active Treatment Specialist described a scenario where the resident's behavior was erratic and potentially dangerous. The incident occurred both inside the day program as well as outside at the GHMRP's van.</p> <p>Later that day, beginning at 4:17 p.m., the Residential Coordinator (RC) was interviewed about the April 30, 2010 incident outside the day program. She confirmed that the resident's behavior was erratic and she had repeatedly refused to get on the facility van. She also confirmed that 911 was called. Emergency Medical Services technicians conducted a partial assessment, which ended when the resident became assaultive.</p> <p>On May 14, 2010, follow-up interviews with the RC and the QMRP, at 10:31 a.m. and 10:38 a.m. respectively, confirmed that the incident involving Emergency Medical Services had not been reported to the Department of Health prior to this survey.</p> <p>It should be noted that the RC's interview indicated that two male staff from the day program applied what was later deemed "inappropriate use of physical restraints" during the April 30, 2010 incident at the van. According to the RC, the staff carried the resident, each holding a leg, and placed her in the van, despite the resident's requests to go back into the day</p>	I 379		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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 379	Continued From page 4  program building. It should be further noted, however, that there was no indication that the resident sustained any physical injuries during the incident.  3. A pre-survey review of incidents revealed that on Thursday, February 25, 2010, the facility reported an injury of unknown origin that was first discovered by staff on Monday, February 22, 2010. According to the incident report, a direct support staff reported for duty and shortly thereafter, at 8:15 a.m., she "discovered a black blister" on Resident #4's "right finger." On May 11, 2010, beginning at 6:49 p.m., review of the corresponding investigation report, dated March 5, 2010, revealed that the incident had been re-categorized as "neglect" based on information obtained through staff interviews. Staff reportedly had fried fish in the facility on Sunday, April 21, 2010, which was not in accordance with the menu. The investigation report noted that "the injury could likely have been sustained from being burned, as the description of it was a blister (blackish in color) on right index finger... circumstances may have contributed to <resident's name> sustaining her injury." The facility, however, failed to notify the Department of Health to the allegation of neglect. [Note: The facility's internal investigation substantiated the allegation of neglect and 5 employees received disciplinary actions.]	I 379		
I 454	3521.9 HABILITATION AND TRAINING  Each GHMRP, in addition to the above provisions, shall assist each resident in obtaining placement in an appropriate educational, employment, or daytime training program; Provided, that the placement shall be consistent with the resident 's Individual Habilitation Plan.	I 454		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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 454	Continued From page 5  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents received appropriate daytime training program services, for one of the three sampled residents. (Resident #1)  The finding includes:  Resident #1 was observed at his day program on May 12, 2010, beginning at 9:53 a.m. At 11:38 a.m., review of the resident's day program active treatment program, dated August 14, 2009, revealed an objective for him to participate in one community outing per month. His record, however, indicated that his most recent outing was in November 2009. At approximately 11:45 a.m., interview with the day program case manager and Resident #1's direct support staff confirmed that he had not been on an outing in the past 5 months. The day program case manager cited inclement weather in February 2010. The day program direct support staff did not offer an explanation. He and the case manager both indicated that transportation services were available.  On May 14, 2010, at 10:20 a.m., the qualified mental retardation professional (QMRP) was asked if she knew whether Resident #1 had been going on community outings in accordance with his day program IPP. She thought he had gone "mostly on rides in the van" since the February blizzards. When asked if day program outings were documented, she replied that they sent her quarterly reports. She then acknowledged, however, that the reports only provided generic statements regarding outings. Further interview revealed that the QMRP had visited Resident	I 454	I 454  In the future the day program will send a monthly recreation schedule to the QMRP. The QMRP will continue with her monthly day program visits, to ensure that recreational activities are completed as documented on the schedule. In addition, the QMRP will document the individual's outings at the day program – in her monthly QMRP progress note.	6/5/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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
1454	Continued From page 6  #1's day program monthly, through March 2010.  Moments later, at 10:27 a.m., review of the forms on which the QMRP had documented her day program visits, dated December 16, 2009, January 18, 2010, February 22, 2010 and March 26, 2010 revealed no problems were identified. On each form, the QMRP had placed a checkmark indicating that the individual's needs were being met, even though he wasn't going on community outings as prescribed in his annual plan.  There was no evidence that the facility had effectively monitored the services being provided by Resident #1's day program, to ensure that his programs were implemented as written.	1454		
1500	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 laws.  This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for one of the three residents in the sample. (Resident #3)  The finding includes:	1500		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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 7</p> <p>The facility failed to protect residents' rights by not informing the residents' medical guardians of changes in their condition and recommended changes to their psychotropic medication regimen for behavior management and/or treatment of mental health disorders [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)], as follows:</p> <p>On May 11, 2010, at approximately 4:43 p.m., interview with the qualified mental retardation professional (QMRP), the registered nurse (RN) and the licensed practical nurse (LPN) coordinator revealed that Resident #3 was receiving Paxil for treatment of obsessive compulsive disorder. She also received Zyprexa for schizophrenia. They stated that beginning in January 2010, her Zyprexa was titrated, as recommended by the psychiatrist and psychotropic medication review team. The resident's mental and emotional status reportedly had shown improvement, with no behavioral incidents in several months. Further interview revealed that approximately two weeks after Resident #3 received her last dose of Zyprexa on April 6, 2010, she began hallucinating and making false accusations of abuse. In response, the psychiatrist wrote a new prescription for Zyprexa on April 26, 2010. They also stated that the resident's father, her designated healthcare decision-maker, had agreed to her starting Zyprexa again on April 26, 2010.</p> <p>On May 11, 2010, at approximately 5:45 p.m., review of Resident #3's individual Support Plan (ISP) and Psychological Evaluation, both dated November 30, 2010, revealed that her diagnoses included moderate mental retardation in adaptive skills, mild cognitive mental retardation and undifferentiated schizophrenia. The documents confirmed that Resident #3's father was the</p>	I 500	<p>I 500</p> <p>In the future the QMRP, RN and LPN will ensure that family members are notified of all medication changes and due process is completed in compliance with HRC policy and procedures - protection of client's rights. They will ensure that medication changes will not be processed till proper consent and HRC procedures are followed.</p> <p>The QMRP, RN and LPN were in serviced on P&amp;P – HRC, Client abuse, client protection and client rights.</p>	6/5/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</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 8</p> <p>designated healthcare decision-maker due to her impaired ability to process information. On May 13, 2010, beginning at 2:32 p.m., review of the resident's Psychotropic Medication Review forms, Physician's Orders and Medication Administration Records from January 2010 - April 2010 verified the graduated titration of Zyprexa between January 13, 2010 - April 6, 2010 and re-introduction of Zyprexa, effective April 26, 2010. Review of consent forms verified that her father consented to increases and/or reintroduction of medications. Further review of the resident's record, however, failed to show evidence that her father was consulted about his daughter's mental status in January 2010, before the medical team began titrating the Zyprexa.</p> <p>On May 13, 2010, beginning at 3:40 p.m., follow-up interview with the QMRP, RN and LPN Coordinator revealed that as a practice, the facility contacted Resident #3's father (and other residents' surrogate healthcare decision-makers) only if/when a physician proposed introduction of a new medication, or if there was a recommendation to significantly increase the dosage of an existing medication. They acknowledged that the facility had not informed the father of Resident #3's improved mental status in January 2010 or discussed with him the potential risks and benefits associated with proposed changes to her psychotropic medication regimen.</p>	I 500		
-------	--	-------	--	--