

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

PRINTED: 06/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2010
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NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, NW WASHINGTON, DC 20012
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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>INITIAL COMMENTS</p> <p>A recertification survey was conducted from June 7, 2010, through June 8, 2010. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a population of four male clients with various levels of intellectual disabilities.</p> <p>The findings of the survey were based on observations at the group home and a day program, interviews with clients, family members and staff and the review of clinical and administrative records including incident reports.</p>	W 000	<p><i>Received 6/29/10</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>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure outside services met the clients needs, for two of the two clients included in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. During day program observations on June 7, 2010, at approximately 12:20 p.m., Client #2 was observed having lunch. The meal consisted of finely chopped taco meat, pureed black beans, ground rice and a whole soft taco shell. The client's lunch had his name preprinted on the top of the food container.</p> <p>Interview with the day program staff on June 7, 2010, at approximately 12:40 p.m. revealed that</p>	W 120	<p>W 120 Nutrition Inc. the company that provides the prepared meals has been resent the diet list for each individual. In the future the staff will ensure that the appropriate diet is served prior to offering it to the individual. A notification and a written report will be sent to Nutrition Inc. if there is an error in the diet dispatched to the day program. Attached: staff in service record on diet</p>	6/22/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Swant. Span</i>	TITLE <i>VP Operations</i>	(X6) DATE <i>6/28/10</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 120	Continued From page 1 the lunch was prepared and provided by a food service company and delivered to the day program. According to the Client #2's mealtime protocol dated February 28, 2009, on June 7, 2010, at approximately 12:45 p.m., the client was recommended to receive a regular high fiber diet. Review of the client's physician's orders (POS) dated June 2010, on June 7, 2010, at approximately 3:00 p.m., confirmed the client's mealtime feeding protocol. At the time of the survey, the day program failed to ensure Client #2 received his diet as prescribed. 2. Cross Ref to W189, 1. The facility failed to ensure that staff working with Client #1 at his day program were using the recommended adaptive feeding equipment.	W 120			
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for one of the two clients in the sample. (Client #2) The finding includes: Interview with the Acting qualified mental	W 140			

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W 140	Continued From page 2 retardation professional (QMRP) and review of the client's financial records on June 7, 2010, at 2:30 p.m., revealed that the facility assisted the client with maintaining his finances. Continued interview and record review revealed that the client received Supplemental Security Income (SSI) in the amount of \$100.00 monthly. Review of Client #2's bank statement from June 2009, through April 2010, revealed a withdrawal in the amount of \$200.00, on June 29, 2009. Additional review revealed receipts totaling \$67.70. Interview with the QMRP and continued record review revealed that the facility could only account for the \$67.70 of the \$200.00 withdrawal. At the time of the survey, the facility failed to ensure a complete accounting of the clients personal funds by proving evidence that justified the aforementioned withdrawal.	W 140	W 140 Metro Homes has a system to reconcile individual's accounts within each 30day period. The QMRP was on maternity leave – unexpectedly early and was unable to reconcile the accounts in time. In the future the QMRP and the RC will ensure completion and reconciliation of accounts as soon as the money is spent or at least within a 30 day period. Attached – reconciled account receipts	6/22/10
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to ensure that clients received the recommended feeding equipment, for two of the two clients included in the sample. (Client #1 and #2) The findings include: The facility failed to provide initial training to all staff to perform his duties effectively, efficiently	W 189		

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W 189	<p>Continued From page 3 and competently.</p> <p>1. On June 7, 2010, beginning at 7:30 a.m., Client #1 was observed screaming, jumping, biting himself and pinching his one to one support staff. The client was also observed attempting to bite his one to one support staff. While the client was displaying his maladaptive behavior, the one to one support staff was observed attempting to redirect the client activity by asking him to stop and telling him "it's okay it's okay". The one to one staff was further observed touching the clients hands then interlocking fingers to prevent the client from biting him. Seconds later, the one to one support staff asked the client if he wanted to go to his room or go outside for a walk. The client chose to go for a walk. At 7:46 a.m., the client was heard screaming from outside. At 7:50 a.m., the client was again observed to jump and bite himself and pinched his one to one support staff. At 7:52 a.m., the one to one support staff asked the nurse to get the client a glass of water. The client was observed calming down as he drank his water.</p> <p>Interview with the one to one support staff on June 7, 2010, at 1:25 p.m., indicated that he is the facility's van driver and Client #1's one to one staff from 6:00 a.m. to 8:00 a.m. Further interview revealed the staff did not have training on how to redirect the client's physical aggression and self-injurious behavior.</p> <p>Review of Client #1's Behavior Support Plan (BSP) dated June 24, 2009, on June 7, 2010, at approximately 10:00 a.m., revealed the following maladaptive behaviors: physical aggression, self-injurious behavior (SIB), pica and bolting. The BSP has the following guidelines for</p>	W 189	<p>W189</p> <p>1. Staff has been scheduled to receive CPI training on July 17-21, 2010.</p> <p>2. Staff has been in serviced on individual's diets and adaptive equipment. Attached: in service record – adaptive equipment and training schedule</p>	6/22/10

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W 189	<p>Continued From page 4 addressing SIB as evidence below:</p> <ul style="list-style-type: none"> - staff should attempt to identify the source of his frustration/agitation; - In spite of staff effort, staff should give an immediate directive to STOP and use Developmental Disability Services (DDS) approved, least restrictive techniques necessary to prevent injury. - once the client calms down staff should give him verbal praise for such and allow him to relax. <p>Interview with the qualified mental retardation professional on June 7, 2010, at approximately 2:00 p.m., revealed that the DDS approved, least restrictive techniques included physical restraints.</p> <p>Review of the training records on June 8, 2010, at 12:00 p.m., revealed no evidence that Client #1's one to one support staff had received the DDS approved, least restrictive techniques.</p> <p>2. On June 7, 2010, at 4:08 p.m., Client # 2 was observed eating chocolate pudding with a built handle spoon. During the dinner meal observation on the same day, at 6:55 p.m., Client #2 was observed eating baked fish, tator tots, squash, and a potato roll with a regular utensil.</p> <p>Review of Client #2's mealtime protocol on June 8, 2010, at 12:06 p.m., revealed the client does not require any adaptive equipment while eating. Interview with the acting qualified mental retardation professional (AQMRP) on the same day, at approximately 1:00 p.m., confirmed that Client #2 does not require a built up handle</p>	W 189		

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W 189	Continued From page 5 utensil.	W 189		
W 252	At the time of the survey, there was no evidence that the facility ensured that Client #2 used the appropriate utensil while eating his snack. 483.440(e)(1) PROGRAM DOCUMENTATION 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, the facility failed to ensure that data was collected in the form and required frequency, for one of the two clients in the sample. (Client #1) The findings include: 1. On June 7, 2010, at 4:00 p.m., during snack observations, Client #1 was observed drooling into his bowl of cookies. After the Client #1 completed his snack at 4:12 p.m., the front of his shirt was soaking wet. At 4:24 p.m., Client #1 was observed with drool hanging from his chin. At 4:30 p.m., Client #1's one to one support staff was overheard asking Client #1 to wipe his mouth. The client required verbal to physical prompts to complete the task. Interview with the one to one support staff on June 7, 2010, at 4:45 p.m., revealed that the client drools constantly. Review of the Client #1's Individual Program Plan (IPP) dated July 16, 2009 on June 8, 2010, at	W 252	W252 1. Staff has been in serviced on IPP for drooling. The IDT has also recommended that he use a 'bib' during mealtimes and this has been approved by the HRC. 2a&b. Staff has been in serviced on IPP and documentation for bathing. In the future the QMRP and RC will ensure all staff complete training IPP and on documentation of IPP. The RC will monitor the IPP data records for accurate documentation at least 3/week. Attached: in service record -- IPP and documentation.	6/22/10

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W 252	<p>Continued From page 6</p> <p>approximately 9:30 a.m., revealed a program objective which stated, "[the client] will wipe his mouth when drooling is noted on 80% of the opportunities provided per month for six consecutive months. Review of the data sheet on June 8, 2010, at approximately 10:00 a.m., revealed no documentation from the previous date (June 7, 2010). Review of the clients's one to one hourly documentation log revealed that Client #1 had participated in programming to include wiping his mouth.</p> <p>There was no evidence that data had been collected in accordance with Client #1's IPP, which was necessary for a functional assessment of the client's progress.</p> <p>2. Review of Client #1's hourly one to one hourly documentation log revealed the client participated in interactive games and he assisted the client with bathing and personal hygiene skills.</p> <p>a. Review of the Client #1's Individual Program Plan (IPP) dated July 16, 2009 on June 8, 2010, at approximately 9:30 a.m., revealed a program objective which stated, "[the client] will bath himself with a washcloth on 80% of the opportunities provided per month for six consecutive months. The task analysis sheet indicated that the program should be implemented daily and documented three times per week (Monday, Wednesday and Friday).</p> <p>Review of the data sheet on June 8, 2010, at approximately 10:00 a.m., revealed no documentation from the previous date (June 7, 2010). Review of the client's one to one hourly documentation log revealed that staff assisted Client #1 with bathing.</p>	W 252			

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W 252	Continued From page 7 b. Similarity, review of the Client #1's Individual Program Plan (IPP) dated July 16, 2009 on June 8, 2010, at approximately 9:30 a.m., revealed a program objective which stated, "[the client] will participate in an interactive game with his one to one staff for 20 minutes or more on 80% of the opportunities provided per month for six consecutive months. The task analysis sheet indicated that the program should be implemented daily and documented three times per week (Monday, Wednesday and Friday). Review of the data sheet on June 8, 2010, at approximately 10:00 a.m., revealed no documentation from the previous date (June 7, 2010). Review of the client's one to one hourly documentation log revealed that Client #1 had participated in programming to include interactive game.	W 252		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide preventive health services for one of four clients residing in the facility. (Client #1) The finding includes: [Cross Ref to W331]. The facility failed to ensure Client #3's physician's orders were transcribed accurately to make certain the client received the correct dosage of Risperdal to effectively address	W 322	W 322 Cross refer to W331	

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W 322	Continued From page 8	W 322		
W 325	his elevated prolactin level. 482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician, for one of two clients included in the sample. (Client #2) The finding includes: The facility failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP). Observations during the medication administration on June 7, 2010, at 5:02 p.m., Client #2 received Depakote sprinkles 1000 mg, Risperidone 4 mg and Prozac 40 mg. Review of Client #2's physician's order (PO) from September 2009, to June 2010, on June 7, 2010, at 11:11 a.m., revealed an order for laboratory studies for Lipase, Amylase and Depakote levels every six months. Subsequent review of his medical records revealed there was no laboratory studies done six months prior to March 1, 2010, for Lipase and Amylase. Continued review revealed there was no laboratory studies done prior to May 24, 2010. There was no evidence the facility conducted the aforementioned laboratory studies as prescribed.	W 325	W 325 In the future the RN Supervisor will ensure that all physicians' orders are implemented in a timely manner. The RN will QA the medical records to ensure completion of orders, at least on a monthly basis. The LPN has received disciplinary action and has received in service on POS. Attached: in service record – physician's orders	6/22/10

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W 325	Continued From page 9	W 325			
W 331	<p>Interview with the license practical nurse (LPN) on June 8, 2010, at approximately 4:15 p.m., confirmed that the laboratory studies were not completed as ordered.</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for one of four clients residing in the facility. (Client #3)</p> <p>The finding includes:</p> <p>The nursing staff failed to transcribe Client #3's physician's orders accurately, as evidence by the following:</p> <p>a. During the evening medication administration on June 7, 2010, at 5:15 p.m., the licensed practical nurse (LPN) was observed preparing Client #3's medications. The LPN punched a 1 mg and a 0.5 mg tablet of Risperdal from the client's prepared medication bubble package. The surveyor stopped the LPN from administering the medications and asked her to review the physician orders (POS).</p> <p>Review of Client #3's records related to his medication regime on June 8, 2010, at 6:40 p.m., revealed the following:</p>	W 331	<p>W331</p> <p>a. The nurse has received disciplinary action for failure to implement the physician's order. In the future the LPN will ensure that all new orders are reported to the RN Supervisor, to ensure completion of follow through. The RN Supervisor will continue to monitor QA of medical records at least on a monthly basis. Attached: Disciplinary action – investigation of reportable incident.</p>	6/23/10	

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W 331	<p>Continued From page 10</p> <p>- A POS dated May 25, 2010, indicated to discontinue Risperdal 1 mg and start Risperdal 0.5 mg , by mouth, one tablet in the evening.</p> <p>- The POS dated June 2010, indicated an order for Risperdal 2 mg tablet, in the morning and 1 mg tablet in the evening.</p> <p>Further review failed to show evidence that the May 25, 2010, POS was discontinued.</p> <p>Review of the May 24, 2010, psychotropic medication review on June 7, 2010, at 7:00 p.m., revealed that interdisciplinary team (IDT) recommended that the Risperdal be decreased due to elevated prolactin laboratory studies. The prolactin levels were 44.6 (range 2.0-18.0) on April 5, 2010. The IDT approved the change of the evening dose (Risperdal 0.5 mg).</p> <p>Further review of the June 2010, POS on June 7, 2010, at approximately 7:30 p.m., revealed that the licensed practical nurse (LPN) and primary care physician (PCP) reviewed and signed the June 2010, POS on June 1, 2010. However the nurse failed to transcribe the May 25, 2010, (discontinue Risperdal 1 mg and start Risperdal 0.5 mg, by mouth, one tablet in the evening) to the June 2010, POS. Interview with the LPN on June 7, 2010, at approximately 7:10 p.m., revealed that the Risperdal 0.5 mg should have been transcribed to the June 2010, POS.</p> <p>There was no evidence that the facility's nurse transcribed Client #3's POS/MARs to reflect the new prescription of Risperdal.</p>	W 331		
W 368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure</p>	W 368		

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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
W 368	<p>Continued From page 11</p> <p>that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders (POS), for one of the four clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>[Cross Refer to W331]. Observation of the evening medication administration on June 7, 2010, at 5:15 p.m., revealed the nurse attempted to administer Client #3 1.5 mg of Risperdal. Interview with the licensed practical nurse (LPN) and record review on June 7, 2010, at 6:40 p.m., revealed the client's order for Risperdal had been decreased on May 25, 2010. The new order prescribed the client to receive Risperdal 0.5 mg in the evening. Although the client's current physician's order (June 2010) documented the client should receive 1 mg of Risperdal in the evening, interview with the LPN on June 7, 2010, 6:50 p.m., revealed the documented order was incorrect and should have indicated 0.5 mg in the evening.</p> <p>This was further verified through review of the client's May 24, 2010, psychotropic medication review on June 7, 2010, at 7:00 p.m. According to the review, Client #3's interdisciplinary team (IDT) recommended that the client's Risperdal be decreased due to elevated prolactin laboratory studies. The prolactin levels were 44.6 (range 2.0-18.0) on April 5, 2010. The IDT approved the change of the evening dose (Risperdal 0.5 mg). Review of Client #3's June 2010 Medication</p>	W 368	<p>W368</p> <p>Cross refer to W 331</p>	

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W 368	Continued From page 12 Administration Records on June 7, 2010, at 6:45 p.m., however, revealed to client received 1.5 mg of Risperdal from June 1, 2010 to June 6, 2010 (6 days). At the time of the survey, the facility failed to ensure Client #3 received his Risperdal in accordance with his POS.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility's nurse failed to ensure drug administration were administered without error, for one of the four clients residing in the facility. (Client #3) The finding includes: [Cross Refer to W331] Observation of the evening medication administration on June 7, 2010, at 5:15 p.m., revealed the nurse attempted to administer Client #3 1.5 mg of Risperdal. Interview with the licensed practical nurse (LPN) and record review on June 7, 2010, revealed the client's order for Risperdal had been decreased on May 25, 2010. The new order prescribed the client to receive Risperdal 0.5 mg in the evening. Although the client's current physician's order (dated June 2010) documented the client should receive 1 mg of Risperdal in the evening, interview with the LPN on June 7, 2010, at 6:50 p.m., revealed the documented order was incorrect and should have indicated 0.5 mg in the evening. At the time of the survey, the facility failed to ensure Client #3 received his medication	W 369	W369 Cross refer to W331	

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W 369	Continued From page 13 without error and in accordance with the physician's orders.	W 369		
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 observations, staff interview, and record review, the facility failed to furnish and teach client to use adaptive feeding equipment as recommended, for one of the two clients included in the sample. (Client #1) The finding includes: Observations on June 7, 2010, at 11:40 a.m., revealed Client #1 having lunch at his day program. The client was observed using a regular plate, teaspoon and regular cup. During snack observations at 4:24 p.m., Client #1 was observed eating pudding using a built up handle spoon. At 6:30 p.m., the direct care staff was observed setting the table for dinner, placing a regular plate, built up handle spoon and regular cup, in the seat setting where Client #1 received his snack. At 6:55 p.m., during dinner observations, Client #1 was observed using a built up handle spoon, regular plate and sippy cup. During dinner, the client was observed with food spillage. Interview with the direct care staff, after Client #1	W 436	W436 Staff has been in serviced on individual's diets and adaptive equipment. In the future the QMRP, RC, LPN, RN will continue to complete mealtime observations at least 2-3x/week to ensure the correct adaptive equipment is used. Attached: in service record – adaptive equipment and training schedule	6/22/10

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W 436	Continued From page 14 completed his meal, revealed that he uses a regular plate, built up handle spoon and a sippy cup. Interview with the acting qualified mental retardation professional (QMRP) on June 8, 2010, at approximately 9:30 a.m., revealed that she was not aware of the client's adaptive feeding equipment further indicated because she was the acting QMRP three weeks. Interview with the LPN on June 8, 2010, at approximately 10:00 a.m., indicated that the client used a built up handle spoon during meals. Review of the Client #1's occupational therapy assessment dated July 11, 2009, on June 8, 2010 at 10:00 a.m., revealed the following assistive devices were needed: raised inner lip sectional plate or scoop plate with a built up handle spoon and spout cup. At the client's individual habilitation plan meeting on July 16, 2009, the interdisciplinary team accepted the recommended feeding equipment. Review of the day program observation form dated January 19, 2010, on June 8, 2010, at approximately 10:45 a.m., revealed that Client #1 was observed having lunch using a scoop plate.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The finding includes:	W 440	W440 All staff was in serviced on fire drills and the schedule has been fixed to include the 8am-4pm shift during weekdays. Attached – in service record on fire drill and safety, fire drill schedule	6/23/10

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W 440	Continued From page 15 Interview with the acting Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on June 7, 2010, at 11:00 a.m., revealed the following primary staffing pattern: Monday - Friday 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.; Sunday - Saturday 8:00 a.m. - 8:00 p.m.; 8:00 p.m. -12:00 a.m.; and 12:00 a.m. - 8:00 a.m. Review of the fire drill log from June 2009 to June 2010 revealed that there were no fire drills held during the week for the 8:00 a.m. - 4:00 p.m., shift, and during the weekend for the 12:00 a.m., to 8:00 a.m., shift. Interview with the acting qualified mental retardation professional (AQMRP) on June 8, 2010, at approximately 12:30 p.m., revealed that the staff failed to hold fire evacuation drills for every shift.	W 440		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure proper infection control procedures, for four of the four clients residing in the facility. (Clients #1, #2, #3, #4)	W 455		

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W 455	Continued From page 16 The findings include: 1. On June 7, 2010, at 3:47 p.m., Client #1, #2, #3, and #4 arrived home from their day program. Moments later, the direct support staff called all the clients to the dining room table for snacks. Client #1, #2, #3, and #4 were observed eating pudding, cookies and brownies. The clients were not observed or asked to wash their hands prior to consuming their snacks. Interview with the acting qualified mental retardation professional (AQMRP), on June 8, 2010, at approximately 4:00 p.m., revealed all clients are required to wash their hands before eating. 2. On June 7, 2010, at 6:49, p.m., the direct support staff was observed preparing the clients dinner in the kitchen. As she prepared dinner, a dish towel fell from the oven door handle onto the floor. The direct support staff stepped on the dish towel. Seconds later, the direct support staff picked up the dish towel and hung it back on the oven handle. Review of the staff in-service training records on June 8, 2010, at 9:45 a.m., revealed that a nurse had conducted training on infection control on June 17, 2009. However, there was no evidence that proper infection control procedures were implemented.	W 455	W455 1&2.All staff was in serviced on infection control. In the future the staff will ensure that all individuals wash their hands prior to consumption of food and after using the rest rooms. The facility is also equipped with soap less hand sanitizers. Attached: in service record – infection control	6/23/10	
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.	W 460			

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W 460	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure that clients received a nourishing, well-balanced diet for one of two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Observation on June 7, 2010, at 6:55 p.m., revealed Client #2 received a double portion of tator tots and a single portion of baked fish, squash, and a potato roll. At 7:11 p.m., Client #2 asked for more food. The direct support staff responded by saying "I do not have anymore food."</p> <p>Interview with the direct support staff on the same day at 7:30 p.m., revealed she did not have anymore baked fish or squash, however, she did have extra tator tots.</p> <p>Review of the physician order dated June 2010, on June 7, 2010, at 10:05 a.m., revealed that Client #2 is on a high fiber, chopped vegetable, double portion diet at dinner. Review of the client's mealtime protocol on June 8, 2010, at 12:06 p.m., revealed a requirement to provide second servings during the dinner meal.</p> <p>Interview with the direct support staff on June 7, 2010 at 7:35 p.m., revealed she was not aware that Client #2 was able to receive second servings during dinner. Interview with the acting qualified mental retardation professional revealed that there is no restrictions for Client #2 to receive seconds during dinner.</p>	W 460	<p>W460 All staff was in serviced on individuals' diets and mealtime protocols, adaptive equipment. In the future the QMRP, RC, LPN, RN will continue to complete mealtime observations at least 2-3x/week to ensure the correct diet/portion is served.</p>	6/22/10,	

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I 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from June 7, 2010, through June 8, 2010. The survey was initiated using the fundamental survey process. A random sample of two residents were selected from a population of two male residents with various levels of intellectual disabilities.</p> <p>The findings of the survey was based on observations at the group home and a day program, interviews with residents, family members and staff and the review of clinical and administrative records including incident reports.</p>	I 000		6/22/10
I 040	<p>3502.1 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall provide each resident with a nourishing, well-balanced diet.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that residents received meals in accordance with their dietary needs, for one of two residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Observation on June 7, 2010, at 6:55 p.m., revealed Client #2 received a double portion of tator tots and a single portion of baked fish, squash, and a potato roll. At 7:11 p.m., Resident #2 asked for more food. The direct support staff responded by saying "I do not have anymore food."</p> <p>Interview with the direct support staff on the same day at 7:30 p.m., revealed she did not have</p>	I 040	<p>I040</p> <p>All staff was in serviced on individuals' diets and mealtime protocols, adaptive equipment.</p> <p>In the future the QMRP, RC, LPN, RN will continue to complete mealtime observations at least 2-3x/week to ensure the correct diet/portion is served.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shawn T. Sloan* TITLE: *VP Operations* (X5) DATE: *6/28/10*

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I 040	Continued From page 1 anymore baked fish or squash, however, she did have extra tator tots. Review of the physician order dated June 2010, on June 7, 2010, at 10:05 a.m., revealed that Resident #2 is on a high fiber, chopped vegetable, double portion diet at dinner. Review of the client's mealtime protocol on June 8, 2010, at 12:06 p.m., revealed a requirement to provide second servings during the dinner meal. Interview with the direct support staff on June 7, 2010 at 7:35 p.m., revealed she was not aware that Resident #2 was able to receive second servings during dinner. Interview with the acting qualified mental retardation professional revealed that there is no restrictions for Resident #2 to receive seconds during dinner.	I 040		
I 052	3502.10 MEAL SERVICE / DINING AREAS Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the correct utensil were furnished, for one of the two residents included in the sample. (Resident #2) The finding includes: On June 7, 2010, at 4:08 p.m., Resident # 2 was observed eating chocolate pudding with a built handle spoon. During the dinner meal observation on the same day, at 6:55 p.m.,	I 052	I052 Staff has been in serviced on individual's diets and adaptive equipment. In the future the QMRP, RC, LPN, RN will continue to complete mealtime observations at least 2-3x/week to ensure the correct adaptive equipment is used. Attached: in service record - adaptive equipment and training schedule	6/22/10

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1052	Continued From page 2 Resident #2 was observed eating baked fish, tator tots, squash, and a potato roll with a regular utensil. Review of Resident #2's mealtime protocol on June 8, 2010, at 12:06 p.m., revealed the client does not require any adaptive equipment while eating. Interview with the acting qualified mental retardation professional (AQMRP) on the same day, at approximately 1:00 p.m., confirmed that Resident #2 does not require a built up handle utensil. At the time of the survey, there was no evidence that the facility ensured that Resident #2 used the appropriate utensil while eating his snack.	1052		
1090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for four of the four residents in the facility. (Residents #1, #2, #3 and #4) The findings include: Observation and interview with the facility's acting qualified mental retardation professional (AQMRP) on June 8, 2010, beginning at 1:15 p.m., revealed the following:	1090	I090 - closet door was fixed - coat closet was fixed - sink/faucet was replaced In the future the RC will continue to complete monthly environmental audits and send the work orders to the maintenance dept. to ensure completion of requests.	6/22/10

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I 090	Continued From page 3 1. Resident #2's closet door was off track. 2. The coat closet on the first floor was off track. 3. The main bathroom sink on the first floor was dripping water from the pipe. The QMRP acknowledged the above cited deficiencies at the conclusion of the environmental walk-through.	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 staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to conduct simulated fire drills in order to test the effectiveness of the plan at least four times a year for each shift, for four of four residents residing in the GHMRP. (Residents #1, #2, #3 and #4) The finding includes: Interview with the acting Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on June 7, 2010, at 11:00 a.m., revealed the following primary staffing pattern: Monday - Friday 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.	I 135	I135 All staff was in serviced on fire drills and the schedule has been fixed to include the 8am-4pm shift during weekdays. Attached – in service record on fire drill and safety, fire drill schedule	6/23/10

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I 135	Continued From page 4 Sunday - Saturday 8:00 a.m. - 8:00 p.m.; 8:00 p.m. -12:00 a.m.; and 12:00 a.m. - 8:00 a.m. Review of the fire drill log from June 2009 to June 2010 revealed that there were no fire drills held during the week for the 8:00 a.m. - 4:00 p.m., shift, and during the weekened for the 12:00 a.m., to 8:00 a.m., shift. Interview with the acting qualified mental retardation professional (AQMRP) on June 8, 2010, at approximately 12:30 p.m., revealed that the staff failed to hold fire evacuation drills for every shift.	I 135		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for one of the two residents in the sample. (Resident #2) The findings include: Interview with the Acting qualified mental retardation professional (QMRP) and review of the client's financial records on June 7, 2010, at 2:30 p.m., revealed that the facility assisted the client with maintaining his finances. Continued interview and record review revealed that the resident received Supplemental Security Income (SSI) in the amount of \$100.00 monthly. Review of Client #2's bank statement from June 2009, through April 2010, revealed a withdrawal	I 189	I189 Metro Homes has a system to reconcile individual's accounts within each 30day period. The QMRP was on maternity leave – unexpectedly early and was unable to reconcile the accounts in time. In the future the QMRP and the RC will ensure completion and reconciliation of accounts as soon as the money is spent or at least within a 30 day period. Attached – reconciled account receipts	6/22/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, NW WASHINGTON, DC 20012		
(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 189	Continued From page 5 in the amount of \$200.00, on June 29, 2009. Additional review revealed receipts totaling \$67.70. Interview with the QMRP and continued record review revealed that the facility could only account for the \$67.70 of the \$200.00 withdrawal.	I 189		
I 405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure professional services had been provided in accordance with each resident's needs, for two of the two residents residing in the facility. (Residents #1 and #2) The findings include: 1. During day program observations on June 7, 2010, at approximately 12:20 p.m., Resident #2 was observed having lunch. The meal consisted of finely chopped taco meat, pureed black beans, ground rice and a whole soft taco shell. The resident's lunch had his name preprinted on the top of the food container. Interview with the day program staff June 7, 2010, at approximately 12:40 p.m. revealed that the lunch was prepared and provided by a food service company and delivered to the day program.	I 405	I405 1&2. Staff has been in serviced on individual's diets and adaptive equipment. In the future the QMRP, RC, LPN, RN will continue to complete mealtime observations at least 2-3x/week to ensure the correct adaptive equipment is used. Attached: in service record – adaptive equipment and training schedule	6/22/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2010
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I 405	Continued From page 6 According to the Resident #2's mealtime protocol dated February 28, 2009, on June 7, 2010, at approximately 12:45 p.m., revealed a regular high fiber diet. Review of the client's physician's orders (POS) dated June 2010, on June 7, 2010, at approximately 3:00 p.m., confirmed the resident's mealtime feeding protocol. 2. Cross Ref to W189, 1. The facility failed to ensure that staff working with Resident #1 at his day program were using the recommended adaptive feeding equipment.	I 405		
I 430	3521.7(a) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observations, staff interview, and record review, the Group Home for the Mentally Retarded (GHMRP) failed to furnish and teach client to use adaptive feeding equipment as recommended, for one of the two residents included in the sample. (Resident #1) The finding includes: Observations on June 7, 2010, at 11:40 a.m., revealed Client #1 having lunch at his day program. The resident was observed using a regular plate, teaspoon and regular cup. During snack observations at 4:24 p.m., Resident #1 was observed eating pudding using a built up handle spoon. At 6:30 p.m., the direct care staff	I 430	I430 1&2. Staff has been in serviced on individual's diets and adaptive equipment. In the future the QMRP, RC, LPN, RN will continue to complete mealtime observations at least 2-3x/week to ensure the correct adaptive equipment is used. Attached: in service record – adaptive equipment and training schedule	6/22/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/08/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, NW WASHINGTON, DC 20012		
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I 430	<p>Continued From page 7</p> <p>was observed setting the table for dinner, placing a regular plate, built up handle spoon and regular cup, in the seat setting where Resident #1 received his snack. At 6:55 p.m., during dinner observations, Resident #1 was observed using a built up handle spoon, regular plate and sippy cup. During dinner, the resident was observed with food spillage.</p> <p>Interview with the direct care staff, after Resident #1 completed his meal, revealed that he uses a regular plate, built up handle spoon and a sippy cup. Interview with the acting qualified mental retardation professional (QMRP) on June 8, 2010, at approximately 9:30 a.m., revealed that she was not aware of the resident's adaptive feeding equipment further indicated because she was the acting QMRP three weeks. Interview with the LPN on June 8, 2010, at approximately 10:00 a.m., indicated that the resident used a built up handle spoon during meals.</p> <p>Review of the Resident #1's occupational therapy assessment dated July 11, 2009, on June 8, 2010 at 10:00 a.m., revealed the following assistive devices were needed: raised inner lip sectional plate or scoop plate with a built up handle spoon and spout cup. At the resident's individual habilitation plan meeting on July 16, 2009, the interdisciplinary team accepted the recommended feeding equipment.</p> <p>Review of the day program observation form dated January 19, 2010, on June 8, 2010, at approximately 10:45 a.m., revealed that Resident #1 was observed having lunch using a scoop plate.</p>	I 430		