

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  06/11/2009
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
1 000	INITIAL COMMENTS  A re-licensure survey was conducted from June 10, 2009 through June 11, 2009. Five male residents with varying degrees of disabilities reside in the facility. Three of the five residents were randomly selected for the sample.  The finding of this survey were based on observation at the group home and at two day programs, interview with the direct care staff and management and the review of habilitation and administrative record to include the facility's incident management system	1 000	<i>Rec'd 6/30/09</i>  GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
1 073	3503.3(b) BEDROOMS AND BATHROOMS  Each bedroom shall be equipped with at least the following items for each resident:  (b) Clean comfortable pillow.  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure client's was furnished with a clean pillow for two of the residents in the sample.  The finding includes:  During the environmental inspection on the morning of June 10, 2009 at approximately 10:38 AM, Resident #1 and Resident #2 's pillows were observed to be stained with a brownish colored substance.  Interview with the facility's Qualified Mental Retardation Professional (QMRP) on the same day at approximately 10:39 AM revealed, she would have the soiled pillowcases exchanged immediately.	1 073	1073  Pillow cases were changed immediately.	6/20/09

Health Regulation Administration

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

*Susan J. Sloan*

TITLE  
*VP Operations*

(X6) DATE  
*6/29/09*

STATE FORM

689

H2UO11

If continuation sheet 1 of 11

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD83-0131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/11/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2268 SUDBURY ROAD, NW WASHINGTON, DC 20012</b>		
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1082	<p><b>3503.10 BEDROOMS AND BATHROOMS</b></p> <p>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all bathrooms were equipped with paper towels and cup dispensers to accommodate the needs of all residents residing in the facility. [Residents #1, #2, #3, #4, and #5]</p> <p>The finding includes:</p> <p>Observation and interview with the facility's House Manager during the environmental inspection on June 10, 2009 at approximately 10:30 AM revealed, the bathrooms in the hallway on the main floor, in Resident #3's bedroom and the basement, were not equipped with either a cup dispenser, paper towels or both.</p>	1082	<p>All bathrooms are equipped with paper cups and paper towels and replenished accordingly.</p> <p>In the future the QMRP and Residential Coordinator will ensure daily that these items are provided for the individuals. All staff have been in serviced on infection control.</p> <p>See attached in service record - Infection control</p>	6/26/09
1090	<p><b>3504.1 HOUSEKEEPING</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure the proper</p>	1090		

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1090	Continued From page 2 maintenance of the facility's environment for five of five residents residing in the facility. [Residents #1, #2, #3, #4, and #5]  The findings include:  During the environmental inspection on June 10, 2009 at approximately 10:30 AM, the following deficient practices were identified:  1. The toilet handle in the basement bathroom was broken and inoperable.  2. Dead insects observed in the lighting fixtures in the basement.  3. The closet doors in Resident #2's bedroom were difficult to slide open and shut, posing as a potential safety risk.  4. The towel rack in Resident #3's bathroom was broken.  5. The sink in Resident #3's bedroom did not drain properly. The water pooled up and remained in the sink while the water temperature was being taken.	1090	1090  1. The toilet handle has been fixed.  2. All dead insects have been removed.  3. The closet doors have been fixed and slide freely.  4. The towel rack has been removed.  5. The sink is currently draining properly.  In the future the QMRP and Residential Coordinator will ensure daily that these items are provided for the individuals.	6/20/09
1092	3504.3 HOUSEKEEPING  Each GHMRP shall be free of insects, rodents and vermin.  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a vermin free environment for five of five residents residing in the facility. [Residents #1, #2, #3, #4, and #5]	1092		

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NAME OF PROVIDER OR SUPPLIER  METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2208 SUDBURY ROAD, NW WASHINGTON, DC 20012		
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I 092	Continued From page 3  The finding includes:  During the environmental inspection on June 10, 2009 at approximately 10:40 AM, a dead garden snake was found caught in a sticky mouse trap in the basement. The mouse bait/trap was near an old treadmill that was being stored in the basement across from the washer and dryer.  Interview with the GHMRP's QMRP on the same day at approximately 10:59 AM, revealed the dead snake would be removed from the premises as soon as the maintenance crew arrived.	I 092	1092  The dead snake was removed immediately.  In the future the QMRP and Residential Coordinator will ensure daily that these items are provided for the individuals. All staff have been in serviced on infection control.	6/26/09
I 096	3504.7 HOUSEKEEPING  No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area.  This Statute is not met as evidenced by: Based on observation, the facility failed to ensure caustic agents were not being stored in a food preparation area for five of five residents residing in the facility. [Residents #1, #2, #3, #4, and #5]  The finding includes:  During the environmental inspection on June 10, 2009 at approximately 10:44 AM revealed a bottle of a cleaning agent was being stored in the kitchen cabinet under the sink. At the time of the observation, the QMRP removed the cleaning agent and instructed the staff not to store these items in the kitchen.	I 096	1096  All chemical agents have been removed from under the sink. All staff have been in serviced on OSHA.  See attached in service record - OSHA.	6/20/09
I 100	3504.10(b) HOUSEKEEPING  Each GHMRP shall provide clean linens as	I 100		

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I 100	Continued From page 4 follows to each resident at least weekly:  (b) One (1) pillowcase;  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure two of the five client's pillow cases was furnished clean.  The finding includes:  During the environmental inspection on the morning of June 10, 2009 at approximately 10:38 AM, Resident #1 and Resident #2's pillows were observed to be stained with a brownish colored substance.  Interview with the facility's Qualified Mental Retardation Professional (QMRP) on the same day at approximately 10:39 AM revealed the soiled pillowcases would be exchanged immediately.	I 100	I100  Pillow cases were changed immediately.  In the future the QMRP and Residential Coordinator will ensure daily that these items are provided for the individuals. All staff have been in serviced on infection control.  See attached in service record - Infection control	6/20/09
I 161	3507.2 POLICIES AND PROCEDURES  The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually.  This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure its policy and procedure manual was updated over the past licensure year.  The finding includes:  Record review on 6/11/2009 at approximately 3:55 PM revealed the current policy and procedure manual was last approved in 2/8/2008.	I 161	I161  The Policy and Procedure manual was approved and updated.  In the future the QMRP will ensure that all Policy and Procedure manuals are current when she completes the monthly QA for the facility.	6/23/09

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I 161	Continued From page 5  There was no evidence presented or on file at the time of survey to validate this document had been reviewed or approved by management over the past year.	I 161		
I 183	3508.4 ADMINISTRATIVE SUPPORT  Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.  This Statute is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning for one of five of the residents residing in the facility. [Resident #1]  The findings include:  1. The QMRP failed to ensure staff followed the agency's procedures for day treatment program "drop-offs" and "pick-ups" as evidenced below:  Interview with the day program's Area Manager on June 10, 2009 at approximately 12:50 PM, revealed a problem with the residential facility's transportation staff. No Direct care staff from the group home was entering the day program to pick up client #2. The direct care staff was allowing one of Client #2's peers to come in and request for "pick ups" on a regular basis. According to the Area Manager, the problem was brought to the attention of one of the residential drivers (date unknown); however, the problem continues to date.	I 183	1183  1. All staff were in serviced on client safety and van log maintenance. The QMRP will monitor the logs on a daily basis to ensure completion.  2. All receipts for client's personal funds have been obtained. The QMRP will ensure that client's personal accounts are maintained and all reconciliations are completed in a timely manner when she completes the monthly QA for the facility.	

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I 183	<p>Continued From page 6</p> <p>Interview with the House Manager (HM) on June 11, 2009 at 11:50 AM revealed the agency procedure requires a two person log sheet to document the drop offs and pick-ups of clients from their day treatment programs. The person who drops off the client was to secure a signature from a day program representative. Likewise, the person who picks up a client should also secure a signature from the day program representative.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on June 11, 2009 at 12:10 PM confirmed the agency procedure required the use of a van log for dropping off and picking up clients from their day treatment programs.</p> <p>Review of the van log on the same day at approximately 3:15 PM revealed a form entitled the "Daily Transportation Transfer Form" was being used to document the drop-offs and pick-ups. Further review of the forms revealed no signature was secured by the staff for the afternoon "pick-ups" of Client #2 on the following dates: May 4, 2009, May 20, 2009, May 21, 2009, May 22, 2009, May 26, 2009, May 27, 2009, May 28, 2009, May 29, 2009, and June 9, 2009.</p> <p>2. The QMRP failed to ensure an accurate accounting of personal funds. [See Federal Deficiency Report Citation W140]</p> <p>3. The QMRP failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently. [See Federal Deficiency Report Citation W189]</p> <p>4. The QMRP failed to ensure that each individual program plan (IPP) provided a clear schedule of</p>	I 183	<p>3. All TMEs were re trained in safety precautions during medication administration, by the DON. The RN Supervisor will ensure that a monthly review is completed for each TME.</p> <p>4. The IPP for self-administration of medications has been amended to provide clarity for the staff to implement the program.</p> <p>5. All staff have been re trained in the implementation and documentation of the money management program.</p> <p>In the future the QMRP and the RN will complete the monthly facility QA audits to ensure that all programs are being implemented and staff are documenting progress.</p> <p>See attached - self medication administration program and receipts with reconciliations, staff in service on client safety and van logs</p>	

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I 183	Continued From page 7 implementation. [See Federal Deficiency Report Citation W235]  5. The QMRP failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives. [See Federal Deficiency Report Citation W252]	I 183		
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 an accurate accounting of personal funds for three of three sampled residents. [Residents #1, #2, and #3]  The findings include:  The facility failed to maintain accurate receipts for each resident's expenditures as evidenced below:  1. Interview with the facility's House Manager and record review on June 11, 2009 at 2:28 PM revealed, Resident #1's financial records outlined the following withdrawals:  a. January 27, 2009 - \$80.00 b. March 13, 2009 - \$100.00 c. May 1, 2009 - \$126.00 d. May 27, 2009 - \$237.54  Interview with the facility's Qualified Mental Retardation Professional (QMRP) and the House Manager on the same day at approximately 2:30 PM revealed the receipts for these withdrawals were not available during the survey. The QMRP further added some of the withdrawals were for	I 189	I 189  1.&2. The QMRP will ensure that supporting documentation and receipts for all clients' funds are reconciled in a timely manner.  See attached - vacation breakdown and receipts	6/23/09

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I 189	<p>Continued From page 8</p> <p>an upcoming vacation, but no documentation was available at the time of the survey.</p> <p>2. Interview with the facility's House Manager and record review on June 11, 2009 at 2:32 PM revealed Resident #2's financial records outlined the following withdrawals:</p> <ul style="list-style-type: none"> <li>a. January 27, 2009 - \$80.00</li> <li>b. March 13, 2009 - \$100.00</li> <li>c. May 1, 2009 - \$126.00</li> <li>d. May 27, 2009 - \$237.54</li> </ul> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) and the House Manager on the same day at approximately 2:34 PM revealed the receipts for these withdrawals were not available during the survey. The QMRP further added some of the withdrawals were for an upcoming vacation, but no documentation was available at the time of the survey.</p> <p>3. Interview with the facility's House Manager and record review on June 11, 2009 at 2:36 PM revealed Resident #3's financial records outlined the following withdrawals:</p> <ul style="list-style-type: none"> <li>a. January 27, 2009 - \$80.00</li> <li>b. March 13, 2009 - \$100.00</li> <li>c. May 1, 2009 - \$126.00</li> <li>d. May 27, 2009 - \$237.54</li> </ul> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) and the House Manager on the same day at approximately 2:38 PM revealed the receipts for these withdrawals were not available during the survey. The QMRP further added some of the withdrawals were for an upcoming vacation, but no documentation was available at the time of the</p>	I 189		

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I 189	Continued From page 9 survey.	I 189		
I 206	3509.6 PERSONNEL POLICIES  Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings in the form and manner as required by this section.  The findings include:  Interview and review of the personnel records on June 11, 2009 revealed the GHMRP failed to have evidence of a current physical examination for five consultants (Primary Care Physician, Physical Therapist, Podiatrist, Social Worker and Occupational Therapist).	I 206	1206  In the future the QMRP will complete a monthly facility QA to ensure all current health certifications are completed in a timely manner and all consultant records are current.  See attached - health certificates	6/23/09
I 222	3510.3 STAFF TRAINING  There shall be continuous, ongoing in-service training programs scheduled for all personnel.  This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff received ongoing training that enable them to perform their duties effectively, efficiently and	I 222		

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I 222	Continued From page 10 competently for three of the three resident's in the sample. (Resident #1, #2 and #3)  The findings include:  1. The facility failed to ensure that the medication closet was locked by the Trained Medication Employee (TME) during the administration of Resident #3 's prescribed medication regimen. (See Federal Deficiency Report Citation W381)  2. The facility failed to ensure that the facility's TME administering medications documented in the Medication Administration Records. (See Federal Deficiency Report Citation W365)  3. The facility failed to ensure that the TME administer one of the five residents his prescribed treatment medication. (See Federal Deficiency Report Citation W389)	I 222	1222  All TMEs were re trained in safety precautions and documentation during medication administration, by the DON. The RN Supervisor will ensure that a monthly review is completed for each TME.  See attached - training records	6/23/09

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

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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  06/11/2009
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W 000	INITIAL COMMENTS  A recertification survey was conducted from June 10, 2009 through June 11, 2009, using the fundamental survey process. A random sample of three clients was selected from a residential population of five males with varying degrees of disabilities.  The survey findings were based on observation at the group home and at two day programs, interview with the direct care staff and management and the review of habilitation and administrative record to include the facility's incident management system.	W 000			
W 104	483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.  This STANDARD is not met as evidenced by: Based on observation, interview and record review the governing body failed to ensure that it policy and procedures were consistently implemented five of the five client residing in the facility. (Client #1, #2, #3, #4 and #5)  The findings include:  1. The Governing Body failed to have established policies for monitoring of the Trained Medication Employees (TME) activities in accordance with the appropriate regulatory requirements.  Interview with the License Practical Nurse Coordinator (LPNC) on June 10, 2009 at approximately 10:30 AM revealed that the TME are monitored by the Registered Nurse (RN).	W 104	W104  1. The agency has a Policy and Procedure for medication administration by a TME. In the future the QMRP and RN will ensure that all policies maintained in the facility are kept current.		

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

*Sharon D. Sloan*

TITLE

*VP Operations*

(X5) DATE

*6/29/09*

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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NAME OF PROVIDER OR SUPPLIER  METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2288 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) COMPLETION DATE	
W 104	<p>Continued From page 1</p> <p>Further interview with the LPNC did not evidence a clear system had been established and was being implemented to ensure TME's were performing their duties as required by the agency policies.</p> <p>On the same day at approximately 1:25 PM, review of the agencies policy and procedure manual failed to evidence a system for monitoring the TME activities as related to administration of client medication. Further review of the medication policies revealed that the following:</p> <ol style="list-style-type: none"> <li>1. Medication Administration Policy</li> <li>2. Medication Administration Procedures</li> <li>3. Hand Washing Procedures</li> <li>4. Trained Medication Employees contractual agreement</li> </ol> <p>Note : It should be further noted that Chapter 61 Trained Medication Employees, section entitled "Supervisory By Registered Nurse Of Trained Medication Employees citation 6108.3, " The registered nurse shall observe, review and evaluate in writing the ability of the TME to properly administer, document and store medication for the program participant every (3) three months for the first year and every (6) six months thereafter 6108.6, "the supervisory nurse shall, on a monthly basis, review the licensed practitioner's orders, MAR, and medication intervals for all program participants."</p> <p>At the time of the survey, however the agency failed to have an established policy and/or procedure manual did not evidence a policy which addressed a clear monitoring system of TME medication administration activities.</p>	W 104	<p>2.3&amp;4.All TMEs were retrained by the DON on medication administration safety principles and documentation. The RN will ensure that the monthly monitoring of all TMEs is completed as per the agency's Policy and Procedure for medication administration by a TME.</p> <p>See attached training records and Policy for med. administration</p>	6/23/09	

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W 104	Continued From page 2	W 104			
W 130	<p>2. The facility's TME failed to secure the medication cabinet in accordance with the agency policy and procedures. (See W381)</p> <p>3. The facility's TME failed to document the administration of each client's medication in the MAR in accordance with the agency policy and procedures. (See W365)</p> <p>4. The facility's TME failed to administered medication in accordance with the physician ' s order as required by the agency policy and procedures. (See W369)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility Trained Medication Employee (TME) failed to ensure that one of the five clients residing in the facility was provided privacy during his medication administration. [Client #4]</p> <p>The finding includes:</p> <p>The facility's TME failed to ensure each client's privacy during medication administration as evidenced below:</p> <p>Observation of the medication administration on June 10, 2009 at approximately 7:50 AM, revealed the TME administered Client #4's medication of Risperdone 0.25 mg tablet for his</p>	W 130	<p>W130</p> <p>All TMEs were re-trained in privacy during medication administration.</p> <p>In the future, the RN will ensure that all TMEs provide privacy during med. administration when she completes the monthly TME monitoring record.</p> <p>See attached training records and monthly TME monitoring record</p>	6/23/09	

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W 130	Continued From page 3 intermittent explosive behavior and Loratadine 10 mg tablet for his allergy. During this medication administration Client #1 and #2 and #5 were standing in the hall observing Client #4 receive his medications. At no time during the medication pass did the TME ask the other clients to wait in another area while he completed Client #4's medication pass in privacy.  Interview with the LPN Coordinator on the same day at approximately 1:00 PM, revealed the TME's initial training included instructions to ensure each client was provided privacy during their individual medication administration. Review of the in-service training manual failed to confirm the TME received training on privacy.	W 130			
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 an accurate accounting of personal funds for three of three sampled clients. [Clients #1, #2, and #3]  The findings include:  The facility failed to maintain accurate receipts for each client's expenditures as evidenced below:  1. Interview with the facility's House Manager and record review on June 11, 2009 at 2:28 PM revealed, Client #1's financial records outlined the following withdrawals:	W 140	W140  In the future, the QMRP will ensure that supporting documentation and receipts for all clients' funds are reconciled in a timely manner.  See attached - vacation breakdown and receipts	6/23/09	

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W 140	<p>Continued From page 4</p> <p>a. January 27, 2009 - \$80.00 b. March 13, 2009 - \$100.00 c. May 1, 2009 - \$126.00 d. May 27, 2009 - \$237.54</p> <p>Interview with the facility 's Qualified Mental Retardation Professional (QMRP) and the House Manager on the same day at approximately 2:30 PM revealed the receipts for these withdrawals were not available during the survey. The QMRP further added some of the withdrawals were for an upcoming vacation, but no documentation was available at the time of the survey.</p> <p>2. Interview with the facility's House Manager and record review on June 11, 2009 at 2:32 PM revealed Client #2's financial records outlined the following withdrawals:</p> <p>a. January 27, 2009 - \$80.00 b. March 13, 2009 - \$100.00 c. May 1, 2009 - \$126.00 d. May 27, 2009 - \$237.54</p> <p>Interview with the facility 's Qualified Mental Retardation Professional (QMRP) and the House Manager on the same day at approximately 2:34 PM revealed the receipts for these withdrawals were not available during the survey. The QMRP further added some of the withdrawals were for an upcoming vacation, but no documentation was available at the time of the survey.</p> <p>3. Interview with the facility's House Manager and record review on June 11, 2009 at 2:36 PM revealed Client #3's financial records outlined the following withdrawals:</p>	W 140		

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W 140	Continued From page 5 a. January 27, 2009 - \$80.00 b. March 13, 2009 - \$100.00 c. May 1, 2009 - \$126.00 d. May 27, 2009 - \$237.54	W 140			
W 159	Interview with the facility's Qualified Mental Retardation Professional (QMRP) and the House Manager on the same day at approximately 2:38 PM revealed the receipts for these withdrawals were not available during the survey. The QMRP further added some of the withdrawals were for an upcoming vacation, but no documentation was available at the time of the survey. <b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b>  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.  This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen.  The findings include:  1. The QMRP failed to ensure staff followed the agency's procedures for day treatment program "drop-offs" and "pick-up's" as evidenced below:  Interview with the day program's Area Manager on June 10, 2009 at approximately 12:50 PM, revealed a problem with the residential facility's transportation staff. No Direct care staff from the group home was entering the day program to pick	W 159			

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W 159	<p>Continued From page 6</p> <p>up client #2. The direct care staff was allowing one of Client #2 's peers to come in and request for " pick ups " on a regular basis. According to the Area Manager, the problem was brought to the attention of one of the residential drivers (date unknown); however, the problem continues to date.</p> <p>Interview with the House Manager (HM) on June 11, 2009 at 11:50 AM revealed the agency procedure requires a two person log sheet to document the drop offs and pick-ups of clients from their day treatment programs. The person who drops off the client was to secure a signature from a day program representative. Likewise, the person who picks up a client should also secure a signature from the day program representative.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on June 11, 2009 at 12:10 PM confirmed the agency procedure required the use of a van log for dropping off and picking up client's from their day treatment programs.</p> <p>Review of the van log on the same day at approximately 3:15 PM revealed a form entitled the "Daily Transportation Transfer Form" was being used to document the drop-offs and pick-ups. Further review of the forms revealed no signature was secured by the staff for the afternoon " pick-ups " of Client #2 on the following dates: May 4, 2009, May 20, 2009, May 21, 2009, May 22, 2009, May 26, 2009, May 27, 2009, May 28, 2009, May 29, 2009, and June 9, 2009.</p> <p>2. The QMRP failed to ensure an accurate accounting of personal funds. [See W140]</p> <p>3. The QMRP failed to ensure that each</p>	W 159	<p>W159</p> <ol style="list-style-type: none"> <li>All staff were in serviced on client safety and van log maintenance. The QMRP will monitor the logs on a daily basis to ensure completion.</li> <li>cross refer W 140</li> <li>cross refer W 189</li> </ol> <p>4&amp;5 All TMEs were retrained, by the DON on medication administration safety principles and documentation. The RN will ensure that the monthly monitoring of all TMEs is completed as per the agency's Policy and Procedure for medication administration by a TME.</p> <p>See attached training records and Policy for med. administration</p>	6/23/09

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W 159	Continued From page 7 employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently. [See W189]	W 159			
W 189	4. The QMRP failed to ensure that each individual program plan (IPP) provided a clear schedule of implementation. [See W235]  5. The QMRP failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives. [See W252] <b>483.430(e)(1) STAFF TRAINING PROGRAM</b>  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, interview and record review the facility failed to ensure that each employee was provided initial and ongoing training that enable them to perform their duties effectively, efficiently and competently for three of the three client's in the sample. (Client #1, #2 and #3)  The findings include:  1. The facility failed to ensure that the medication closet was locked by the Trained Medication Employee (TME) during the administration of Client #3 's prescribed medication regimen. (See W381)  2. The facility failed to ensure that the facility's	W 189	W189  1,2&3 All TMEs were retrained by the DON on medication administration safety principles and documentation. The RN will ensure that the monthly monitoring of all TMEs is completed as per the agency's Policy and Procedure for medication administration by a TME.  See attached training records and Policy for med. administration	6/23/09	

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W 189	Continued From page 8 TME administering medications documented in the Medication Administration Records. (See W365)	W 189			
W 235	3. The facility failed to ensure that the TME administer one of the five clients his prescribed treatment medication. (See W369) 483.440(c)(5)(ii) INDIVIDUAL PROGRAM PLAN  Each written training program designed to implement the objectives in the individual program plan must specify the schedule for use of the method.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all individual program plans (IPP) provided a clear schedule of implementation for one of three sampled clients. [Client #1]  The finding includes:  The facility's QMRP failed to ensure Client #1's self-medication objective had a clear method for implementation as evidenced below:  During the morning medication administration on June 10, 2009, the Trained Medication Employee (TME) was not observed to implement Client #1's self-medication program. Later that evening on the same day, the facility's Licensed Practical Nurse was observed to implement the self medication program when she administered Client #1 his medications.  Record review on June 11, 2009 at approximately 1:00 PM revealed, Client #1's Self-Medication	W 235	W235  The IPP for self-administration of medications has been amended to provide clarity for the staff to implement the program.  See attached self med IPP and training records	6/23/09	

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W 235	Continued From page 9 Assessment dated January 5, 2009 recommended, " [Client #1] will participate in self medication administration process by pouring out his Metamucil powder into an eight (8) OZ cup of water, then stirring it until properly mixed, then drinking his Metamucil. [Client #1] will be assisted as needed during medication administration by the nurse/TME staff."  Review of Client #1's Physician Order Sheets on the same day at approximately 1:05 PM revealed an order for " Metamucil ... one (1) packet dissolved in liquid by mouth twice daily for constipation."  Further record review on the same day at approximately 1:10 PM revealed the written objective for the self medication program did not specify " when " the program was to be implemented. Additionally, the physician order provided the Metamucil be administered twice a day.  Interview with QMRP and the LPN Coordinator on June 11, 2009 at 1:15 PM revealed they agreed to retrain their TME's to properly implement all their Residents self-medication programs. Further interview with the QMRP revealed that the self-medication program for Client #1 should be implemented twice a day and data documented in the PM.	W 235			
W 252	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.	W 252			

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W 252	Continued From page 10  This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives for one of the three client's in the sample. (Clients #2)  The finding includes:  The facility failed to ensure that direct care staff documented on Client #2's money management objective in accordance with the individual program plan.  On June 11, 2009, at approximately 2:00 PM, interview with the QMRP and review of Client #2's Individual Program Plan (IPP) revealed a program objective to improve his money management. The objective stated "[The client] will make a simple purchase of \$5.00 with verbal prompts on 85% of records trials".  Review of the program data failed to evidence that data had been documented for the month of May 2009. According to the QMRP, the frequency this objective implementation was once a week and the data collection was to be recorded at that time. At the time of the survey, there was no documented evidence that this objective was being implemented and data being recorded consistently.	W 252	W252  All staff have been retrained in active treatment and documentation.  In the future the QMRP will ensure that staff document program progress data as written in the IPP. The Residential Coordinator will ensure that all data logs are monitored daily for completion and accuracy.  See attached in service record	6/23/09	
W 365	483.460(j)(4) DRUG REGIMEN REVIEW  An individual medication administration record must be maintained for each client.  This STANDARD is not met as evidenced by:	W 365			

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W 252	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.	W 252		

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W 252	Continued From page 10  This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives for one of the three client's in the sample. (Clients #2)  The finding includes:  The facility failed to ensure that direct care staff documented on Client #2's money management objective in accordance with the individual program plan.  On June 11, 2009, at approximately 2:00 PM, interview with the QMRP and review of Client #2's Individual Program Plan (IPP) revealed a program objective to improve his money management. The objective stated "[The client] will make a simple purchase of \$5.00 with verbal prompts on 85% of records trials"  Review of the program data failed to evidence that data had been documented for the month of May 2009. According to the QMRP, the frequency this objective implementation was once a week and the data collection was to be recorded at that time. At the time of the survey, there was no documented evidence that this objective was being implemented and data being recorded consistently.	W 252	W252  All staff have been retrained in active treatment and documentation on all IPPs.  In the future the QMRP will ensure that staff document program progress data as written in the IPP. The Residential Coordinator will ensure that all data logs are monitored daily for completion and accuracy.  See attached in service record	6/23/09
W 365	483.460(j)(4) DRUG REGIMEN REVIEW  An individual medication administration record must be maintained for each client.  This STANDARD is not met as evidenced by:	W 365		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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  06/11/2009
NAME OF PROVIDER OR SUPPLIER  METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2244 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) COMPLETION DATE
W 365	<p>Continued From page 11</p> <p>Based on observation, interview and record review, the facility failed to ensure the Trained Medication Employee (TME) documented administered medications in the Medication Administration Records (MAR) for one of the five client residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>The facility's TME failed to document medication administered during the medication pass in accordance with the agency's policy.</p> <p>Observation of the medication on June 10, 2009 at approximately 7:50 AM, revealed the TME administering Client #4 oral medication of Risperdone 0.25 mg tablet for his intermittent explosive behavior and Loratadine 10 mg tablet for his allergy.</p> <p>Interview with the TME at the same time revealed that these two aforementioned medications were the only medication prescribed for Client #4's AM medications.</p> <p>Review of the MAR at 8:35 AM revealed that the TME had not signed his initial in the designated areas for Client #4's medications which had been administered earlier in the AM.</p>	W 365	<p>W365</p> <p>All TMEs were retrained by the DON on medication administration safety principles and documentation. The RN will ensure that the monthly monitoring of all TMEs is completed as per the agency's Policy and Procedure for medication administration by a TME.</p> <p>See attached training records and Policy for med. administration</p>	6/23/09
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Trained Medication Employee</p>	W 369		

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NAME OF PROVIDER OR SUPPLIER  METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2208 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) COMPLETION DATE
W 369	Continued From page 12 (TME) failed to administer prescribed treatment medication for one of the five clients in the sample. (Client #4)  The finding includes:  The facility's TME failed to administer Client #4's prescribed ear treatment in accordance with the agency policy.  Observation of the medication on June 10, 2009 at approximately 7:50 AM, revealed the TME administering Client #4 morning medication regimen of Risperdone 0.25 mg tablet for his intermittent explosive behavior and Loratadine 10 mg tablet for his allergy.  Interview with the TME at the same time revealed that these two aforementioned medications were the only medications prescribed for Client #4.  Review of the medication administration records at 8:35 AM revealed that Client #4 was to have received Ear Drops 6.5 % Debrox solution in his right ear. Further review of Client #4's MAR revealed that " Instill 4 drop into right ear every day. (NO STOP DATE YET) "	W 369	W369  A medication variance form has been filled and Dr. [REDACTED] was aware that the Medication was administered 1 hr late.  Staff were in serviced on medication policy and procedures and safety principles.  See attached - medication variance report	6/27/09
W 381	483.460(I)(1) DRUG STORAGE AND RECORDKEEPING  The facility must store drugs under proper conditions of security.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Trained Medication Employee (TME) failed to ensure that the medication cabinet was secure during the medication	W 381		

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NAME OF PROVIDER OR SUPPLIER  METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2288 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) COMPLETION DATE	
W 381	<p>Continued From page 13</p> <p>administration for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>The facility's TME failed to ensure that the medication closet was locked at the time of medication administration in accordance with the agency policy as evidenced below:</p> <p>Observation of the medication pass on June 10, 2009 at approximately 7:24 AM revealed that the Trained Medication Employee (TME) repeatedly called out for Client #3 to come and take his AM medications. After several attempts with no success, the TME took Client #3's cup with medication, closed the medication closet door and proceeded to Client #3's bedroom. Further observation revealed that the medication closet was left slightly ajar and the keys remained in the door knob with the door unlocked. It should be further noted that while the TME was in Client #3's bedroom other direct care staff and other client were observed walking down the hallway where the medication closet was located. At no time prior to the TME going into the client bedroom during the administration of Client #3 medication regimen was the TME observed to secure the medication cabinet.</p>	W 381	<p>W381</p> <p>All TMEs were retrained by the DON on medication administration safety principles and documentation. The RN will ensure that the monthly monitoring of all TMEs is completed as per the agency's Policy and Procedure for medication administration by a TME.</p> <p>See attached training records and Policy for med. administration</p>	6/23/09	