

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2010
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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019
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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 000	INITIAL COMMENTS An recertification survey was conducted from August 11, 2010, through August 13, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of five males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	W 000	<p style="text-align: center;">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> <p style="text-align: center;">SEP 28 2010</p>	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to sign physician orders (POs), for two of the three clients in the sample. (Clients #2 and #3) The findings include: 1. Observation during the dinner meal on August 11, 2010, at 6:20 p.m., revealed Client #2 received a bottle of Boost Plus. Interview with the staff indicated that the client receives five bottles per day. Review of Client #2's POs on August 13, 2010, beginning at 10:10 a.m., revealed a telephone order (TO) dated June 29, 2010, transcribed by the licensed practical nurse (LPN). The POs indicated to increase Boost Plus five times a day and bi-weekly weights for three months. Further review revealed that the order was not signed by the prescribing physician.	W 114		<p>W 114 – 1,2&3 In the future the QMRP and RN Supervisor will ensure that all POS are signed by the PCP in the 3-5day time period as per the Medication Administration Policy and Procedure. The RN Supervisor that all telephone and consultant POS are signed by the PCP every Tuesday of the week. See attached – IN-SERVICE RECORD NURSING STAFF – Medication Administration Policy /Procedure</p>

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *[Signature]* (X6) DATE: **9/1/10**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 114	<p>Continued From page 1</p> <p>2. During the evening medication administration on August 11, 2010, at 4:48 p.m., revealed Client #3 received mineral oil 30 ml. Interview with the trained medication employee indicated that the client received the medication to address his diagnosis of constipation.</p> <p>Review of Client #3's POs on August 12, 2010, at 10:10 a.m., revealed a telephone order dated June 29, 2010, transcribed by the LPN. The TO indicated give mineral oil 30 ml, by mouth, once a day for constipation. Further review revealed that the order was not signed by the prescribing physician.</p> <p>3. Similarly, review of Client #3's POs revealed the following TO transcribed by the LPN:</p> <ul style="list-style-type: none"> - On July 16, 2010, liver function test and dilantin levels every six months. The TO was not signed by the prescribing physician; and - On September 28, 2009, Vit D 50,000 units 1 cap, by mouth, once a week for osteoporosis. The telephone orders was signed by the primary care physician (PCP) on October 15, 2009. <p>Interview with the registered nurse on August 12, 2010, at approximately 1:30 p.m., indicated that TO should be signed by the PCP within 5 days.</p> <p>Review of the facility's policy on August 13, 2010, at approximately 11:00 a.m., revealed a medication administration policy. The policy indicated that when a new orders are written by the nurse, the nurse will ensure that the POs is signed by the PCP within 3-5 days.</p>	W 114		
W 120	483.410(d)(3) SERVICES PROVIDED WITH	W 120		

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W 120	<p>Continued From page 2 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 one of the two clients included in the sample. (Client #1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> During day program observations on August 12, 2010, at 10:50 a.m., the day program staff placed a communication device in front of Client #1 and asked him "what is your name". When the client did not respond the staff pressed the communication button approximately two or three times. At the same time the staff stated, " it needs batteries but he only uses it on Wednesdays" <p>On August 12, 2010, at 11:15 a.m., review of Client # 1's individual program plan (IPP) dated April 23, 2010, revealed the following objective: "Given a low tech communication device (Big Mack), <the client> will activate the device in response to social greetings for 4 out of 5 days per week as measured by program documentation". Further review revealed that the communication program was documented once a week. Interview with the day program staff at the same time, revealed that she was told to implement the communication program once a week.</p> <p>At the time of the survey, the day program failed to ensure Client #1's communication program</p>	W 120	<p>W 120 - 1&2 In the future the QMRP / Activities Coordinator will ensure that all staff are trained and well equipped with individual's programming and dietary needs. The Residential QMRP/RC/RN will ensure that mealtime observations and program observation is completed at the Day Program at least once a month. See attached – IN-SERVICE RECORD – Communication Program and Mealtime Protocol</p>	9/01/10
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 120	<p>Continued From page 3 was implemented as recommended.</p> <p>2. During day program observations on August 12, 2010, at 12:40 p.m., the day program staff was observed feeding Client #1 pureed roast beef, sweet potatoes and peas with a built up spoon. Review of the client's mealtime protocol dated April 7, 2010, on the same day at approximately 11:30 a.m., revealed the following feeding techniques:</p> <p>a. Provide hand over hand assistance with feeding.</p> <p>b. If the client fatigues or resists hand over hand assistance after 5 attempts, then feed him.</p> <p>In an interview on the same day, at 12:45 p.m., the day program staff revealed that she fed the client because he does not know how to hold his spoon very well. Further interview revealed that she did not attempt to feed the client with hand over hand assistance as specified in the mealtime protocol.</p>	W 120		
W 124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p>	W 124		

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W 124	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and record review, facility failed to establish a system that ensured clients and/or legal guardian was informed of the risks and benefits of restrictive programs and supports, for one of the three clients included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>The facility failed to provide evidence that informed consent was obtained from Client #3's legal guardian for sedation given during medical appointments as evidenced below:</p> <p>During the entrance conference on August 11, 2010, beginning at 3:45 p.m., qualified mental retardation professional (QMRP) indicated that Client #3 had a court appointed legal guardian to assist him in making health care decisions.</p> <p>Review of Client #3's physician orders (POS) on August 12, 2010, beginning at 10:10 a.m., revealed the following orders:</p> <ul style="list-style-type: none"> - On November 30, 2009, Ativan 4 mg, prior to dental examination; and - On October 29, 2009, Ativan 4 mg, prior to bone density test. <p>Review of Client #3's medication administration record (MAR), confirmed that the client was administered the aforementioned sedation.</p> <p>Review of Client #3's Psychological Assessment dated November 3, 2009, on August 12, 2010 at approximately 3:30 p.m., revealed that the client was not competent to make decisions regarding</p>	W 124	<p>W 124</p> <p>In the future the QMRP and RN Supervisor will ensure that the legal guardians are informed and consent is received prior to the use of restrictive programs and supports. All programs and/or medications will not be initiated till Informed Consent and HRC approval is received. See attached – in-service record – HRC Policy & Procedure, Restrictive Procedures etc.</p>	9/1/10
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W 124	Continued From page 5 his health, safety, financial or residential placement. Further review of the client's record failed to provide evidence that informed consent had been obtained for the use of the sedation. On the same day, at approximately 4:15 p.m., interview with the QMRP confirmed that informed consent had not been obtain for for Client #3.	W 124		
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 review, the facility failed to ensure staff received training to address the needs of the clients, for two of three clients in the sample. (Clients #1 and #2) The findings include: 1. During evening observations, on August 11, 2010, at 4:25 p.m., revealed Client #1 was sitting in his wheelchair playing the tambourine. At 4:45 p.m., the client was sitting in his wheelchair playing the drum with his direct support staff. At 5:10 p.m., the client was sitting in his wheelchair playing tennis on the Wii game with staff. At no time during the observation and activities was the client observed wearing a chest harness.	W 189	W 189 – 1&2 In the future the QMRP/PT/RN will ensure that all staff are adequately and efficiently trained to provide services to our individuals. The QMRP/PT/RN will through observation and coaching on a daily basis ensure that all staff is providing services that address the needs of our individuals adequately. See attached – IN-SERVICE RECORD – chest harness	9/1/10

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W 189	<p>Continued From page 6</p> <p>Review of Client #1's physician orders (POs) dated June 2010, on August 12, 2010, at 2:25 p.m., revealed Client #1 required a wheelchair with a chest harness for support.</p> <p>In an interview with the registered nurse (RN) on August 12, 2010, at 5:00 p.m., she indicated "the client's chest harness is usually taken off when Client # is eating or taking his medications. Further interview confirmed that Client #1's chest harness was not worn at all times.</p> <p>2. On August 11, 2010, at 5:12 p.m., Client #2 was observed sitting in his wheelchair leaning forward with his face directly in front of another client's wheelchair handle. Moments later, the RN removed Client #2 away from the wheelchair handle.</p> <p>Review of Client #2's POs dated June 2010, on August 13, 2010, at 10:00 a.m., revealed Client #2 required a wheelchair with a chest harness for support.</p> <p>In an interview with the RN on August 12, 2010, at 5:00 p.m., she stated, "the client's chest harness is usually taken off when eating or taking their medications. Further interview confirmed that Client #2's chest harness was not worn at all times.</p> <p>There was no evidence that the facility ensured Clients #1 and #2 wore their chest harness as ordered.</p>	W 189		
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed</p>	W 192		

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W 192	<p>Continued From page 7 toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure that staff followed client's meal time protocol and physician orders (POS), for two of the three clients included in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. On August 11, 2010, at 6:29 p.m., a direct support staff was observed assisting Client #1 with his dinner meal. The staff informed the surveyor that Client #1's liquids required a thickener consisting of nectar consistency. The staff person was observed to place two tablespoons of thickener into a spout cup full of milk. He stirred it briefly then added a half tablespoon of thickener in the milk and stirred it again. Immediately after the client consumed about a third of the milk staff poured more milk into the cup, then handed it to the client to consume.</p> <p>On August 12, 2010, review of Client #1's POs dated June 2010, revealed he was ordered honey consistency liquids.</p> <p>Interview with the facility nurse on August 13, 2010, at approximately 12:35 p.m., verified that the liquid texture should be thick, like honey, and that the staff must ensure that the liquid consistency is accurate before allowing the client to consume the beverage.</p> <p>Review of the facility's in-service training records on August 13, 2010, at approximately 1:30 p.m.,</p>	W 192	<p>I 192 – 1&2 In the future the QMRP/RN/Nutritionist will ensure that all staff are adequately and effectively trained to provide competent care to our individuals. The QMRP/RN/Nutritionist will ensure this is done by mealtime observations with documentation at least weekly. See attached – IN-SERVICE RECORD – Mealtime Protocol – Thickener</p>	9/1/10
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W 192	Continued From page 8 revealed that all staff had received nutritional training on March 27, 2010. There was no evidence that training had been effective. 2. During dinner observation, on August 11, 2010, at 6:20 p.m., revealed Client #3 received chicken, broccoli, noodles, bread and fruit. The dinner was provided in a puree consistency. As the client scooped his food onto the spoon and took it to his mouth, a quarter of the food fell on his bib. During day program observations, on August 12, 2010, at 12:40 p.m., revealed Client #3 consuming his lunch. The client received his lunch in a chopped consistency. There was minimal spillage noted during the meal. Interview with the registered nurse (RN) on August 12, 2010, at approximately 2:00 p.m., who assisted other client's during the meal on August 11, 2010, confirmed that Client #3 received a pureed diet. Review of the client's current physician orders dated June 2010, on August 12, 2010, at 3:00 p.m., revealed a diet order of finely chopped, high fiber, low cholesterol diet. Review of the facility's in-service training records on August 13, 2010, at approximately 10:15 a.m., revealed that all staff had received training on Client #3's mealtime protocol on March 27, 2010. However, there was no evidence that training had been effective.	W 192			
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to	W 262			

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W 262	<p>Continued From page 9 client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Minutes taken at meetings of the facility's HRC for the period July 2009 through June 2010, were reviewed on August 13, 2010, at 1:25 p.m. According to the documents, sedations are part of the review process.</p> <p>Review of Client #3's medical chart on August 12, 2010, beginning 10:10 a.m., revealed the following telephone order:</p> <p>On October 27, 2009, Ativan 4 mg, prior to a bone density test.</p> <p>Interview with the qualified mental retardation professional (QMRP) on August 13, 2010, at approximately 2:10 p.m., revealed that Client #3 received the sedation to address his non-compliance prior to the medical appointments.</p> <p>Record review revealed HRC meeting notes dated October 28, 2009. The HRC minutes approved for Client #3 to receive Ativan for a bone density study. Further review however, revealed no evidence that the facility's HRC reviewed and/or approved the milligrams, prior to the study. The QMRP confirmed that the HRC</p>	W 262	<p>W 262 In the future the QMRP and RN Supervisor will ensure that the legal guardians are informed and consent is received prior to the use of restrictive programs and supports. All programs and/or medications will not be initiated till Informed Consent and HRC approval is received. See attached – in-service record – HRC Policy & Procedure, Restrictive Procedures etc.</p>	9/1/10

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W 262	Continued From page 10 failed to review the amount of medication prescribed.	W 262		
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to maintain clients adaptive equipment, for two of three clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>The facility failed to maintain Client #1 and #3's adaptive feeding spoon in good repair as evidenced below:</p> <p>1. During dinner observations on August 11, 2010, beginning at 6:20 p.m., revealed staff feeding or assisting Clients #and #3. The staff were observed using coated spoons with metal exposed on spoons. During the environmental inspection on August 13, 2010, at 11:15 a.m., revealed four coated spoons with the metal exposed.</p> <p>Interview with qualified mental retardation</p>	W 436	<p>W 436 – 1&2</p> <p>In the future the QMRP/RN/RC will ensure that all adaptive equipment is maintained and in good repair. The QMRP/RN/Nutritionist will ensure this is done by mealtime observations with documentation at least weekly and monitor all utensils in use.</p> <p>See IN-SERVICE RECORD – Adaptive Eating Utensils, Elbow/Knee pads</p>	9/1/10

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W 436	<p>Continued From page 11</p> <p>professional (QMRP) on August 13, 2010, at approximately 11:40 a.m., confirmed that the spoons used during the dinner meal on August 11, 2010, had the metal exposed.</p> <p>According to Clients #1 and #3 feeding protocol, the client's required coated adaptive feeding spoons.</p> <p>At the time of the survey, the facility failed to ensure clients adaptive feeding spoons were maintained in good repair.</p> <p>2. The facility failed to ensure Client #3's elbow and knee pads were maintained in good repair.</p> <p>On August 11, 2010, at 3:50 p.m., Client #3 was observed wearing elbow and knee pads. The elbow pads were observed on his upper arms and the knee pads were observed on his lower calves. On August 12, 2010, at 12:40 p.m., during day program observations, the client's elbow and knee pads were tied in knots.</p> <p>Interview with the day program staff on August 12, 2010, at approximately 1:00 p.m., indicated that adjustments are made to the elbow and knee pads, "all day long." Further interview indicated that the elbow pads were tied in knots, to help keep the pads in place. Interview with the registered nurse at the facility on August 13, 2010, at 2:30 p.m., revealed that the pads are used to provide safety for Client #3's unsteady gait. According to the qualified mental retardation professional (QMRP), the client just received those elbow and knee pads because the ones he had, were causing skin breakdown.</p> <p>Review of Client #3's physical therapy</p>	W 436		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2010
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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019
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W 436	Continued From page 12 assessment dated November 11, 2009, on August 13, 2010, at 11:00 a.m., revealed that the client required elbow and knee pads to provide safety for unsteady gait.	W 436		
W 455	483.470(I)(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, staff interview and record review, the facility failed to implement infection control techniques, for three of the three clients residing in the facility. (Client #1, #2 and #3) The finding includes: During evening observations, on August 11, 2010, at 5:15 p.m., revealed Client #2 was in the active treatment room, participating in programming (playing the Wii and counting money). At 6:05 p.m., Clients #1 was observed tossing a ball back and forth with the qualified mental retardation professional (QMRP). At 6:15 p.m., direct care staff was observed assisting Clients #1, #2 and #3 and their peers in the dining area for dinner. Prior to the clients, reaching the dining area and receiving their dinner, the staff did not prompt or encourage them to wash their hands. Interview with the QMRP on August 12, 2010, at	W 455	W 455 In the future the RN/QMRP will ensure that all staff are adequately and competently trained to ensure Infection Control practices are implemented for our individuals. The QMRP/RN/Nutritionist will ensure this is done by mealtime observations with documentation at least weekly and monitor whether individuals hands are washed prior to meals. See IN-SERVICE RECORD – Infection Control	9/1/10

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W 455	Continued From page 13 10:30 a.m., confirmed that staff did not assist the clients with washing their hands, prior to dinner.	W 455		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency as prescribed, for two of the three clients in the sample. (Clients #1 and #3) The finding includes: Cross refer to W192 1 and 2. The facility failed to ensure that staff followed client's meal time protocol, for two of the three clients included in the sample. (Clients #1 and #3)	W 474	W 474 In the future the QMRP/RN/Nutritionist will ensure that all staff are adequately and effectively trained to provide competent care to our individuals. The QMRP/RN/Nutritionist will ensure this is done by mealtime observations with documentation at least weekly. See attached – IN-SERVICE RECORD – Mealtime Protocol – Thickener	9/1/10

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1 000	<p>INITIAL COMMENTS</p> <p>An licensure survey was conducted from August 11, 2010, through August 13, 2010. A random sample of three clients was selected from a population of five males with various levels of mental retardation and disabilities.</p> <p>The findings of the survey were based on observations at the group home and two day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.</p>	1 000		
1 052	<p>3502.10 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident.</p> <p>This Statute is not met as evidenced by: Based on observations, interview and record review, Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure that clients were provided with necessary adaptive feeding equipment, for two of the three residents included in the sample. (Residents #1 and #3)</p> <p>The finding includes:</p> <p>During dinner observations on August 11, 2010, beginning at 6:20 p.m., revealed staff feeding or assisting Residents #1 and #3. The staff were observed using coated spoons with metal exposed. During the environmental inspection on August 13, 2010, at 11:15 a.m., revealed four coated spoons with the metal exposed.</p> <p>Interview with qualified mental retardation</p>	1 052	<p>1052</p> <p>In the future the QMRP/RN/RC will ensure that all adaptive equipment is maintained and in good repair. The QMRP/RN/Nutritionist will ensure this is done by mealtime observations with documentation at least weekly and monitor all utensils in use.</p> <p>See IN-SERVICE RECORD - Adaptive Eating Utensils, Elbow/Knee pads</p>	9/1/10

Health Regulation Administration
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 STATE FORM

Susan J. Sloan

TITLE
VP Operations

(X6) DATE
9/1/10

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I 052	Continued From page 1 professional (QMRP) on August 13, 2010, at approximately 11:40 a.m., confirmed that the spoons used during the dinner meal on August 11, 2010, had the metal exposed. According to Resident #1 and #3's feeding protocol revealed that the resident's required coated adaptive feeding spoons. At the time of the survey, the facility failed to ensure residents adaptive feeding spoons were maintained in good repair.	I 052		
I 055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils. This Statute is not met as evidenced by: Based on observation and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure staff were effectively trained to implement the mealtime protocols for two of three included in the sample. (Residents #1 and #3) The findings include: 1. On August 11, 2010, at 6:29 p.m., a direct support staff was observed assisting Resident #1 with his dinner meal. The staff informed the surveyor that Resident #1's liquids required a thickener consisting of nectar consistency. The staff person was observed to place two tablespoons of thickener into a spout cup full of milk. He stirred it briefly then added a half tablespoon of thickener in the milk and stirred it,	I 055	I 055 – 1&2 In the future the QMRP/RN/Nutritionist will ensure that all staff are adequately and effectively trained to provide competent care to our individuals. The QMRP/RN/Nutritionist will ensure this is done by mealtime observations with documentation at least weekly. See attached – IN-SERVICE RECORD – Mealtime Protocol – Thickener	9/1/10

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I 055	<p>Continued From page 2</p> <p>again. Immediately after the resident consumed about a third of the milk staff poured more milk into the cup, then handed it to the resident to consume.</p> <p>On August 12, 2010, review of Resident #1's POS dated June 2010, revealed he was ordered honey consistency liquids.</p> <p>Interview with the facility nurse on August 13, 2010, at approximately 12:35 p.m., verified that the liquid texture should be thick, like honey, and that the staff must ensure that the liquid consistency is accurate before allowing the Resident to consume the beverage.</p> <p>Review of the facility's in-service training records on August 13, 2010, at approximately 1:30 p.m., revealed that all staff had received nutritional training on March 27, 2010. There was no evidence that training had been effective.</p> <p>2. During dinner observation, on August 11, 2010, at 6:20 p.m., revealed Resident #3 received chicken, broccoli, noodles, bread and fruit. The dinner was provided in a puree consistency. As the resident scooped his food onto the spoon and took it to his mouth, a quarter of the food fell on his bib. During day program observations, on August 12, 2010, at 12:40 p.m., revealed Resident #3 consuming his lunch. The Resident received his lunch in a chopped consistency. There was minimal spillage noted during the meal.</p> <p>Interview with the registered nurse (RN) on August 12, 2010, at approximately 2:00 p.m., who assisted other Resident's during the meal on August 11, 2010, confirmed that Resident #3</p>	I 055		

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I 055	Continued From page 3 received a pureed diet. Review of the Resident's current physician orders dated June 2010, on August 12, 2010, 3:00 p.m., revealed a diet order of finely chopped, high fiber, low cholesterol diet. Review of the facility's in-service training records on August 13, 2010, at approximately 10:15 a.m., revealed that all staff had received training on Resident #3's mealtime protocol on March 27, 2010. However, there was no evidence that training had been effective	I 055		
I 090	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 Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner for three of the three clients in the sample (Client #1 #2 and #3) The findings include: During an environmental inspection of the facility on August 13, 2010, beginning at 11:15 a.m., the following concerns were identified: Exterior: 1. The the front walkway and driveway had broken cement which would be considered to be a trip hazard.	I 090	I090 1. Front walkway – cemented – no more cracks 2. Hanging cable wires were fixed by Comcast 3. Tree braches and leaves were cleaned 4. Fence was fixed 5. Laundry room base board around the floor was fixed 6. The cracked tiles in the BR were replaced	

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I 090	<p>Continued From page 4</p> <p>2. On the right side of the house the cable wires were hanging from the roof.</p> <p>3. In the rear of the yard, tree branches and leaves were in the corner of the yard.</p> <p>4. On the right of the house the fence was broken which could be a potential safety issue.</p> <p>Interior:</p> <p>5. In the laundry room, the border around the floor was off the wall.</p> <p>6. In the bathroom located close to residents bedrooms, there were cracked floor tiles.</p> <p>These deficiencies were acknowledge by the House Manager at approximately 12:45 p.m. the same day.</p>	I 090	<p>In the future the QMRP/RC/Maintenance Manager will ensure environmental issues are maintained in safe, clean, orderly and fair repair. Monthly environmental QA will be completed by the QMRP/RC/Maintenance Manager See attached – Environmental QA record</p>	9/1/10
I 109	<p>3504.16 HOUSEKEEPING</p> <p>Each GHMRP shall label inconspicuously each item of clothing as belonging to a particular resident as indicated in his or her Individual Habilitation Plan (IHP).</p> <p>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 clothing items were labeled inconspicuously, for one of the three residents included in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>On August 12, 2010, at 12:40 p.m., Resident #3</p>	I 109	<p>I 109 In the future the QMRP/RC will ensure that all individuals' clothing will be labeled by them. All clothing with conspicuous labeling have been replaced.</p>	9/1/10

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I 109	Continued From page 5 was observed wearing a light blue polo style shirt. The resident's initials were written across the top back of the shirt in large black letters. Interview with the direct care staff confirmed that the resident's initial's were written on the back of the shirt. During the survey on August 12, 2010, at , approximately 4:00 p.m., the qualified mental retardation professional acknowledged she had observed the initials on his shirt.	I 109		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home form Mentally Retarded Persons (GHMRP) failed to sign physician orders (POs), for two of the three residents in the sample. (Residents #2 and #3) The findings include: 1. Observation during the dinner meal on August 11, 2010, at 6:20 p.m., revealed Resident #2 received a bottle of Boost Plus. Interview with the staff indicated that the resident receives five bottles per day. Review of Resident #2's POs on August 13, 2010, beginning at 10:10 a.m., revealed a telephone order (TO) dated June 29, 2010, transcribed by the licensed practical nurse (LPN). The POs indicated to increase Boost Plus five times a day and bi-weekly weights for three months. Further review revealed that the order was not signed by the prescribing physician. 2. During the evening medication administration on August 11, 2010, at 4:48 p.m., revealed Resident #3 received mineral oil 30 ml. Interview	I 291	I 291 In the future the QMRP and RN Supervisor will ensure that all POS are signed by the PCP in the 3-5day time period as per the Medication Administration Policy and Procedure. The RN Supervisor that all telephone and consultant POS are signed by the PCP every Tuesday of the week. See attached – IN-SERVICE RECORD NURSING STAFF – Medication Administration Policy /Procedure	9/01/10

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I 291	<p>Continued From page 6</p> <p>with the trained medication employee indicated that the resident received the medication to address his diagnosis of constipation.</p> <p>Review of Resident #3's POs on August 12, 2010, at 10:10 a.m., revealed a telephone order dated June 29, 2010, transcribed by the LPN. The TO indicated give mineral oil 30 ml, by mouth, once a day for constipation. Further review revealed that the order was not signed by the prescribing physician.</p> <p>3. Similarity, review of Resident #3's POs revealed the following TO transcribed by the LPN:</p> <ul style="list-style-type: none"> - On July 16, 2010, liver function test and dilantin levels every six months. The TO was not signed by the prescribing physician; and - On September 28, 2009, Vit D 50,000 units 1 cap, by mouth, once a week for osteoporosis. The telephone orders was signed by the primary care physician (PCP) on October 15, 2009. <p>Interview with the registered nurse on August 12, 2010, at approximately 1:30 p.m., indicated that TO should be signed by the PCP within 5 days.</p> <p>Review of the facility's policy on August 13, 2010, at approximately 11:00 a.m., revealed a medication administration policy. The policy indicated that when a new orders are written by the nurse, the nurse will ensure that the POs is signed by the PCP within 3-5 days.</p>	I 291		
I 405	<p>3520.7 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall be provided by programs operated by the GHMRP or personnel</p>	I 405		

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I 405	<p>Continued From page 7</p> <p>employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure professional services had been provided in accordance with each resident's needs, for one of the three residents included in the sample. (Resident #1)</p> <p>The findings include:</p> <p>1. During day program observations on August 12, 2010, at 10:50 a.m., the day program staff placed a communication device in front of Resident #1 and asked him "what is your name". When the resident did not respond the staff pressed the communication button approximately two or three times. At the same time the staff stated, " it needs batteries but he only uses it on Wednesdays"</p> <p>On August 12, 2010, at 11:15 a.m., review of Resident # 1's individual program plan (IPP) dated April 23, 2010, revealed the following objective: "Given a low tech communication device (Big Mack), <the Resident> will activate the device in response to social greetings for 4 out of 5 days per week as measured by program documentation". Further review revealed that the communication program was documented once a week. Interview with the day program staff at the same time, revealed that she was told to implement the communication program once a week.</p>	I 405	<p>I 405 In the future the QMRP / Activities Coordinator will ensure that all staff are trained and well equipped with individual's programming and dietary needs. The Residential QMRP/RC/RN will ensure that mealtime observations and program observation is completed at the Day Program at least once a month. See attached – IN-SERVICE RECORD – Communication Program and Mealtime Protocol</p>	9/1/10

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I 405	<p>Continued From page 8</p> <p>At the time of the survey, the day program failed to ensure Resident #1's communication program was implemented as recommended.</p> <p>2. During day program observations on August 12, 2010, at 12:40 p.m., the day program staff was observed feeding Resident #1 pureed roast beef, sweet potatoes and peas with a built up spoon. Review of the resident's mealtime protocol dated April 7, 2010, on the same day at approximately 11:30 a.m., revealed the following feeding techniques:</p> <p>a. Provide hand over hand assistance with feeding.</p> <p>b. If the resident fatigues or resists hand over hand assistance after 5 attempts, then feed him.</p> <p>In an interview on the same day, at 12:45 p.m., the day program staff revealed that she fed the resident because he does not know how to hold his spoon very well. Further interview revealed that she did not attempt to feed the resident with hand over hand assistance.</p> <p>At the time of the survey, the day program failed to implement Resident #1's mealtime protocol.</p>	I 405		
I 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on staff interview, and record review, the</p>	I 500		

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I 500	<p>Continued From page 9</p> <p>Group Home for Mentally Retarded Persons (GHMRP) failed to establish a system that ensured clients and/or legal guardian was informed of the risks and benefits of restrictive programs and supports, for one of the three residents included in the sample. (Resident #3)</p> <p>The findings include:</p> <p>1. The facility failed to provide evidence that informed consent was obtained from Resident #3's legal guardian for sedations given during medical appointments as evidenced below:</p> <p>During the entrance conference on August 11, 2010, beginning at 3:45 p.m., qualified mental retardation professional (QMRP) indicated that Resident #3 had a court appointed legal guardian to assist him in making health care decisions.</p> <p>Review of Resident #3's physician orders (POS) on August 12, 2010, beginning at 10:10 a.m., revealed the following orders:</p> <ul style="list-style-type: none"> - On November 30, 2009, Ativan 4 mg, prior to dental examination; and - On October 29, 2009, Ativan 4 mg, prior to bone density test. <p>Review of Resident #3's medication administration record (MAR), confirmed that the resident was administered the aforementioned sedations.</p> <p>Review of Resident #3's Psychological Assessment dated November 3, 2009, on August 12, 2010 at approximately 3:30 p.m., revealed that the resident was not competent to make decisions regarding his health, safety, financial or</p>	I 500	<p>I 500</p> <p>In the future the QMRP and RN Supervisor will ensure that the legal guardians are informed and consent is received prior to the use of restrictive programs and supports. All programs and/or medications will not be initiated till Informed Consent and HRC approval is received. See attached – in-service record – HRC Policy & Procedure, Restrictive Procedures etc.</p>	9/1/10
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 10 residential placement. Further review of the resident's record failed to provide evidence that informed consent had been obtained for the use of the sedation. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using these medications, or Resident #3's right to refuse treatment had been explained to the resident and/or court appointed legal guardian. 2. Minutes taken at meetings of the facility's HRC for the period July 2009 through June 2010, were reviewed on August 13, 2010, at 1:25 p.m. According to the documents, sedations are part of the review process. Review of Resident #3's medical chart on August 12, 2010, beginning 10:10 a.m., revealed the following a telephone order: On October 27, 2009, Ativan 4 mg, prior to a bone density test. Interview with the qualified mental retardation professional (QMRP) on August 13, 2010, at approximately 2:10 p.m., revealed that Resident #3 received the sedation to address his non-compliance prior to the medical appointments. Record review revealed HRC meeting notes dated October 28, 2009. The HRC minutes approved for Resident #3 to receive Ativan for a bone density study. Further review revealed no evidence that the facility's HRC reviewed and/or approved the milligrams, prior to the study. The QMRP confirmed that the HRC failed to review the amount of medication prescribed.	I 500		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2010
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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019
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I 500	Continued From page 11 There was no evidence, however, that the HRC reviewed and/or approved the use of Ativan 4 mg for Resident #3's bone density study.	I 500		