

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

PRINTED: 02/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2014
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 14TH STREET, NW WASHINGTON, DC 20011	
(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 A recertification survey was conducted from January 27, 2014 through January 29, 2014. A sample of three clients was selected from a population of two females and four males with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations, interviews, review of client and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. Department of Health, Health Regulation and Licensing Administration - DOH/HRLA Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHID Individual Program Plan - IPP Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN DON - Director of Nursing DPS - Day Program Staff	W 000	Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002 2/21/14	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Emily A. Horned TITLE
Executive Director of Operations (X6) DATE
2/21/14

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 249	<p>Continued From page 1 and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the IPP included the communication program objective to meet the client's needs as recommended by the speech pathologist, for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On January 27, 2014, beginning at 12:26 p.m., Client #3 was observed learning sign language with flash cards at her day program. At 12:30 p.m., Client #3 signed bathroom without the use of the flash card. DPS #1 assisted the client to the bathroom. At 3:40 p.m., Client #3 arrived home from the day program. At 3:54 p.m., DSP #2 asked Client #3 to set the table for snack. At 3:57 p.m., DSP #3 asked the client to choose what she wanted to eat for snack. At 3:59 p.m., Client #3 gestured for DSP #2 to open the pudding container. At 5:43 p.m., DSP #2 asked Client #3 to wash her hands for dinner.</p> <p>Review of Client #3's record revealed the client had an ISP meeting on September 10, 2013, at 10:54 a.m. At the ISP meeting, the IDT reviewed consultant recommendations and approved the program goals and objectives to be implemented the following year.</p> <p>Review of Client #3's speech assessment dated August 26, 2013, on January 29, 2014, at 10:16 a.m., revealed the client was required to</p>	W 249	<p>W 249 The QIDP will re-inservice staff #2 and all staff working with individual #3 on the program goals recommended by the speech pathologist, and approved by the IDT. SYSTEM: The QIDP will at least monthly review the documentation for the goals and observe the implementation of the goal that ensure that staff are consistently implementing the speech goal and all goals consistently.</p>	2/21/14	Ongoing

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W 249	Continued From page 2 participate in a communication program with the use of manual signs. Further review revealed the following program objective: "Client #4 will produce manual signs to label activities of daily living for 8 of 10 trials offered with 80% accuracy." Continued review of the assessment revealed that the objective intended the client to manually learn the words: eat, drink, bathroom hello, goodbye, sleep, wash hands, shoes, ride and finish. Review of the IPP dated September 10, 2013, on January 29, 2014, at 11:27 a.m., revealed no evidence of a training program to address the aforementioned communication program by the speech pathologist. Interview with the QIDP on January 29, 2014, at 3:00 p.m., confirmed that the communication to produce manual signs was not implemented.	W 249			
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure medications were secured during the medication administration, while not in the direct supervision of the nurse administering the medications, for six of six persons residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) On January 27, 2014, during the medication	W 382	W 382 LPN #2 will be re-inserviced on ensuring and keeping all drugs and biologicals locked except when being prepared for administration. SYSTEM: The supervising RN will, at least every 6 months, observe any LPN's passing medication at Metro Homes, Inc. and document all observations.	2/21/14 Ongoing	

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W 382	Continued From page 3 administration beginning from 8:23 a.m., through 9:09 a.m., LPN #2 was observed to leave the medication closet door open and unsecured on six separate occasions. Additionally a small medication refrigerator which was position next to the medication cabinet was also noted to be unsecured. The medication refrigerator was used to store medications including insulin. As LPN #2 administered the medications, the nurse was observed to leave the direct oversight of the medications. The surveyor remained in the medication area each time the nurse left the medications unsecured. Furthermore Client #3 and DPS #1, #2, #3 and #4 were observed to have direct access to the medication area. Interview with LPN #2 on January 29, 2014, at 3:23 p.m., confirmed that the medication should have been secured and unaccessible to staff, the clients and the surveyor.	W 382		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for two individuals (out of six clients that reside in the facility) whose blood glucose was being tested by facility staff. (Clients #1 and #5) The finding includes: On January 27, 2014, at 8:37 a.m., LPN #2 was	W 393	W 393 The Director of Nursing will obtain a current CLIA for the home for glucose monitoring for individual #1 and #5. SYSTEM: The Director of Nursing will obtain an updated CLIA every two years as required by part 493 of the Clinical Laboratory improvement Act.	2/21/14 Ongoing

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W 393	Continued From page 4 observed performing a finger stick glucose test on Client #5 using a glucometer. Interview with the nurse at 8:38 a.m., revealed that Client #5 had a diagnosis of diabetes and was prescribed Metformin and Januvia to treat his health condition. Similarly, on January 27, 2014, at 9:05 a.m., LPN #2 was observed performing a finger stick glucose test on Client #1 using a glucometer. Interview with the nurse at 9:06 a.m., revealed that Client #1 had a diagnosis of diabetes and was prescribed Metformin to treat his health condition. Interview with the facility's DON on January 29, 2014, at approximately 4:30 p.m., revealed that the provider did not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA) to perform glucose monitoring in the facility. Further interview revealed that the DON started the process to obtain a CLIA certificate. The facility failed to obtain a clinical laboratory improvement amendment (CLIA) certificate prior to conducting laboratory testing.	W 393		
W 440	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly, for five of the five shift of duties reviewed (Weekday 8:00 a.m. - 4:00 p.m., 4:00 p.m. - 12:00 a.m., and	W 440	W440 The Residential Coordinator will be re-inserviced on the requirement as it relates to printing evacuation drills on a monthly basis, and file in the fire drill book . SYSTEM: The Residential Coordinator will monthly review fire drills in electronic system to ensure they are completed per regulation, and follow filing process.	2/21/14 Ongoing

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W 440	<p>Continued From page 5 12:00 a.m. - 8:00 a.m., and weekend 8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.).</p> <p>The finding includes:</p> <p>The GHIID failed to conduct simulated fire drills at least four times a year for each shift, as evidenced below:</p> <p>On January 27, 2014, at 11:00 a.m., interview with the QIDP revealed that there were five designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.) for the weekend (Saturday/Sunday).</p> <p>Review of the GHIID's fire drill records on January 29, 2014, beginning at 3:07 p.m. revealed that no drills were held during the weekday and weekend shift (12:00 a.m. - 8:00 a.m.) from April 2013 through January 2014. Further review revealed that no drills were held during the weekday and weekend shift (8:00 a.m. - 4:00 p.m., and 4:00 p.m. - 12:00 a.m.) from June 2013 through January 2014.</p> <p>Interview with the QIDP on January 29, 2014, at approximately 4:15 p.m., revealed that fire drills were to be completed for every shift.</p>	W 440			

Health Regulation & Licensing Administration

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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from January 27, 2014 through January 29, 2014. A sample of three residents was selected from a population of two females and four males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews, review of residents and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Department of Health, Health Regulation and Licensing Administration - DOH/HRLA Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID Individual Program Plan - IPP Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN DON - Director of Nursing DPS - Day Program Staff</p>	1 000		
1 090	<p>3504.1 HOUSEKEEPING</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:</p>	1 090		

Health Regulation & Licensing Administration
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Emily J. Horner Executive Director of Operations
 TITLE
 (X6) DATE
 2/21/14
 STATE FORM 4599 7HNC11 If continuation sheet 1 of 6

Health Regulation & Licensing Administration

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1 090	<p>Continued From page 1</p> <p>Based on observation and interview, the GHIID failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>Observation during the inspection of the environment on January 29, 2014, beginning at 4:50 p.m., revealed the following:</p> <ol style="list-style-type: none"> Residents #3, #4 and #5's dresser drawers were off track, creating a potential safety hazard. One dining room chair arm rest was broken. There was an electric space heater observed in Residents #3 and #4's bedroom. Additionally, there were two unplugged electric space heaters were observed in the nurses' office. Resident #5's blind was broken. The gutter outside was leaking water onto the front steps. <p>The QIDP who was present during the inspection, confirmed the above findings. The QIDP stated she would address the findings.</p>	1 090	<p>1090</p> <ol style="list-style-type: none"> Individuals #3 and #4 dresser drawers were repaired. The dining room chair was repaired. The electric space heaters have been removed from the home. Additionally, the space heaters in individuals #3 and #4 bedroom have been removed and replaced by an approved heater. Individual #5's blind has been replaced. The gutter outside was cleaned, and repaired. <p>SYSTEM: The Residential Coordinator will conduct monthly environmental checks, and note any repairs needed. The repairs will be put in the electronic system within 24 hours of discovery, and follow maintenance protocol.</p>	<p>2/3/14</p> <p>2/3/14</p> <p>2/12/14</p> <p>2/3/14</p> <p>2/3/14</p> <p>Ongoing</p>
1 135	<p>3505.5 FIRE SAFETY</p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p>	1 135	cross reference W 440	

Health Regulation & Licensing Administration

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I 135	<p>Continued From page 2</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to hold evacuation drills quarterly, for five of the five shift of duties reviewed (Weekday 8:00 a.m. - 4:00 p.m., 4:00 p.m. - 12:00 a.m., and 12:00 a.m. - 8:00 a.m., and weekend 8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.).</p> <p>The finding includes:</p> <p>The GHIID failed to conduct simulated fire drills at least four times a year for each shift, as evidenced below:</p> <p>On January 27, 2014, at 11:00 a.m., interview with the QIDP revealed that there were five designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.) for the weekend (Saturday/Sunday).</p> <p>Review of the GHIID's fire drill records on January 29, 2014, beginning at 3:07 p.m. revealed that no drills were held during the weekday and weekend shift (12:00 a.m. - 8:00 a.m.) from April 2013 through January 2014. Further review revealed that no drills were held during the weekday and weekend shift (8:00 a.m. - 4:00 p.m., and 4:00 p.m. - 12:00 a.m.) from June 2013 through January 2014.</p> <p>Interview with the QIDP on January 29, 2014, at approximately 4:15 p.m., revealed that fire drills were to be completed for every shift.</p>	I 135		
I 206	3509.6 PERSONNEL POLICIES	I 206		

Health Regulation & Licensing Administration

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I 208	<p>Continued From page 3</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to ensure that all employees and health care professionals had current health certificates on file, for six (6) of nineteen (19) DSPs (DSPs #4, #5, #6, #7, #8 and #9), one (1) of one (1) RN (RN #1), and one (1) of (ten) consultants .</p> <p>The findings include:</p> <p>On January 29, 2014, beginning at 12:57 p.m., review of the personnel records for all employees including nurses and consultants revealed the following:</p> <ol style="list-style-type: none"> 1. There was no evidence of a complete physician's health inventory/certificate for DSPs #4, #5, #6, #7, #8 and #9. 2. There was no evidence of a complete physician's health inventory/certificate for RN #1. 3. There was no evidence of a complete physician's health inventory/certificate for the pharmacist (Consultant #1). <p>On January 29, 2014, at 3:30 p.m., the QIDP, who had facilitated the review, acknowledged the aforementioned findings. No additional information was made available for review before</p>	I 206	<p>1206</p> <p>The Director of Human Resources has obtained the current health certificates for 3 DSP's. The DSP's that have failed to get current health certificates to Human Resources have been removed from the schedule. Additionally, she obtained current health certificates for RN #1, and consultant #1(Pharmacist).</p> <p>SYSTEM: The Director of Human Resources will distribute, quarterly, a checklist to all employees to ensure that they are aware of the status/due date of their required documents. Furthermore, should the required documents expire, the employee shall be removed from the schedule, until received by the employee/consultant.</p>	<p>2/21/14</p> <p>Ongoing</p>

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I 206	Continued From page 4 the survey ended.	I 206		
I 420	<p>3521.1 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHID failed to ensure habilitation and training to its residents to enable them to acquire and maintain those life skills that is needed to communicate, for one of three residents in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>On January 27, 2014, beginning at 12:26 p.m., Resident #3 was observed learning sign language with flash cards at her day program. At 12:30 p.m., Resident #3 signed bathroom without the use of the flash card. DPS #1 then assisted the Resident to the bathroom. At 3:40 p.m., Resident #3 arrived home from the day program. At 3:54 p.m., DSP #2 asked Resident #3 to set the table for snack. At 3:57 p.m., DSP #3 asked the Resident to choose what she wanted to eat for snack. At 3:59 p.m., Resident #3 gestured for DSP #2 to open the pudding container. At 5:43 p.m., DSP #2 asked Resident #3 to wash her hands for dinner.</p> <p>Review of Resident #3's speech assessment dated August 26, 2013, on January 29, 2014, at 10:16 a.m., revealed the Resident was required</p>	I 420	1420 Cross Reference W 249	

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 14TH STREET, NW WASHINGTON, DC 20011
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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) COMPLETE DATE
I 420	<p>Continued From page 5</p> <p>to participate in a communication program with the use of manual signs. Further review revealed the following program objective:</p> <p>The Resident will produce manual signs to label activities of daily living for 8 of 10 trials offered with 80% accuracy. The Resident will manually learn the words eat, drink, bathroom, hello, goodbye, sleep, wash hands, shoes, ride and finish.</p> <p>Review of the IPP dated September 10, 2013, on January 29, 2014, at 11:27 a.m., revealed no evidence of a training program to address the aforementioned communication program by the speech pathologist.</p> <p>Interview with the QIDP on January 29, 2014, at 3:00 p.m., revealed that the training objective was not implemented.</p>	I 420		