| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G169 | A. BUILDING _____ B. WING _____ | 03/13/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| METRO HOMES | 8020 EASTERN AVENUE, 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 |
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| W 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted from March 11, 2014 through March 13, 2014. A sample of three clients was selected from a population of four female and two males with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process.<br><br>The findings of the survey were based on observations, interviews, review of client and administrative records.<br><br>Note: The below are abbreviations that may appear throughout the body of this report.<br><br>Behavioral Support Plan-BSP<br>Cardiopulmonary Resuscitation - CPR<br>Comprehensive Functional Assessment-CFA<br>Department of Health, Health Regulation and Licensing - DOH/HRLA<br>Direct Support Professional - DSP<br>Group Home for Individuals with Intellectual Disabilities - GHID<br>House Manager - HM<br>Intermediate Care Facility - ICF<br>Qualified Intellectual Disabilities Professional - QIDP<br>Registered Nurse - RN | W 000 | APR 1 2014<br><br>APR 1 2014<br><br>Department of Health<br>Health Regulation & Licensing Administration<br>Intermediate Care Facilities Division<br>899 North Capitol St., N.E.<br>Washington, D.C. 20002 | |
| W 137 | 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. | W 137 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Emily A Horner, Exec. Director of Operations 3/31/14

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 disclosable90 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 disclosable14 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 137 | Continued From page 1<br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure the right of each client to wear their clothing without a bib for one of the three clients in the sample. (Client #3)<br><br>The finding includes:<br><br>On March 11, 2014, at 4:10 p.m., Client #3 was observed wearing a bib. The client continued to wear the bib throughout the dinner observation that ended at 4:41 p.m. At the conclusion of the meal, there was no spillage or saliva observed on the bib.<br><br>On March 12, 2014, at 11:12 a.m., Client #3 was observed at his day program wearing blue jeans, a blue and white striped shirt, white tennis shoes, and a bib. Further observation of Client #3 eating a snack revealed that Client #3 did not spill food or drool on the bib. Throughout the survey, the bib was free from food and saliva.<br><br>On March 12, 2014, at 11:46 a.m., interview with DSP #2 at Client #3's day program revealed that Client #3 has been wearing a bib since he started working with him in 2012. Further interview with DSP #2 revealed that the bib was worn to prevent Client #3 from tearing his clothing. When asked how often Client #3 attempts to tear his clothing, DSP #2 revealed he does not attempt to tear his clothing that often.<br><br>On March 13, 2014, at 1:52 p.m., record review of Client #3's CFA did not include an assessment of Client #3's behavior of tearing his clothing.<br><br>On March 13, 2014, at 4:02 p.m., interview with | W 137 | W 137<br>The QIDP will hold a team meeting to for individual #3 to discuss the use of the clothing protector and the possibility of discontinuation of the use for the use of the clothing protector.<br>SYSTEM: The IDT team will meet annually, and as needed for individual #3 and all individuals to discuss the use of restrictive devices and the need for them. | 4/7/14<br><br>Ongoing |

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| W 137 | Continued From page 2<br>the QIDP revealed that Client #3 does not wear a bib to protect his clothing from saliva and food spillage. Continued discussion with the QIDP revealed the bib was worn to prevent Client #1 from tearing his clothing. When asked to provide Client #3's BSP for review, the QIDP revealed that Client #3 does not have a BSP.<br><br>At the time of the survey, the facility failed to ensure that Client #3 had the right to wear his clothes without a bib. | W 137 | | |
| W 153 | 483.420(d)(2) STAFF TREATMENT OF CLIENTS<br><br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that all allegations of abuse were reported immediately to the Department of Health, Health Regulation and Licensing Administration (HRLA), for one of six clients residing in the facility. (Client #1)<br><br>The finding includes:<br><br>On March 11, 2014, beginning at 9:18 a.m., review of an "internal investigative summary" dated November 16, 2013, revealed that on November 12, 2013, Client #1 grabbed DSP #1 by her blouse. After the incident, DSP #1 reported to the RN that Client #1 had a behavior | W 153 | W 153<br>The report for allegation of abuse for Individual #1 was reported to DOH on March 17, 2014.<br>Furthermore the incident was investigated by the Incident Management Coordinator. The QIDP, and the Residential Coordinator were re-inserviced on the incident reporting protocol.<br>SYSTEM:<br>The QIDP, Residential Coordinator, and all direct support staff will be trained at least annually or as needed. | 3/28/14<br><br>Ongoing |

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| W 153 | Continued From page 3<br>that resulted in a scratch on the client's chest.<br><br>Interview with the QIDP on March 11, 2014, at 11:00 a.m., revealed that on November 12, 2013, Client #1's day program staff informed the QIDP that Client #1 was scratched by DSP #1. When asked about the status of reporting the allegation of abuse to DOH, the QIDP indicated that he did not report the incident. According to the QIDP, Client #1 later reported that she was scratched by another client. Continued discussion with the QIDP and review of Client #1's record on March 12, 2014, at 10:49 a.m., revealed the client has behaviors which include false allegations. The QIDP revealed that the the aforementioned incident was reported as a physical injury instead of an allegation of abuse.<br><br>It should be noted that review of HRLA internal records on March 10, 2014, at approximately 2:00 p.m., confirmed that the November 12, 2013, incident was reported as a physical injury (skin tear) instead of an allegation of abuse.<br><br>At the time of the survey, the facility failed to ensure that all allegations of abuse or mistreatment were reported immediately to DOH/HRLA. | W 153 | | |
| W 154 | 483.420(d)(3) STAFF TREATMENT OF CLIENTS<br><br>The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to thoroughly investigate an | W 154 | | |

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| W 154 | Continued From page 4<br>allegation of abuse, for one of six clients residing in the facility. (Client #1)<br><br>The finding includes:<br><br>On March 11, 2014, beginning at 9:18 a.m., review of an "internal investigative summary" dated November 16, 2013, revealed that on November 12, 2013, Client #1 reported to her day program that she had a fight with DSP #1. According to the report, DSP #1 stated that Client #1 grabbed her (DSP#1) blouse after she stopped the client from trying to throw away another client's food. Continued review of the investigative summary revealed that Client #1, who is able to communicate orally, was not interviewed.<br><br>Interview with the QIDP on March 11, 2014, at 11:00 a.m., indicated that he interviewed Client #1 but he did not document the interview. Further interview revealed that he did not substantiate the allegation because Client #1 first stated that DSP #1 scratched her then stated that another client scratched her.<br><br>The facility failed to provide evidence that Client #1's allegation of abuse was thoroughly investigated. | W 154 | W 154<br>The incident for allegation of abuse for individual #1 was reported to DOH on March 17th, 2014.<br>The allegation of abuse has been thoroughly investigated, and documented as such by the Incident Management Coordinator.<br>SYSTEM:<br>The QIDP, Residential Coordinator, and all Direct support Staff are re-trained annually and as needed on the protocols and policies for Incident Reporting. | 3/28/14<br><br>Ongoing |

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| | HFD03-0164 | A. BUILDING: _____ B. WING _____ | 03/13/2014 |

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| I 000 | INITIAL COMMENTS<br><br>A lisensure survey was conducted from March 11, 2014 through March 13, 2014. A sample of three clients was selected from a population of four female and two males with varying degrees of intellectual disabilities.<br><br>The findings of the survey were based on observations, interviews, review of client and administrative records.<br><br>Note: The below are abbreviations that may appear throughout the body of this report.<br><br>Behavioral Support Plan-BSP<br>Cardiopulmonary Resuscitation - CPR<br>Comprehensive Functional Assessment-CFA<br>Department of Health, Health Regulation and Licensing - DOH/HRLA<br>Direct Support Professional - DSP<br>Group Home for Individuals with Intellectual Disabilities - GHIID<br>House Manager - HM<br>Intermediate Care Facility - ICF<br>Qualified Intellectual Disabilities Professional - QIDP<br>Registered Nurse - RN | I 000 | | |
| I 090 | 3504.1 HOUSEKEEPING<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview, the GHIID | I 090 | | |

Health Regulation & Licensing Administration

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| I 090 | Continued From page 1<br>failed to dispose of old furnishings, bags, and boxes to prevent the collection of clutter.<br><br>The findings include:<br><br>On March 13, 2014, beginning at 4:03 p.m., the QIDP and HM accompanied the surveyor to conduct an inspection of the environment. The following concerns were identified:<br><br>1. The porch leading directly into the kitchen contained a green swing set. The swing set was rusted and inoperable. The swing set was located less than one foot from the table in which the clients ate on warm days. The swing consumed approximately three feet of additional space from the porch that was only approximately eight feet in length causing space to be consumed by the inoperable swing set.<br><br>2. The basement housed a soiled mattress against the wall, a couch, several bags and boxed items that required bulk trash for pick -up.<br><br>On March 14, 2014, at 4:08 p.m., interview with the QIDP and the HM confirmed that the above identified concerns were present in the facility. The QIDP stated that he has an appointment set for bulk trash on Wednesday, March 19, 2014, and will include a photo with the plan of corrections.<br><br>At the time of the survey, the facility failed to ensure each area of the environment was free from clutter and inoperable items. | I 090 | 1. The green swing has been removed from the porch.<br>2. The soiled mattress, couch, and several bags and boxed items have been removed.<br><br>SYSTEM: The residential Coordinators will conduct monthly environmental checklists to ensure that 8020 Eastern Avenue NW and all homes operated by Metro Homes, Inc remains free from clutter, and inoperable items. | 3/19/14<br><br>3/19/14<br><br>Ongoing |