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

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	•	09G179	B. WING_		08/30/2013
NAME OF METRO	PROVIDER OR SUPPLIER HOMES			STREET ADDRESS, CITY, STATE, ZIP COL 5701 13TH STREET, NW WASHINGTON, DC 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
W 000	INITIAL COMMENT	rs	W 00	00	
W 159	August 28, 2013 the sample of three clie population of six fer intellectual disabilitiutilizing the fundam. The findings of the observations in the interviews with one direct support staff, staff, as well as a readministrative recor. [Qualified mental re (QMRP) will be refe disabilities profession 483.430(a) QUALIF RETARDATION PRESENCE CONTROLLER CON	ds, including incident reports. tardation professional rred to as qualified intellectual rnal (QIDP) within this report.] ED MENTAL	W 15	8	HOLD TOND
d.	Based on observation review, the qualified professional (QIDP, services timely (spectaffing in accordance for one of three client The finding includes: On August 27, 2013, support staff (Staff #	not met as evidenced by: on, interview and record intellectual disabilities Staff #1) failed to coordinate cifically, secure one on one the with physician's orders), ts in the sample. (Client #2) at 8:02 a.m., a direct 2) was observed to place a	ATURE	TITLE	(X6) DATE
CALL ON	O HOWNON	EDD EVO CUTIO	PI	Sinctoo	9/77/13
her safegual llowing the d	ds provide sufficient prote ate of survey whether or I the date these document	ction to the patients. (See instructions not a plan of correction is provided. For	 Except for nursing he 	olion may be excused from correcting provious nursing homes, the findings stated above omes, the above findings and plans of correction is are cited, an approved plan of correction in	e are disclosable 90 days ection are disclosable 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENIE	RS FUR MEDICARE	& MEDICAID SERVICES				JIND NO.	0900-009
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1/19/10CH2500000000000000000000000000000000000		E CONSTRUCTION		E SURVEY PLETED
		09G179	B. WING	*		08/	30/2013
NAME OF	PROVIDER OR SUPPLIER			-	TREET ADDRESS, CITY, STATE, ZIP CODE		
METRO	HOMES				701 13TH STREET, NW /ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 159	moment later, Staff ambulate, using a rethat she provided of client on weekdays. The staff and client program shortly the QIDP (Staff #1) stated the day program on sustained head injustated that the December of the program hours. On August 27, 2013 review of Client #2's revealed that Client.	ait belt on Client #2. A #3 assisted the client to ofling walker. Staff #3 stated ne on one support for the from 8:00 a.m 4:00 p.m. left the facility for day reafter. At 10:28 a.m., the ted that Client #2 fell while at a December 14, 2012. She ries and was taken to a room (ER). The QIDP further ember 14, 2012 incident was ation of one on one support for	W	159	The QIDP will be re-trained or and responsibilities related to monitoring and coordinating alindividuals recommendations aneeds for each person. SYSTEM: There Program Direct least semi annually conduct book reviews to ensure that Q (staff #1) and all QIDP's are mand coordinating services, include one on one's per physician recommendation.	tend ector will a IDP onitoring	9/27/13
	December 14, 2012	ecember 3, 2012. On 2, she fell again at the day les required emergency room					
	queried regarding C needs, beginning at that the client begar for day program hou return to day progra 2013. She further st process of coordina	I, the QIDP was further staffing the Hz's one on one staffing 11:46 a.m. The QIDP stated in receiving one on one staffing ars once she was cleared to mat the end of February ated that she was in the ting an interdisciplinary team.		10 14 (14 (14 (14 (14 (14 (14 (14 (14 (14			
	one staffing coverage and weekends (24 has week) in the home collent's behaviors.	QIDP wanted to add one on je for evenings, overnights nours per day, 7 days per lue to an increase in the		325		,	
		, beginning at 3:19 p.m., investigation report (dated		į			

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

VEITE	TO TON WEDICANE	A MILLIONID OLIVIOLO				MD MO. 0830-0381
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ISSUSTINGUIS CONT	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
<u> </u>		09G179	B. WING)		08/30/2013
METRO	PROVIDER OR SUPPLIER HOMES			STREET ADDRESS, CITY, STATE, ZIP 5701 13TH STREET, NW WASHINGTON, DC 20011	CODE	4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD I	BE COMPLETION
W 159	program on Decemshe fell a third time, fall occurred at her abrasion to the head on December 21, 20 According to the repmedical one to one gait belt, protective it consultation and borwalker.	to Client #2's fall at the day ber 14, 2012, revealed that on December 19, 2012. The residence. She sustained and and was taken to the ER. occumented that her IDT met 2012, to discuss the falls. Fort, the IDT recommended supports for both settings, nelmet, neurological ne density scan" and a rolling	W 1	159		
	beginning at 3:50 p.n that the team consel was for one on one sweek. She presented which showed two difrom 4:00 p.m 12:0 assigned overnight (QIDP reiterated that evenings and overnigassisting five clients #6) and Client #2 wastaffing in the home overnights and on we Client #1 was receiving 24 hours a day, 7 day	12:00 a.m 8:00 a.m.). The the two staff on duty on ghts were responsible for (Clients #2, #3, #4, #5 and s not receiving one on one on weekday evenings, eekends. [Note: At the time, ng skilled nursing services ys a week.]				
1	the primary care physhad ordered one on could be licensed practical (LPN #1) replied "yes belephone orders show 2012, the PCP had one of the physhad of the PCP had one of the physhad of the PCP had one of the pours a day for sa	at 4:15 p.m., when asked if sician (PCP, Consultant #1) one staffing, the QIDP and nurse (LPN) coordinator." LPN #1 presented wing that on December 19, refered: "One on one staffing fety. Rollator walker. Helmet wake for safety. Gait belt."				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	NO FOR WEDICARE	& MEDICAID SEKVICES			OMP M	J. 0930-039 I
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The same of the sa	IPLE CONSTRUCTION		ATE SURVEY EMPLETED
		09G179	B. WING_		08	3/30/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
115500	HALIFA			5701 13TH STREET, NW		
METRO	HOMES			WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	401 676 30 540					8/29/13
W 159	Continued From pa	ge 3	W 15	9;		
	The QIDP and LPN	#1 said to their knowledge,				
	the PCP had not dis	scontinued the orders in the 8				
	months since then.					
				i v		
		3, at 4:27 p.m., the QIDP		•		3
		yor that Client #2's team had		2		
	secured funding for	one on one staffing supports				
		ve immediately. A one on one				
		gned for that afternoon (4:00	1			
		nift), and the staffing pattern Rect Client #2's one on one				
		day, 7 days a week.				
	support, 24 Hours a	day, 7 days a week.				
:	At the time of the su	rvey, the QIDP failed to show		1		
	evidence that the fa	cility would ensure provision				
	of one on one staffir	ng timely if/when ordered by a				
	client's physician an			•		
W 189	483.430(e)(1) STAF	F TRAINING PROGRAM	W 189	The QIDP (staff #1)will be tra	ined on t	he
				standing protocol for training	staff on	
		vide each employee with		services that are to be initially		l
*		training that enables the		by a licensed clinician. The L		
	efficiently, and comp	n his or her duties effectively,		Physical Therapist re-trained		
	emolethly, and comp	betently.		and all staff on the walking/fa		
				<u> </u>		
	This STANDARD is	not met as evidenced by:		precaution protocol, the use o		
	Based on observation	on, interview and record		helmet, and the gait belt. The		
	review, the facility fa	iled to ensure that staff was		(staff #1) was trained on abou	/e	
		manage the provisions		mentioned adaptive equip. pr	otocol.	8/29/13
		nt's Walking/Fall Risk		SYSTEM: All staff including th	ne QIDP	
	Precaution protocol,	for one of the three clients in		(staff #1) has been initially tra	ined by	1
	the sample. (Client#	2)		licensed clinician on the walki	•	I
	The fieding last de-			risk precaution protocol, the u	•	İ
	The finding includes:			helmet, and the gait belt.	99 OI IIIB	= 4
1	On August 28, 2013	at 4:23 p.m., Client #2 was		nemet, and the gait beit.		Ongoing
		wn the hallway towards the				
		lirect support staff (Staff #3)				1

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

	- 07 CHARLES		1			Tara	5475 SUBUSU	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3)	(X3) DATE SURVEY COMPLETED	
		09 G 179	B. WING	i			08/30/2013	
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP COD	Ę		
METRO	HOMES				13TH STREET, NW			
I III	TTO III E O			WAS	SHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION E DATE	
W 189	Continued From pa	ae 4	W 1	189.				
		assisting the client that						
		erved walking approximately 4		1				
		nt while she ambulated down						
		was not using her walker at		9				
		3 was carrying the client's		i				
		., Staff #3 came to the dining						
		ed the walker from the dining it down the hall. It should be						
		was present in the dining		×				
		owever, observations during		T				
	the previous two da	ys revealed Client #2 had		į				
		met and used the rolling		1				
		ating. In addition, staff had		1				
	while she ambulated	er side (not 4 feet behind her)						
	Willio Silo Billbulator			8				
	On August 27, 2013	, at approximately 2:40 p.m.,					i.e	
		#2's fall-related incidents and		6				
		ds revealed documented		ě.				
		ring staff in-service training: se of Client #2's rollator		15			ĺ	
	walker;	30 01 Gliefft #2 3 foliator						
		Client #2's soft helmet and		1				
	gait belt;						l	
		Client #2's Walking/Fall Risk		1			İ	
	following instructions	The protocol included the						
		et while in standing position					1	
¥.		on. (4) Staff should stand by						
	individual at all times	during ambulation. (5) Use		1			Į	
	gait belt and rollator	walker during ambulation."		8			ĺ	
		was on the attendance		*			l	
	sessions.	aforementioned training]	
	Observations on the	evening of August 28, 2013,					is the second	
		nat training on Client #2's					İ	
		ecaution protocol had not					8	
	heen effective	acancerosdedevi Dawendocr©i III-7/55 Pilifiti		í			1	

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

CLIVIL	NO FOR WEDIONIC	A WILDIONID OLIVIOLO				SIND INC. COOL COO.	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G179	8, WING	i		08/30/2013	
NAME OF METRO	PROVIDER OR SUPPLIER			5701	EET ADDRESS, CITY, STATE, ZIP CODE 1 13TH STREET, NW SHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
	Support Plan (ISP), a team recommend on the use of <clien (december="" 2013="" 2013).<="" 2013,="" 29,="" approxima="" at="" august="" in-service="" next="" of="" regarding="" staff="" td="" the="" to="" use=""><td>hat Client #2's Individual dated April 4, 2013 reflected lation that "staff be retrained it's name> gait belt." Review aining records on August 30, tely 2:20 p.m., revealed that training that was documented a gait belt was provided on uring the survey), almost 5 am recommended it at the ISP</td><td>W</td><td>189</td><td></td><td></td></clien>	hat Client #2's Individual dated April 4, 2013 reflected lation that "staff be retrained it's name> gait belt." Review aining records on August 30, tely 2:20 p.m., revealed that training that was documented a gait belt was provided on uring the survey), almost 5 am recommended it at the ISP	W	189			
				S. C. Company and C. C. Company C. C. C. C. C. C. C. C. C. C. C. C. C.			

If continuation sheet 1 of 8

Health Regulation & Licen				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Parameter State of the Control of th	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
	HFD03-0185	B. WING		08/30/2013
NAME OF PROVIDER OR SUPPLIE	R STREET AG	DRESS, CITY	, STATE, ZIP CODE	
METRO HOMES		H STREET,		
		GTON, DC	20011	
PRÉFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
1000 INITIAL COMME	NTS	1000		
28, 2013 through three residents w	y was conducted from August August 30, 2013. A sample of as selected from a population of arying degrees of intellectual			
observations in th interviews with on direct support sta staff, as well as a	e survey were based on e home and two day programs, e resident's medical guardian, f, nursing and administrative review of resident and ords, including incident reports.			3
(QMRP) will be re	retardation professional ferred to as qualified intellectual sional (QIDP) within this report.]			
I 180 3508.1 ADMINIST	RATIVE SUPPORT	I 180	Cross reference with W159	
administrative sup	Il provide adequate port to efficiently meet the ents as required by their			
Based on observa review, the group I intellectual disabilithat the qualified in professional (QIDF referrals timely (specifing in accordation for one of three research (Resident #2)	met as evidenced by: ion, staff interview and record iome for individuals with ies (GHIID) failed to ensure tellectual disabilities) coordinated services and ecifically, secure one on one nce with physician's orders), idents in the sample.	The state of the s		
The finding include	ess.			
support staff (Staff	3, at 8:02 a.m., a direct #2) was observed to place a			
alth Regulation & Licensing Admini	stration DER/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	TITLE	(X6) DATE

	Health Regulation & Licensin	ng Administration			TORWATROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED
		HFD03-0185	B. WING		08/30/2013
The Parket	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	#
ı	METRO HOMES		STREET, N		
ŀ	(VA) ID SIMMARY STA	TEMENT OF DEFICIENCIES	TON, DC 2		M
	PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETE
ı	1 180 Continued From page	ge 1	I 180		
	moment later, Staff ambulate, using a re that she provided or resident on weekdar. The staff and reside program shortly their QIDP (Staff #1) state at the day program of sustained head injur hospital emergency stated that the December what prompted initial day program hours. On August 27, 2013 review of Resident # revealed that Reside head injury at home December 14, 2012,	alt belt on Resident #2. A #3 assisted the resident to olling walker. Staff #3 stated ne on one support for the ys, from 8:00 a.m 4:00 p.m. ent left the facility for day reafter. At 10:28 a.m., the ed that Resident #2 fell while on December 14, 2012. She ries and was taken to a room (ER). The QIDP further ember 14, 2012 incident was ation of one on one support for beginning at 10:49 a.m., te's incident-related records and #2 fell and sustained a on December 3, 2012. On she fell again at the day es required emergency room	Appendix and the second		
	queried regarding Restaffing needs, begin stated that the reside one staffing for day poleared to return to defebruary 2013. She is the process of coordicteam (IDT) meeting, one on one staffing covernights and weeked days per week) in the the resident's behavior	the QIDP was further esident #2's one on one uning at 11:46 a.m. The QIDP ent began receiving one on orogram hours once she was ay program at the end of further stated that she was in inating an interdisciplinary. The QIDP wanted to add overage for evenings, ends (24 hours per day, 7 e home due to an increase in ors. beginning at 3:19 p.m., investigation report (dated Resident #2's fall at the day			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD03-0185	B. WING		08/30/2013
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
METOO	UOMES	5701 131	H STREET, N	w	
METRO	HOMES	WASHIN	GTON, DC 20	0011	9.1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
	she fell a third time, fall occurred at her abrasion to the hear The report further don December 21, 20 According to the repmedical one to one gait belt, protective to consultation and bot walker. When queried further beginning at 3:50 p.1 that the team conservas for one on one week. She presente which showed two drom 4:00 p.m 12:0 assigned overnight (QIDP reiterated that evenings and overnigassisting five resider and #6) and Resider on one staffing in the evenings, overnights the time, Resident #7 nursing services 24 from the licensed practical (LPN #1) replied "yestelephone orders should be the proper services and 24 hours a day for sa	ber 14, 2012, revealed that on December 19, 2012. The residence. She sustained and and was taken to the ER. occumented that her IDT met 012, to discuss the falls. Ont, the IDT "recommended supports for both settings, helmet, neurological ne density scan" and a rolling er on August 27, 2013, m., the QIDP acknowledged in the current staffing pattern, irrect support staff assigned 200 a.m. and two staff 12:00 a.m8:00 a.m.). The the two staff on duty on ghts were responsible for ints (Residents #2, #3, #4, #5 at #2 was not receiving one in the thing on weekends. [Note: At 1 was receiving skilled in ours a day, 7 days a week.] at 4:15 p.m., when asked if sician (PCP, Consultant #1) one staffing, the QIDP and I nurse (LPN) coordinator as: LPN #1 presented owing that on December 19, redered: "One on one staffing afety. Rollator walker. Helmet	1180	DEFICIENCY)	
	The QIDP and LPN # the PCP had not disc	awake for safety. Gait belt." 1 said to their knowledge, ontinued the orders in the 8			
h Regulat	tion & Licensing Administr				**************************************
FORM		68	359 Z60	0511	If continuation sheet 3 of

Health Regulation & Licen	sing Administration			
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
	HFD03-0185	B. WING		08/30/2013
NAME OF DOOMOGD OD SHODIE	D STORET AN	INDESS CITY	STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIE		H STREET,		
METRO HOMES		STON, DC 2		
				ON NO
(74.7)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD (
	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	
		1	DEFICIENCY)	······································
1 180 Continued From	page 3	1 180		
months since the	n.			
On August 20, 20	13, at 4:27 p.m., the QIDP			
	reyor that Resident #2's team	ļ		
	ing for one on one staffing			
	me, effective immediately. A			
	nad been assigned for that	1		
	m 12:00 a.m. shift), and the	- - - - - -		
	as amended to reflect Resident	! !		
	upport, 24 hours a day, 7 days			
a week.		ĺ		22
At the time of the	survey, the QIDP failed to show			# #
	facility would ensure provision			
	ffing timely if/when ordered by a			
resident's physicia				
1229 3510.5(f) STAFF	TRAINING	1229	Cross reference with W189	
	ram shall include, but not be			
limited to, the follo	wing:			
(0.0.1.1)				
	related to the GHMRP and the			
	rved including, but not limited gement, sexuality, nutrition,			
	ommunications, and assistive			
technologies;	timamodiono, and dobiotivo			
,,				1
This Statute is no	t met as evidenced by:			
	tion, staff interview and record			l
	home for individuals with			
	ties (GHIID) failed to ensure			
	effective training on each			
	/Fall Risk Precaution protocol, e residents in the sample.			
(Resident #2)	a residents in the sample.			
(TOSIGETT #2)	a			l
The finding include	es:			İ
•				

Health	regulation & Licensin	ng Administration			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HFD03-0185	B. WING		08/30/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	27		STREET, N	The Air	
METRO	HOMES		TON, DC 2		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE COMPLETE
TAG	NEODENON1 ON E	OO DENTI THO IN ORINATION	TAG	DEFICIENCY)	NATE
1 220	Continued From pa		1229		****
1 229	S		1229		
		3, at 4:23 p.m., Resident #2			
		ing down the hallway towards			
		The direct support staff (Staff			
9		red assisting the resident that erved walking approximately 4	81		
		dent while she ambulated			9
		resident was not using her			
		nd Staff #3 was carrying the			
		t 4:26 p.m., Staff #3 came to	1		
		ne, retrieved the walker from			
		d wheeled it down the hall. It			*
		t the QIDP was present in the			9
		me. However, observations two days revealed Resident	1		
		the helmet and used the	1		
		ambulating. In addition, staff			
	had always walked t	to her side (not 4 feet behind	1		
	her) while she ambu	ılated.			
	On August 27, 2013	at approximately 2:40 n m			
		, at approximately 2:40 p.m., ent #2's fall-related incidents			
		needs revealed documented	1		
		ring staff in-service training:			
	- January 5, 2013, u	se of Resident #2's rollator			
	walker;		- 1		
	- January 18, 2013, I gait belt;	Resident #2's soft helmet and			
		Resident #2's Walking/Fall			
		ocol. The protocol included	Ì		
	the following instruct				
	"(3) Use head helme	t while in standing position			- 3
		on. (4) Staff should stand by	and the same of th		
		during ambulation. (5) Use	j	*	9
		walker during ambulation."			
		was on the attendance aforementioned training			
	sessions.	a.c.c.montonea training			
			ļ		
		evening of August 28, 2013,	1		
	however, revealed th	at training on Resident #2's			*

PRINTED: 09/17/2013 FORM APPROVED

Health Regulation & Licensii	ng Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	EATTOR OF THE TOTAL SHARE SHARE SHARE SHOW	(X3) DATE SURVEY COMPLETED
	HFD03-0185	B. WING_		08/30/2013
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE	
METRO HOMES	5701 13TI	H STREET,	NW	
		STON, DC		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
1229 Continued From pa	ge 5	1 229		
Walking/Fall Risk P been effective.	recaution protocol had not			
Support Plan (ISP), a team recommend	hat Resident #2's Individual dated April 4, 2013 reflected ation that "staff be retrained lent's name> gait belt."			9
Review of staff in-se August 30, 2013, at	ervice training records on approximately 2:20 p.m.,			
documented regard	ext in-service training that was ing use of the gait belt was 29, 2013 (during the survey),			
almost 5 months aft at the ISP meeting.	er the team recommended it			
1379 3519.10 EMERGEN		1 379	1379 The QIDP will be in-serviced on	the
each GHMRP shall	porting requirement in 3519.5, notify the Department of lities Division of any other		timeliness per Department of He regulations as it relates to incide	
unusual incident or	event which substantially ident's health, welfare, living		at 5701 13th Street NW. SYSTEM: The Incident Manager	9/27/13
 places the resident a 	eing or in any other way at risk. Such notification shall ne immediately and shall be		Coordinator will follow up on all incidences with the QIDP to ensi	2.
followed up by writte			all notifications per Department on Health Regulations has been	of
	-		completed.	Ongoing
records, including in	and review of resident cident reports and			
intellectual disabilitie that all incidents that	oup home for individuals with s (GHIID) failed to ensure present a risk to residents' re reported immediately to			
the Department of H	ealth, Health Regulation and ition (DOH/HRLA), for two of	, ,		

(X4) ID PREFIX TAG 1 379 Co the #2 The Or rev	OVIDER OR SUPPLIER	115000 0405	S 4 V	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
(X4) ID PREFIX TAG 1 379 Co the #2 The Or rev	VIDER OR SUPPLIER	HFD03-0185	B. WING		08/30	/2013	
I 379 Co the #2 Th		5701 13T	DDRESS, CITY, S H STREET, N GTON, DC 20	W			
the #2 Th Or rev	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
I. C a h bree Sh 200 hos pre DC inc evice Dec ER pre DO incience evice 201 DO 3. C p.m prof #2 h	Continued From page 6 the six residents of the facility. (Residents #1 and #2) The findings include: On August 27, 2013, beginning at 10:35 a.m., review of the facility's incident reports and corresponding documentation revealed the following: I. On August 11, 2013, Resident #1 was taken to a hospital emergency room (ER) for shortness of breath. The resident was subsequently admitted. She was released from the hospital on August 24, 2013, with a recommendation that she receive hospice care (multiple systems failing). A pre-survey review of incidents reported to DOH/HRLA as well as onsite review of incident-related documentation failed to show evidence that the August 11, 2013 ER visit and hospitalization was reported to DOH/HRLA in accordance with this regulation. 2. According to incident and investigation reports, Resident #2 fell and sustained head injuries on December 3, 2012, December 14, 2012 and December 19, 2012. She was taken to a hospital ER following each of the three events. A pre-survey review of incidents reported to DOH/HRLA as well as onsite review of incident-related documentation failed to show evidence that the ER visits on December 14, 2013, and December 19, 2012, were reported to DOH/HRLA as well as onsite review of incident-related documentation failed to show evidence that the ER visits on December 14, 2013, and December 19, 2012, were reported to DOH/HRLA. 3. On August 27, 2013, at approximately 2:55 p.m., the qualified intellectual disabilities professional (QIDP, Staff #1) stated that Resident #2 had fallen in her bedroom on August 25, 2013. At 5:28 p.m. that evening, she presented an		1379			4	
th Regulation of TE FORM	o.∠o p.m. tnat eve		-				

Health	Regulation & Licensing	ng Administration					
STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 .8	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HFD03-0185	B. WING		08/30/2013		
NAME O	F PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
METRO HOMES 5701 13TH			TH STREET, NW GTON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	SHOULD BE COMPLETE		
	been found with an of her head. The pri instructed the GHIII x-rays on the follow review of incidents review documentation failed discovery of an unexher head was report. On August 30, 2013 stated that she was ER visits had been retold by Resident #2's day program) had ree ER visit on December explain how the other	revealed the resident had unexplained knot on the back mary care physician had to to take the resident for heading morning. A pre-survey reported to DOH/HRLA as v of incident-related d to show evidence that the explained knot on the back of the dot DOH/HRLA, at 4:30 p.m., the QIDP of the understanding that all reported. She reportedly was a day program that they (the reported the resident's fall and the residents had not been	1379				
	reported to DOH/HR gathered at the Exit verbal notifications, v submitted within 24 I	LA. She assured those conference that in addition to written notification would be nours or the next business order to be in compliance with					