STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G179	A. BUILDING _____ B. WING _____	08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	5701 13TH 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 August 28, 2013 through August 30, 2013. A sample of three clients was selected from a population of six females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and two day programs, interviews with one client's medical guardian, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the qualified intellectual disabilities professional (QIDP, Staff #1) failed to coordinate services timely (specifically, secure one on one staffing in accordance with physician's orders), for one of three clients in the sample. (Client #2) The finding includes: On August 27, 2013, at 8:02 a.m., a direct support staff (Staff #2) was observed to place a	W 159		

Received DOH-HCLA 1CFD - 9/27/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily J Haines, EDD	Executive Director	9/27/13

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 159	Continued From page 1 soft helmet and a gait belt on Client #2. A moment later, Staff #3 assisted the client to ambulate, using a rolling walker. Staff #3 stated that she provided one on one support for the client on weekdays, from 8:00 a.m. - 4:00 p.m. The staff and client left the facility for day program shortly thereafter. At 10:28 a.m., the QIDP (Staff #1) stated that Client #2 fell while at the day program on December 14, 2012. She sustained head injuries and was taken to a hospital emergency room (ER). The QIDP further stated that the December 14, 2012 incident was what prompted initiation of one on one support for day program hours. On August 27, 2013, beginning at 10:49 a.m., review of Client #2's incident-related records revealed that Client #2 fell and sustained a head injury at home on December 3, 2012. On December 14, 2012, she fell again at the day program. Both injuries required emergency room treatment. On August 27, 2013, the QIDP was further queried regarding Client #2's one on one staffing needs, beginning at 11:46 a.m. The QIDP stated that the client began receiving one on one staffing for day program hours once she was cleared to return to day program at the end of February 2013. She further stated that she was in the process of coordinating an interdisciplinary team (IDT) meeting. The QIDP wanted to add one on one staffing coverage for evenings, overnights and weekends (24 hours per day, 7 days per week) in the home due to an increase in the client's behaviors. On August 27, 2013, beginning at 3:19 p.m., review of an internal investigation report (dated	W 159	The QIDP will be re-trained on her roles and responsibilities related to monitoring and coordinating all individuals recommendations and needs for each person. 9/27/13 SYSTEM: There Program Director will at least semi annually conduct a book reviews to ensure that QIDP (staff #1) and all QIDP's are monitoring and coordinating services, including the one on one's per physicians recommendation. Ongoing	

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W 159	Continued From page 2	W 159		

January 3, 2013) into Client #2's fall at the day program on December 14, 2012, revealed that she fell a third time, on December 19, 2012. The fall occurred at her residence. She sustained an abrasion to the head and was taken to the ER. The report further documented that her IDT met on December 21, 2012, to discuss the falls. According to the report, the IDT "recommended medical one to one supports for both settings, gait belt, protective helmet, neurological consultation and bone density scan" and a rolling walker.

When queried further on August 27, 2013, beginning at 3:50 p.m., the QIDP acknowledged that the team consensus on December 21, 2012 was for one on one support 24 hours, 7 days a week. She presented the current staffing pattern, which showed two direct support staff assigned from 4:00 p.m. - 12:00 a.m. and two staff assigned overnight (12:00 a.m. - 8:00 a.m.). The QIDP reiterated that the two staff on duty on evenings and overnights were responsible for assisting five clients (Clients #2, #3, #4, #5 and #6) and Client #2 was not receiving one on one staffing in the home on weekday evenings, overnights and on weekends. [Note: At the time, Client #1 was receiving skilled nursing services 24 hours a day, 7 days a week.]

On August 27, 2013, at 4:15 p.m., when asked if the primary care physician (PCP, Consultant #1) had ordered one on one staffing, the QIDP and the licensed practical nurse (LPN) coordinator (LPN #1) replied "yes." LPN #1 presented telephone orders showing that on December 19, 2012, the PCP had ordered: "One on one staffing 24 hours a day for safety. Rollator walker. Helmet on at all times while awake for safety. Gait belt."

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W 159	Continued From page 3 The QIDP and LPN #1 said to their knowledge, the PCP had not discontinued the orders in the 8 months since then. On August 29, 2013, at 4:27 p.m., the QIDP informed this surveyor that Client #2's team had secured funding for one on one staffing supports in the home, effective immediately. A one on one staff had been assigned for that afternoon (4:00 p.m. - 12:00 a.m. shift), and the staffing pattern was amended to reflect Client #2's one on one support, 24 hours a day, 7 days a week. At the time of the survey, the QIDP failed to show evidence that the facility would ensure provision of one on one staffing timely if/when ordered by a client's physician and/or the IDT.	W 159		8/29/13
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, interview and record review, the facility failed to ensure that staff was effectively trained to manage the provisions outlined in each client's Walking/Fall Risk Precaution protocol, for one of the three clients in the sample. (Client #2) The finding includes: On August 28, 2013, at 4:23 p.m., Client #2 was observed walking down the hallway towards the bedroom area. The direct support staff (Staff #3)	W 189	The QIDP (staff #1)will be trained on the standing protocol for training staff on services that are to be initially trained by a licensed clinician. The Licensed Physical Therapist re-trained staff #3 and all staff on the walking/fall risk precaution protocol,the use of the helmet, and the gait belt. The QIDP (staff #1) was trained on above mentioned adaptive equip. protocol. 8/29/13 SYSTEM: All staff including the QIDP (staff #1) has been initially trained by licensed clinician on the walking/fall risk precaution protocol, the use of the helmet, and the gait belt. Ongoing	

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W 189	Continued From page 4	W 189		

that was observed assisting the client that afternoon was observed walking approximately 4 feet behind the client while she ambulated down the hall. The client was not using her walker at the time and Staff #3 was carrying the client's helmet. At 4:26 p.m., Staff #3 came to the dining room alone, retrieved the walker from the dining room, and wheeled it down the hall. It should be noted that the QIDP was present in the dining room at the time. However, observations during the previous two days revealed Client #2 had always worn the helmet and used the rolling walker while ambulating. In addition, staff had always walked to her side (not 4 feet behind her) while she ambulated.

On August 27, 2013, at approximately 2:40 p.m., review of the Client #2's fall-related incidents and her ambulation needs revealed documented records of the following staff in-service training:
- January 5, 2013, use of Client #2's rollator walker;
- January 18, 2013, Client #2's soft helmet and gait belt;
- February 2, 2013, Client #2's Walking/Fall Risk Precaution protocol. The protocol included the following instructions:
"(3) Use head helmet while in standing position and during ambulation. (4) Staff should stand by individual at all times during ambulation. (5) Use gait belt and rollator walker during ambulation."
Staff #3's signature was on the attendance sheets for the three aforementioned training sessions.

Observations on the evening of August 28, 2013, however, revealed that training on Client #2's Walking/Fall Risk Precaution protocol had not been effective.

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It should be noted that Client #2's Individual Support Plan (ISP), dated April 4, 2013 reflected a team recommendation that "staff be retrained on the use of <client's name> gait belt." Review of staff in-service training records on August 30, 2013, at approximately 2:20 p.m., revealed that the next in-service training that was documented regarding use of the gait belt was provided on August 29, 2013 (during the survey), almost 5 months after the team recommended it at the ISP meeting.

Health Regulation & Licensing Administration

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	HFD03-0185	A. BUILDING: _____ B. WING _____	08/30/2013

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 28, 2013 through August 30, 2013. A sample of three residents was selected from a population of six females with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with one resident's medical guardian, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated services and referrals timely (specifically, secure one on one staffing in accordance with physician's orders), for one of three residents in the sample. (Resident #2) The finding includes: On August 27, 2013, at 8:02 a.m., a direct support staff (Staff #2) was observed to place a	I 180	Cross reference with W159	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 180	Continued From page 1 soft helmet and a galt belt on Resident #2. A moment later, Staff #3 assisted the resident to ambulate, using a rolling walker. Staff #3 stated that she provided one on one support for the resident on weekdays, from 8:00 a.m. - 4:00 p.m. The staff and resident left the facility for day program shortly thereafter. At 10:28 a.m., the QIDP (Staff #1) stated that Resident #2 fell while at the day program on December 14, 2012. She sustained head injuries and was taken to a hospital emergency room (ER). The QIDP further stated that the December 14, 2012 incident was what prompted initiation of one on one support for day program hours. On August 27, 2013, beginning at 10:49 a.m., review of Resident #2's incident-related records revealed that Resident #2 fell and sustained a head injury at home on December 3, 2012. On December 14, 2012, she fell again at the day program. Both injuries required emergency room treatment. On August 27, 2013, the QIDP was further queried regarding Resident #2's one on one staffing needs, beginning at 11:46 a.m. The QIDP stated that the resident began receiving one on one staffing for day program hours once she was cleared to return to day program at the end of February 2013. She further stated that she was in the process of coordinating an interdisciplinary team (IDT) meeting. The QIDP wanted to add one on one staffing coverage for evenings, overnights and weekends (24 hours per day, 7 days per week) in the home due to an increase in the resident's behaviors. On August 27, 2013, beginning at 3:19 p.m., review of an internal investigation report (dated January 3, 2013) into Resident #2's fall at the day	I 180		

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I 180	Continued From page 2	I 180		

program on December 14, 2012, revealed that she fell a third time, on December 19, 2012. The fall occurred at her residence. She sustained an abrasion to the head and was taken to the ER. The report further documented that her IDT met on December 21, 2012, to discuss the falls. According to the report, the IDT "recommended medical one to one supports for both settings, gait belt, protective helmet, neurological consultation and bone density scan" and a rolling walker.

When queried further on August 27, 2013, beginning at 3:50 p.m., the QIDP acknowledged that the team consensus on December 21, 2012 was for one on one support 24 hours, 7 days a week. She presented the current staffing pattern, which showed two direct support staff assigned from 4:00 p.m. - 12:00 a.m. and two staff assigned overnight (12:00 a.m. - 8:00 a.m.). The QIDP reiterated that the two staff on duty on evenings and overnights were responsible for assisting five residents (Residents #2, #3, #4, #5 and #6) and Resident #2 was not receiving one on one staffing in the home on weekday evenings, overnights and on weekends. [Note: At the time, Resident #1 was receiving skilled nursing services 24 hours a day, 7 days a week.]

On August 27, 2013, at 4:15 p.m., when asked if the primary care physician (PCP, Consultant #1) had ordered one on one staffing, the QIDP and the licensed practical nurse (LPN) coordinator (LPN #1) replied "yes." LPN #1 presented telephone orders showing that on December 19, 2012, the PCP had ordered: "One on one staffing 24 hours a day for safety. Rollator walker. Helmet on at all times while awake for safety. Gait belt." The QIDP and LPN #1 said to their knowledge, the PCP had not discontinued the orders in the 8

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I 180	Continued From page 3 months since then. On August 29, 2013, at 4:27 p.m., the QIDP informed this surveyor that Resident #2's team had secured funding for one on one staffing supports in the home, effective immediately. A one on one staff had been assigned for that afternoon (4:00 p.m. - 12:00 a.m. shift), and the staffing pattern was amended to reflect Resident #2's one on one support, 24 hours a day, 7 days a week. At the time of the survey, the QIDP failed to show evidence that the facility would ensure provision of one on one staffing timely if/when ordered by a resident's physician and/or the IDT.	I 180		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that staff received effective training on each resident's Walking/Fall Risk Precaution protocol, for one of the three residents in the sample. (Resident #2) The finding includes:	I 229	Cross reference with W189	

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I 229	Continued From page 4 On August 28, 2013, at 4:23 p.m., Resident #2 was observed walking down the hallway towards the bedroom area. The direct support staff (Staff #3) that was observed assisting the resident that afternoon was observed walking approximately 4 feet behind the resident while she ambulated down the hall. The resident was not using her walker at the time and Staff #3 was carrying the resident's helmet. At 4:26 p.m., Staff #3 came to the dining room alone, retrieved the walker from the dining room, and wheeled it down the hall. It should be noted that the QIDP was present in the dining room at the time. However, observations during the previous two days revealed Resident #2 had always worn the helmet and used the rolling walker while ambulating. In addition, staff had always walked to her side (not 4 feet behind her) while she ambulated. On August 27, 2013, at approximately 2:40 p.m., review of the Resident #2's fall-related incidents and her ambulation needs revealed documented records of the following staff in-service training: - January 5, 2013, use of Resident #2's rollator walker; - January 18, 2013, Resident #2's soft helmet and gait belt; - February 2, 2013, Resident #2's Walking/Fall Risk Precaution protocol. The protocol included the following instructions: "(3) Use head helmet while in standing position and during ambulation. (4) Staff should stand by individual at all times during ambulation. (5) Use gait belt and rollator walker during ambulation." Staff #3's signature was on the attendance sheets for the three aforementioned training sessions. Observations on the evening of August 28, 2013, however, revealed that training on Resident #2's	I 229		

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I 229	Continued From page 5 Walking/Fall Risk Precaution protocol had not been effective. It should be noted that Resident #2's Individual Support Plan (ISP), dated April 4, 2013 reflected a team recommendation that "staff be retrained on the use of <resident's name> gait belt." Review of staff in-service training records on August 30, 2013, at approximately 2:20 p.m., revealed that the next in-service training that was documented regarding use of the gait belt was provided on August 29, 2013 (during the survey), almost 5 months after the team recommended it at the ISP meeting.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for two of	I 379	1379 The QIDP will be in-serviced on the timeliness per Department of Health regulations as it relates to incidences at 5701 13th Street NW. SYSTEM: The Incident Management Coordinator will follow up on all incidences with the QIDP to ensure all notifications per Department of Health Regulations has been completed.	9/27/13 Ongoing

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I 379	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: 1. 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. 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	I 379		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0185	A. BUILDING: _____ B. WING _____	08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	5701 13TH STREET, NW WASHINGTON, DC 20011

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I 379	Continued From page 7 incident report that revealed the resident had been found with an unexplained knot on the back of her head. The primary care physician had instructed the GHIID to take the resident for head x-rays on the following morning. 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 discovery of an unexplained knot on the back of her head was reported to DOH/HRLA On August 30, 2013, at 4:30 p.m., the QIDP stated that she was of the understanding that all ER visits had been reported. She reportedly was told by Resident #2's day program that they (the day program) had reported the resident's fall and ER visit on December 14, 2012. She could not explain how the other incidents had not been reported to DOH/HRLA. She assured those gathered at the Exit conference that in addition to verbal notifications, written notification would be submitted within 24 hours or the next business day in the future, in order to be in compliance with this regulation.	I 379		