STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G219	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from July 17, 2013 through July 19, 2013. A sample of three clients was selected from a population of six males 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 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	Received 8/7/13 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered in accordance with physician's orders, for one of the six clients residing in the facility. (Client #6) The finding includes: On July 17, 2013, at 5:48 p.m., a trained medication employee (TME, Staff #1) was observed administering 1 capsule of Cranberry Fruit 475 milligrams (mg) to Client #6. On July 18,	W 368	W 368 Staff #1 (TME) and all TME's administering medication at 615 55th Street NE will be re-inserviced on the proper protocol for administration of medication to include a three way check for accuracy of the medication being administered for individual #6 and all individuals residing at 615 55th Street NE. Additionally, Staff #1 (TME) and all TME's will be re-trained on the proper dosage of Cranberry Fruit capsule for individual #6. SYSTEM: The delegating nurse will quarterly observe TME's for appropriate medication administration procedures and document.	8/9/13 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emily A Homes, EDO | TITLE | (X6) DATE: 8/7/13

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 368	Continued From page 1 2013, at 9:30 a.m., review of the client's physician's order sheets (POS) dated June 1, 2013, and medication administration record (MAR) for July 2013 reflected the order was for administration of 2 capsules of Cranberry Fruit, twice a day, as a prophylactic for recurring urinary tract infections. Staff #1 was asked about Client #6's Cranberry Fruit shortly after she reported for work on July 18, 2013, at 1:56 p.m. She stated she administered 1 capsule every evening and thought the order was for 1 capsule twice a day. Upon review of the client's POS, she acknowledged that it read 2 capsules twice a day.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered without error, for one of the six clients residing in the facility. (Client #6) The finding includes: [Cross-reference to W368] On July 17, 2013, at 5:48 p.m., a trained medication employee (TME, Staff #1) was observed administering 1 capsule of Cranberry Fruit 475 milligrams (mg) to Client #6. On July 18, 2013, at 9:30 a.m., review of the client's	W 369	W 369 Staff #1 (TME) and all TME's will be re-inserviced on proper administration of medication protocol to include a three way check for accuracy of medication being administered to individual #6 and all individuals residing at 615 55th Street NE. Additionally staff #1(TME) and all TME's will be re-inserviced on proper dosage of Cranberry Fruit capsule for individual #6. SYSTEM: The delegating RN will observe quarterly all TME's for appropriate medication administration procedures and document.	8/9/13 Ongoing

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W 369	Continued From page 2 physician's order sheets (POS) dated June 1, 2013, and medication administration record (MAR) for July 2013 reflected the order was for administration of 2 capsules of Cranberry Frult, twice a day, as a prophylactic for recurring urinary tract infections. In a follow-up interview on July 18, 2013, at 1:56 p.m., Staff #1 stated she administered 1 capsule Cranberry Fruit to Client #6 every evening and she thought the order was for 1 capsule twice a day. Upon review of the POS, medication administration record and the label on the Cranberry Fruit, she acknowledged the error. [Note: The supervisory registered nurse (RN, Staff #2), who was present at the time of the follow-up interview with Staff #1, provided training immediately thereafter. On July 19, 2013, at 8:34 a.m., Staff #2 provided documentation showing that she had observed Staff #1 administer medications on February 22, 2013 and on May 3, 2013. Both administrations reportedly were without error.]	W 369		

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from July 17, 2013 through July 19, 2013. A sample of three residents was selected from a population of six males 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 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 500	3523.1 RESIDENT'S RIGHTS 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. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for individuals with intellectual disabilities (GHIID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for one of six residents residing in the facility. (Resident #6) The finding includes:	I 500	1500 Cross Reference W 368 and W369	

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I 500	Continued From page 1 [483.460(k)(2)] The GHIID failed to ensure Resident #6's right to receive medications in accordance with physician's orders and without error, as follows: On July 17, 2013, at 5:48 p.m., a trained medication employee (TME, Staff #1) was observed administering 1 capsule of Cranberry Fruit 475 milligrams (mg) to Resident #6. On July 18, 2013, at 9:30 a.m., review of the resident's physician's order sheets (POS) dated June 1, 2013 revealed the order was for administration of 2 capsules of Cranberry Fruit, twice a day, as a prophylactic for recurring urinary tract infections. In a follow-up interview on July 18, 2013, at 1:56 p.m., Staff #1 stated she administered 1 capsule Cranberry Fruit to Resident #6 every evening and she thought the order was for 1 capsule twice a day. Upon review of the POS, medication administration record and the label on the Cranberry Fruit, she acknowledged the error. [Note: The supervisory registered nurse (RN, Staff #2), who was present at the time of the follow-up interview with Staff #1, provided training immediately thereafter. On July 19, 2013, at 8:34 a.m., Staff #2 provided documentation showing that she had observed Staff #1 administer medications on February 22, 2013 and on May 3, 2013. Both administrations reportedly were without error.]	I 500		