

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
W 000	INITIAL COMMENTS A recertification survey was conducted from April 29, 2013 through April 30, 2013. A sample of three clients was selected from a population of four females and two 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 two clients, 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 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. This STANDARD is not met as evidenced by: Based on interview and review of client records, including incident reports and investigations, the facility failed to ensure that all client to client abuse were reported immediately to the administrator and the Department of Health, Health Regulation and Licensing Administration (HRLA), for one of the six clients residing in the facility. (Client #3)	W 153	The QIDP will re-inservice staff on the incident management policy and procedures for allegations of mistreatment neglect or abuse, as well as injuries of unknown origin to ensure that all incidents are reported in a timely manner to the Incident Management Coordinator for immediate reporting to the administrator and Department of Health, Health Regulation and licensing administration, as well as Department of Disabilities Services. 5/14/13 SYSTEM: The QIDP will review progress notes monthly to ensure that all incidences have been reported in a timely fashion to the administrator, Department of Health, Health Regulation as well as		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Emily A. Homes Exec. Director of Operations
TITLE
DATE
5/23/13

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.

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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
W 153	Continued From page 1 The finding includes: On April 30, 2013, at 9:21 a.m., review of Client #3's medical records revealed a primary care physician note dated March 26, 2013. The note indicated that Client #3 was pushed to the floor by another client. Client #3 was examined and no injuries were present. Review of the incident report book on April 29, 2013, beginning at 10:27 a.m., failed to reveal a report for the aforementioned incident. Interview with the qualified intellectual disabilities professional (Staff #1) on April 30, 2013, at approximately 4:00 p.m., revealed that she was informed that Client #1 pushed Client #3 on March 20, 2013. Further interview revealed that the staff did not complete an incident report when she witnessed the physical aggression towards Client #3. The facility failed to ensure that all allegations of abuse were reported immediately to the administrator and to HRLA.	W 153	Developmental Disabilities Services.	Ongoing
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 and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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
W 249	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure each client's behavior support plan (BSP) was implemented consistently, for one of three clients in the sample with maladaptive behaviors. (Client #3)</p> <p>The finding includes:</p> <p>The facility failed to ensure that Client #3's 1:1 staff implemented the BSP, as evidenced below:</p> <p>On April 29, 2013, at 9:21 a.m., while the surveyor was conducting observations of the medication administration, Client #3 was walking around the house in a circle then reached out and scratched the surveyor's hand. The trained medication employee (TME, Staff #3) told the client no. At 9:28 a.m., Client #3 scratched the surveyor on the hand again, in the presence of Staff #3. After the second incident, a staff member that was present in the room (Staff #4) was asked which staff was primarily responsible for assisting Client #3 during the shift. Staff #4 responded by indicating that he was responsible for providing 1:1 support for the client, while Staff #3 was administering medications. Staff #3 would resume 1:1 supports afterwards. It should be noted however, that Staff #4 was observed to be assisting other clients onto the facility's van at the time of the second incident. Staff #4 further indicated that he had asked the registered nurse (Staff #2) to assist Client #3 during his absence.</p> <p>Interview with Staff #3 on April 29, 2013, at approximately 10:15 a.m., verified that she was assigned to Client #3 as the 1:1 staff during the</p>	W 249	<p>The QIDP will re-inservice staff #3 and #4 and all staff working at 8020 Eastern Avenue, NW WDC 20012 on the behavior support plan for individual #3. Staff #3 will be relieved from their responsibilities of TME immediately to ensure that they are executing the role of the 1:1 staff.</p> <p>SYSTEM: The QIDP will provide oversight to the home and implementation of the plan evidenced by quarterly documentation of observation, and re training as needed for all staff working at 8020 Eastern Avenue NW, WDC 20012.</p>	05/24/13 Ongoing

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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
W 249	Continued From page 3 8:00 a.m. to 4:00 p.m. shift. Further interview revealed that Staff #4 was assigned to the client during the medication administration. On April 30, 2013, at 10:00 a.m., review of Client #3's behavior support plan (BSP) dated February 25, 2013, revealed that the client's behaviors included physical aggression (hitting, scratching, spitting, and grabbing others forcefully). According to the BSP, the 1:1 staff was required to emphasize communication skills using picture books, visual schedules, and self-soothing techniques such as rubbing hand/arm gently with lotion. Further review revealed techniques such as verbal redirection, touch control if verbal redirection is ineffective, or if the situation demands immediate physical intervention, and direct client to another room or remove others from the room where she is. At the time of survey, the client was observe to walk around the house in a circle before she went to the day program, therefore the facility 1:1 staff failed to implement Client #3's BSP as recommended.	W 249		
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 licensed practical nurse failed to ensure that each client 's nasal spray was administered as prescribed, for one of three clients in the sample. (Clients #2)	W 368		

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
W 368	Continued From page 4 The findings include: During the morning medication administration, the trained medication employee (TME, Staff #3) failed to administer medications without error, as follows: On April 29, 2013, beginning at 8:34 a.m., Staff #3 was observed preparing Client #2's medications. At 8:40 a.m., Staff #3 administered one spray of Deep Sea nasal spray in each of Client #2's nostrils. At approximately 10:00 a.m., review of the client's medication administration record (MAR) and physician ' s order sheets (POS) dated April 1, 2013, revealed an order to give two sprays of deep sea nasal spray in each nostril. Interview with Staff #3 on April 29, 2013, at approximately 4:00 p.m., revealed she administered two sprays of the Deep Sea nasal spray. At the time of survey, Staff #3 failed to administer two sprays of the aforementioned medication as ordered.	W 368	The supervising Registered Nurse will re-train staff #3 on appropriate administration of nasal spray for individual #2. SYSTEM: The supervising Registered Nurse will perform quarterly oversight per District of Columbia Board of Nursing Trained Medication Employee (TME) regulations, and document accordingly.	5/24/13	Ongoing
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 licensed practical nurse failed to ensure that each client 's nasal spray was	W 369			

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
W 369	Continued From page 5 administered without error, for one of three clients in the sample. (Clients #2) The findings include: During the morning medication administration, the trained medication employee (TME, Staff #3) failed to administer medications without error, as follows: On April 29, 2013, beginning at 8:34 a.m., Staff #3 was observed preparing Client #2's medications. At 8:40 a.m., Staff #3 administered one spray of Deep Sea nasal spray in each of Client #2's nostrils. At approximately 10:00 a.m., review of the client's medication administration record (MAR) and physician 's order sheets (POS) dated April 1, 2013, revealed an order to give two sprays of deep sea nasal spray in each nostril. Interview with Staff #3 on April 29, 2013, at approximately 4:00 p.m., revealed she administered two sprays of the Deep Sea nasal spray. At the time of survey, Staff #3 failed to administer two sprays of the aforementioned medication as ordered.	W 369	The supervising Registered Nurse will re- train staff #3 (TME) proper administration of client #3 deep sea nasal spray. 5/24/13 SYSTEM: The supervising registered Nurse will perform quarterly oversight per the District of Columbia Board of Nursing Trained Medication Employee (TME) regulations, and document accordingly. Ongoing		
W 370	483.460(k)(3) DRUG ADMINISTRATION The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits. This STANDARD is not met as evidenced by: Based on observation, staff interview and record	W 370			

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
W 370	Continued From page 6 verification, the facility failed to ensure that unlicensed personnel were not permitted to administer peridex for one of six clients residing in the facility. (Client #5) The finding includes: Observation of the medication administration on April 29, 2013, beginning at 9:00 a.m., revealed the trained medication employee (TME, Staff #3) poured Client #5's Peridex (oral rinse) 15 milliliters into a medication cup and handed the medication to Staff #5, who is not a TME. Staff #5 then walked into the bathroom with Client #5 to assist her with the prescribed oral rinse. Review of the medication administration record (MAR) on April 29, 2013, at approximately 10:00 a.m., revealed Staff #3 initialed the MAR, indicating that she assisted Client #5 with the peridex. Interview with the registered nurse (Staff #2) on April 30, 2013, at approximately 4:30 p.m., revealed drugs are administered by licensed nurses, or staff trained and certified in medication administration.	W 370	The Registered nurse will re-train staff #3, #5 and all staff to ensure that unlicensed staff are not permitted to administer peridex for individual # 5 and any individual receiving medication of any kind. 5/24/13 SYSTEM: The supervising Registered Nurse will perform medication observations for all TME's per District of Columbia Board of Nursing Trained Medication Employee regulations to ensure that only licensed personnel are administering any medications for individuals residing at 8020 Eastern Ave NW WDC 20012. Ongoing		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD Is not met as evidenced by: Based on observation and interview, the trained medication employee (TME) failed to ensure medications were secure under proper conditions	W 381			

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 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
W 381	Continued From page 7 of security, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The finding includes: On April 29, 2013, at 8:52 p.m., the TME (Staff #3) was observed to leave the medication closet door open as she went into another room to retrieve a chair. At 9:10 a.m., the staff left the closet door open again to retrieve a cup of water for Client #4. During this time, all the clients and facility staff were in close proximity to the medication. When interviewed on April 29, 2013, at approximately 4:00 p.m., Staff #3 acknowledged that the medication had been left unsecured	W 381	The supervising Registered Nurse will re-train Staff #3(TME) on storing medication under proper conditions of security. SYSTEM: The RN will conduct quarterly observations per DC Board of Nursing and document accordingly.	5/24/13 Ongoing
W 440	483.470(i)(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 on one of the five shifts (8 PM - 8 AM) for, six of the six clients residing in the facility. (Clients #1, #2, #3 #4, #5 and #6) The finding includes: The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On April 29, 2013, at 3:24 p.m., interview with the house manager #1 (HM1) revealed that there	W 440		

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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
W 440	Continued From page 8 were three 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). Review of the facility's fire drill records on April 29, 2013, beginning at 3:27 p.m., revealed that no drills were held during the weekend shift (8 p.m. - 8 a.m.) from July 2012 through September 2012. At 5:26 p.m., the fire drills records were reviewed again at the request of HM1. After the second review of the fire drill records, HM1 acknowledged that fire drills were not conducted during the weekend shift (8 p.m. - 8:00 a.m.) from July 2012 through September 2012.	W 440	HM #1 will be re-trained by the QIDP to ensure that fire drills are ran on all shifts. Furthermore QIDP will re-train staff to ensure that each staff is conducting at least one fire drill quarterly per shift to include weekdays and weekend shifts. SYSTEM: The QIDP will at least quarterly sign all fire drills to ensure simulated fire drills are conducted at quarterly for each shift.	5/14/13 Ongoing
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on observation, interview and review of the fire drill records, clients who were being trained, assisted and supported failed to use different escape routes during fire drills, for six of six clients included in the facility. (Clients #1, #2, #3, #4, #5 and #6) The finding includes: Morning observations conducted on April 29, 2013, at 9:28 a.m., revealed clients were exiting the front door for day program. Five (5) clients were observed to ambulate independently while one client required assistance due to being blind.	W 441	The QIDP will re-inservice all staff on conducting evacuation drills under varied conditions to include utilizing different escape routes during fire drills. SYSTEM: The QIDP will review and sign all fire drills conducted quarterly per shift to ensure that all drills are being conducted under varied conditions utilizing different escape routes.	5/14/13 Ongoing

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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)	
W 441	<p>Continued From page 9</p> <p>Interview with house manager #1 (HM1) on April 29, 2013, at 3:24 p.m., revealed that the facility had at least 3 methods of egress (front door, back door and basement door exits).</p> <p>Review of the facility's fire drill records on April 29, 2013, beginning at 3:27 p.m., revealed that all of the fire drills were conducted utilizing the front door exit. Further review of the fire drill records revealed that the back door and the basement door exit were not used from May 2012 to present. Interview with Client #1 at approximately 4:05 p.m., revealed she was trained to go out the front door when fire drills were conducted. She stated that she could not recall ever exiting through the back door and/or basement exit during fire drills. Moments later, interview with Client #1 also confirmed that she always used the front door exit during fire drills.</p> <p>Continued interview with HM1 on the same day at 5:25 p.m. revealed that the clients utilized the basement for laundry duties and active treatment activities (i.e. working on the computer). Further interview with HM1 confirmed that the back door and basement door exits were not utilized during the past year.</p> <p>At the time of the survey, there was no evidence on file at the time of survey to substantiate that all exits were used.</p>	W 441		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1 000	INITIAL COMMENTS A licensure survey was conducted from April 29, 2013 through April 30, 2013. A sample of three residents was selected from a population of four females and two males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and at two day programs, interviews with two clients, 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.]	1 000		
1 090	3504.1 HOUSEKEEPING 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. This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHID) failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6) The finding includes: Observation during the inspection of the environment on April 30, 2013, beginning 2:35	1 090		

Health Regulation & Licensing Administration

Emily J. Homer Sec. of Director Operations
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE -

(X6) DATE

5/23/13

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 090	Continued From page 1 p.m., revealed the following: - There was a mirror missing in the basement bathroom. The blinds also located in the basement bathroom were torn. - The top of the black leather loveseat located in the living room was observed to be worn which exposed the white thread underneath the leather. - There was a missing stove knob located on the right front of the stove. - There was a small piece (approximately 5 inches) of wood siding torn from the counter just above the dishwasher. - There was debris (trash/leaves) located in the front of the facility. Qualified intellectual disabilities professional #1 (QIDP1) who was present during the inspection, confirmed the above findings. QIDP1 stated that they were going to replace the loveseat. She also stated that she would address the other aforementioned findings with maintenance.	I 090	On 5/13/13 the mirror was fixed, and the blinds replaced. 05/13/13 The couch has been ordered, and will be replaced. 06/01/13 The stove knob will be replaced. 05/25/13 The small piece of torn wood siding from the counter above the dishwasher has been repaired. 05/25/13 The debris (trash/leaves) located in the front of the facility has been cleaned up. 05/12/13 The Quality assurance coordinator will re-train the Residential Coordinator on the monthly environmental checklist, and the procedure for reporting needed repairs. 05/24/13 SYSTEM: The Residential Coordinator will complete a monthly environmental checklist to ensure that all environmental issues are identified and reported immediately for repair. Ongoing	
I 135	3505.5 FIRE SAFETY 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. This Statute is not met as evidenced by: Based on interview and record review, the group for persons with intellectual disabilities (GHIID) failed to hold evacuation drills quarterly on one of the five shifts (8 PM - 8 AM) for, six of the six residents residing in the GHIID. (Residents #1,	I 135		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
I 135	Continued From page 2 #2, #3 #4, #5 and #6) The finding includes: The GHIID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On April 29, 2013, at 3:24 p.m., interview with the house manager #1 (HM1) revealed that there were three 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). Review of the GHIID's fire drill records on April 29, 2013, beginning at 3:27 p.m., revealed that no drills were held during the weekend shift (8 p.m. - 8 a.m.) from July 2012 through September 2012. At 5:25 p.m., the fire drills records were reviewed again at the request of HM1. After the second review of the fire drill records, HM1 acknowledged that fire drills were not conducted during the weekend shift (8 p.m. - 8:00 a.m.) from July 2012 through September 2012.	I 135	The Residential Coordinator (HM1) will be re-trained on the policies and procedures pertaining to the requirements of conducting fire drills for all individuals residing at 8020 Eastern Avenue NW WDC 20011. SYSTEM: The Residential Coordinator (HM1) will review and sign all fire drills conducted at 8020 Eastern Avenue NW, WDC 20011 on a monthly basis to ensure all shifts are conducting fire drills at least 4 times per year.	05/24/13 Ongoing	
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.	I 379	Cross Reference with W 153	05/17/13	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 379	Continued From page 3 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 persons with intellectual disabilities (GHIID) failed to ensure that all resident to resident abuse were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the six residents residing in the facility. (Resident #3) The finding includes: On April 30, 2013, at 9:21 a.m., review of Resident #3's medical records revealed a primary care physician note dated March 26, 2013. The note indicated that Resident #3 was pushed to the floor by another resident. Resident #3 was examined and no injuries were present. Review of the incident report book on April 29, 2013, beginning at 10:27 a.m., failed to reveal a report for the aforementioned incident. Interview with the qualified intellectual disabilities professional (Staff #1) revealed that she was informed that Resident #1 pushed Resident #3 on March 20, 2013. Further interview revealed that the staff did not complete an incident report when she witnessed the physical aggression towards Resident #3. The facility failed to ensure that all allegations of abuse were reported immediately to the administrator and to HRLA.	I 379		
I 422	3521.3 HABILITATION AND TRAINING	I 422		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 422	Continued From page 4 Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure each Resident's behavior support plan (BSP) was implemented consistently, for one of three Residents in the sample with maladaptive behaviors. (Resident #3) The finding includes: The facility failed to ensure that Resident #3's 1:1 staff implemented the BSP, as evidenced below: On April 29, 2013, at 9:21 a.m., while the surveyor was conducting observations of the medication administration, Resident #3 was walking around the house in a circle then reached out and scratched the surveyor's hand. The trained medication employee (TME, Staff #3) told the resident no. At 9:28 a.m., Resident #3 scratched the surveyor on the hand again, in the presence of Staff #3. After the second incident, a staff member that was present in the room (Staff #4) was asked which staff was primarily responsible for assisting Resident #3 during the shift. Staff #4 responded by indicating that he was responsible for providing 1:1 support for the resident, while Staff #3 was administering medications. Staff #3 would resume 1:1 supports afterwards. It should be noted however, that Staff #4 was observed to be assisting other residents onto the facility's van at the time of the second incident. Staff #4 further indicated that he had asked the registered nurse (Staff #2) to assist Resident #3 during his absence.	I 422	Cross Reference W 249	05/24/13

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 422	Continued From page 5 Interview with Staff #3 on April 29, 2013, at approximately 10:15 a.m., verified that she was assigned to Resident #3 as the 1:1 staff during the 8:00 a.m. to 4:00 p.m. shift. Further interview revealed that Staff #4 was assigned to the resident during the medication administration. On April 30, 2013, at 10:00 a.m., review of Resident #3's behavior support plan (BSP) dated February 25, 2013, revealed that the resident's behaviors included physical aggression (hitting, scratching, spitting, and grabbing others forcefully). According to the BSP, the 1:1 staff was required to emphasize communication skills using picture books, visual schedules, and self-soothing techniques such as rubbing hand/arm gently with lotion. Further review revealed techniques such as verbal redirection, touch control if verbal redirection is ineffective, or if the situation demands immediate physical intervention, and direct resident to another room or remove others from the room where she is. At the time of survey, the resident was observe to walk around the house in a circle before she went to the day program, therefore the facillty 1:1 staff failed to implement Resident #3's BSP as recommended.	I 422		
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure	I 473	Cross Reference W 368	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 473	Continued From page 6 that each resident ' s prescribed drugs were administered without error, for two of the three residents in the sample. (Residents #2 and #3) The findings include: During the morning medication administration, the trained medication employee (TME, Staff #3) failed to administer medications without error, as follows: On April 29, 2013, beginning at 8:34 a.m., Staff #3 was observed preparing Resident #2's medications. At 8:40 a.m., Staff #3 administered one spray of Deep Sea nasal spray in each of Client #2's nostrils. At approximately 10:00 a.m., review of the resident's medication administration record (MAR) and physician 's order sheets (POS) dated April 1, 2013, revealed an order to give two sprays of Deep Sea nasal spray in each nostril. Interview with Staff #3 on April 29, 2013, at approximately 4:00 p.m., revealed she administered two sprays of the Deep Sea nasal spray. At the time of survey, Staff #3 failed to administer two sprays of the aforementioned medication as ordered.	I 473		