

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

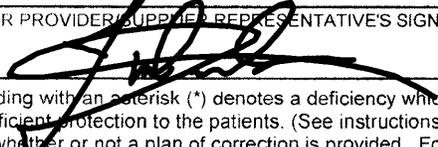
PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from May 29, 2012, through May 31, 2012. A sample of three clients was selected from a population of five men with various degrees of intellectual disabilities. The survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and one client, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	W 000	<p>The following constitutes the facility's response to the findings of the Department of Health and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.</p> <p>This plan of correction is prepared as required by the provisions of the Health and Safety Code, 42 CFR and constitutes the facility's written credible plan of correction to address citations W189, W368, W370, and W371 respectively.</p>
W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff was provided with initial and continuing training that enabled them to perform their duties effectively, efficiently, and competently, for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to provide initial training to all staff to perform their duties effectively, efficiently</p>	W 189	<p>Response to W189</p> <p>Metro Homes confirmed Client #1's 1:1 staff received his initial training on Client #1's behavior support plan (BSP) on 3/17/2012. The QIDP ensured Client #1's 1:1 staff received additional training on the BSP on 6/21/2012 to address the deficient practice.</p> <p>The QIDP will also monitor all other staff and all other clients in the residence at least weekly to ensure that their BSP's are implemented as written. Additional training will be scheduled should other staff fail to implement all the proactive measures outlined in the other individual's BSPs</p> <p>The QIDP will conduct weekly monitoring of Client #1's Behavior Support Plan, to ensure compliance as indicated.</p> <p>6/29/2012</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



COMPLIANCE OFFICER 6/18/12

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: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 189	<p>Continued From page 1 and competently.</p> <p>On May 29, 2012, beginning at 4:20 p.m., Client #1 was observed outside screaming and jumping when one to one staff #3 repeatedly told him to stop touching the grill, (which was not hot.) The client was also observed attempting to bite his one to one support staff. While the client was displaying this behavior, the evening one to one support staff was observed attempting to redirect the client activity's by asking him to stop. The one to one staff was further observed touching the client's hands then interlocking fingers to prevent the client from biting him. At 4:23 p.m., one to one staff #3 then allowed the client to move the grill a couple inches away from its original location. The evening one to one then asked the client, "Are you satisfied."</p> <p>Interview with the one to one support staff on May 29, 2012, at 1:26 p.m., revealed that when Client #1 displays his maladaptive behaviors, he "should stand next to him, but not cage him."</p> <p>On May 31, 2012, at 2:15 p.m., review of Client #1's behavior support plan (BSP) dated July 19, 2011, revealed the following maladaptive behaviors: physical aggression, self-injurious behavior (SIB), and bolting. The BSP has the following guidelines for addressing physical aggression:</p> <ul style="list-style-type: none"> - Staff should monitor for signs of frustration and agitation; - Staff should anticipate his needs and desires and respond to initial signs of agitation and frustration; 	W 189		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 189 Continued From page 2

W 189

- Staff should reduce demands and ignore minor low intensity, self injury;
- Staff should encourage community walks and participate in gym activities;
- Staff should keep the client occupied with different activities;
- Provide verbal or tactile cues (softly touch his arm);
- Provide verbal praise for desired behaviors;

On May 31, 2012, at 3:30 p.m., review of the in service training records revealed that the one to one support staff had received training on Client #1's behavior support plan on March 17, 2012. However, Staff #3 failed to offer different activities to redirect Client #1.

W 368 483.460(k)(1) DRUG ADMINISTRATION

W 368

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, record review and interview, the facility failed to ensure that all prescribed medications were administered in accordance with each client's physician orders, for one of the five clients residing in the facility. (Client #3)

The finding includes:

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012	
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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	<p>Continued From page 3</p> <p>Observation of the medication administration on May 30, 2012, at 6:08 p.m., revealed Client #3 received Artificial Tears. Interview with the trained medication employee (TME) at the same time revealed the eye drops were prescribed for the client's dry eyes. At 6:54 p.m., review of the client's May 2012 medication administration record (MAR) and current physician orders dated May 2012, revealed an order to administer the aforementioned eye drops four times a day. Continued review revealed the eye drops were only administered three times a day (Monday through Friday).</p> <p>Interview with the licensed practical nurse coordinator (LPNC) on May 31, 2012, at approximately 4:15 p.m., revealed the aforementioned medication was not taken to the day program. Therefore, the client did not receive his 12:00 p.m., drops as ordered.</p> <p>At the time of the survey, the facility failed to ensure Client #3's Artificial Tears were administered as prescribed by the primary care physician.</p>	W 368	<p>Response to W368</p> <p>The facility's nursing staff contacted the day program about Client #3's eye drops. Additional dosages of the medication were obtained and forwarded to the day program to address the deficient practice.</p> <p>Weekly visits to Client #3's day program will be conducted to ensure that all medications are being administered as prescribed by the physician. In addition, Weekly day program visits will be conducted for any other individual who receives mid-day medications to ensure compliance with their physician's orders.</p> <p>The Registered Nurse (RN) re-trained the Licensed Practical Nurse (LPN) Coordinator on the process of conducting a monthly review of the MAR no later than the 5th of each month to ensure that all medications for client #3, as well as all other individuals are present and available at the day program as prescribed by the primary care physician (PCP).</p> <p>The RN will conduct a monthly day program visit to ensure that all prescribed medications are available for client #3, as well as all other individuals by the 7th of each month as a measure to monitor LPN compliance.</p>	6/29/2012
W 370	<p>483.460(k)(3) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that unlicensed personnel were not permitted to administer drugs for four of the five clients residing in the facility. (Client #1, #3, #4, and #5)</p>	W 370		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012	
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 4 The findings include: Observation of the medication administration on May 29, 2012, beginning at 5:30 p.m., revealed clients were administered medications by an unlicensed trained medication employee (TME) (Staff #2) as follows: a. At 5:30 p.m., Client #1 was administered Depokote, Seroquel, Risperdal, and Calcium. b. At 5:43 p.m., Client #5 was administered Cogentin, Depokote, Prozac, and Risperdal. c. At 5:53 p.m., Client #4 was administered Generlac, Docusate Sodium, Calcium, Cogentin, and Metamucil. d. At 6:01 p.m., Client #3 was administered Clonidine, Oxybutynin Chloride, Amantadine, and Artificial Tears. Review of the personnel files on May 30, 2012, beginning at 10:50 a.m., revealed Staff #2 had an expired TME certificate that expired on October 31, 2011. Interview with the human resource coordinator on May 30, 2012, at approximately 11:15 a.m., confirmed that Staff #2 TME certificate was expired.	W 370	Response to W370 The Trained Medication Employee (TME) with the expired certification was taken of the TME schedule. The licensed practical nurse (LPN) on duty is now scheduled to administer all medications. The RN followed up with the DC Board of nursing and is awaiting a copy of the TME's certification to be delivered by postal mail on 7/15/12. All staff members who are Medication Techs have been tagged with the acronym 'TME' on all open schedules for easy identification. That designation allows our Registered Nurses (RN) to easily identify and inspect all TME certifications prior to medication administrations. All expiration dates are in process of being entered into our new management information system (MIS) with the help of our Information Technology (IT) team. This web based computer system will provide notice to all employees thirty (30) before any certificate and/or license expires. The MIS will also send an alert to the Human Resources department, the QDDP, and the RN as a reminder that an employee is due to renew their certificate/license. The director of nursing (DON) will meet with HR and the IT team on monthly bases to review all TMEs certifications and ensure accuracy of the data being entered into the MIS. Upon review, any staff without an active certification or license will be removed from the TME schedule and the pertinent home will be notified of said action.	6/29/2012
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications	W 371		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 371 Continued From page 5
is an appropriate objective, and if the physician does not specify otherwise.

W 371

This STANDARD is not met as evidenced by:
Based on observations, interviews, and the review of records, the facility failed to properly assess to develop written self administration objectives, for one of three clients in the sample. (Client #3)

The finding includes:

On May 29, 2012, beginning at 5:00 p.m., Client #3 was observed reading his book. When asked, the client stated he was reading an American university book. Interview with the qualified intellectual disabilities professional (QIDP) at approximately 4:30 p.m., indicated that the client knew how to read. At 5:07 p.m., the client went into the kitchen, and began to grease the muffin pan then he poured the batter into the pan. After dinner at 6:28 p.m., the client was observed helping the staff with the dishes. Observation of the medication administration beginning at 5:58 p.m., revealed the trained medication employee (TME) prepared Client #3's medications. The TME punched Client #3's medications into a medication cup. The TME then handed the client his medications. At 6:02 p.m., the TME retrieved the client's artificial tears then instilled one drop in each eye.

Record review on May 29, 2012, beginning at 7:00 p.m., failed to reveal a self medication assessment for Client #3.

Interview with the TME on May 29, 2012, at

Response to W371

The RN completed Client #3's self-medication assessment on 6/4/2012. A self-medication program was initiated for client #3 the following day (6/5/2012).

7/1/2012

The Registered Nurse (RN) will also ensure that the self-medication assessments for all the other individuals residing in this facility are re-evaluated to ensure all individuals are taking part in taking their medications to the fullest extent of the abilities. The re-evaluation of the self-medication assessments will be completed 7/1/2012.

The facility's nursing staff (Licensed Practical Nurses) will ensure the continuous re-assessments of all individuals' skill levels on a monthly basis and the RNs will also conduct a secondary evaluation every quarter.

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 371	<p>Continued From page 6</p> <p>approximately 6:30 p.m., revealed Client #3 did not have a self medication assessment. Interview with the QIDP and the licensed practical nurse coordinator on May 31, 2012, at approximately 4:20 p.m., confirmed that a self medication assessment was not completed for Client #3.</p> <p>The facility failed to assess and develop a self medication administration program for Client #3.</p>	W 371		
-------	--	-------	--	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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)
I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 29, 2012, through May 29, 2012. A sample of three residents was selected from a population of five men with various degrees intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and one client, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	I 000	
I 043	<p>3502.2(c) MEAL SERVICE / DINING AREAS</p> <p>Modified diets shall be as follows:</p> <p>(c) Reviewed at least quarterly by a dietitian.</p> <p>This Statute is not met as evidenced by: Based on observation, record review and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure that the modified diet for residents had been reviewed at least quarterly by a dietitian, for one of the three residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Observation of Resident #2's dinner meal on May 29, 2012, at 6:13 p.m., revealed the resident was served an 1800 calorie meal consisting bite size barbeque chicken, spinach, and a whole cornbread. However, the client did not eat his</p>	I 043	

Health Regulation & Licensing Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 043	Continued From page 1 cornbread. For his beverage he was served water. Record review of Resident #2's nutritional assessment dated July 11, 2011, on May 30, 2012, at 9:37 a.m., revealed that the resident was prescribed a 1800 calorie, high fiber diet. Further review failed to show evidence that the facility's nutritionist had reviewed Resident #2's diet on a quarterly basis. On May 31, 2012, at approximately 2:00 p.m., interview with the qualified intellectual disabilities professional (QIDP) confirmed that there was no evidence that the nutritionist conducted a quarterly after the residents' nutritional assessment. At the time of the survey, the GHMRP failed to have a nutrition review after the residents' assessment.	I 043		
I 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 facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was in an orderly manner, for five of the five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The findings include:	I 090		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 2 1. The shed on the side of the house was full of broken equipment, trash, and debris. 2. In the kitchen the Venetian blinds at the rear door was broken. 3. The sink in the common bathroom appeared to be clogged. The water drained excessively slow and filled up rather quickly when the faucet was turned on. 4. In the laundry room area of the basement there was a wall socket where the wires were exposed and in need of a face plate. The staff indicated this was a pull station for the fire system that has not been repaired at the time of the survey. 5. The ceiling light globe in the basement is broken and in need of replacement. At approximately 4:50 p.m., the above deficiencies were discussed with the qualified intellectual disabilities (QIDP) professional and the agency maintenance personnel (MP) who had arrived at the facility and indicated that all of the above deficiencies would be abated.	I 090		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by:	I 436		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 436	Continued From page 3 Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the two residents in the sample. (Resident #3) The finding includes: On May 29, 2012, beginning at 5:00 p.m., Resident #3 was observed reading his book. When asked, the client stated he was reading an American university book. Interview with the qualified intellectual disabilities professional (QIDP) at approximately 4:30 p.m., indicated that the resident knew how to read. At 5:07 p.m., the resident went into the kitchen, and began to grease the muffin pan, then he poured the batter into the pan. After dinner at 6:28 p.m., the resident was observed helping the staff with the dishes. Observation of the medication administration beginning at 5:58 p.m., revealed the trained medication employee (TME) prepared Resident #3's medications. The TME punched Resident #3's medications into a medication cup. The TME then handed the resident his medications. At 6:02 p.m., the TME retrieved the resident's artificial tears then instilled one drop in each eye. Record review on May 29, 2012, beginning at 7:00 p.m., failed to reveal a self medication assessment for Resident #3. Interview with the TME on May 29, 2012, at approximately 6:30 p.m., revealed Resident #3 did not have a self medication assessment. Interview with the QIDP and the licensed practical nurse coordinator on May 31, 2012, at	I 436		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 436	Continued From page 4 approximately 4:20 p.m., confirmed that a self medication assessment was not completed for resident #3. The facility failed to assess and develop a self medication administration program for resident #3.	I 436			
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 verification, the Group Home for Persons with Intellectual Disability (GHPID) failed to report any irregularities to the Primary Care Physician (PCP) for one of three residents in the sample. (Resident #3) The finding includes: Observation of the medication administration on May 30, 2012, at 6:08 p.m., revealed Resident #3 received Artificial Tears. Interview with the trained medication employee (TME) at the same time revealed the eye drops were prescribed for the resident's dry eyes. At 6:54 p.m., review of the resident's May 2012 medication administration record (MAR) and current physician orders dated May 2012, revealed an order to administer the aforementioned eye drops four times a day. Continued review revealed the eye drops were only administered three times a day (Monday through Friday). Interview with the licensed practical nurse coordinator (LPNC) on May 31, 2012, at	I 473			

Health Regulation & Licensing Administration

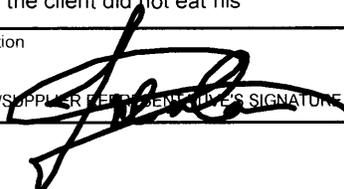
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 5 approximately 4:15 p.m., revealed the aforementioned medication was not taken to the day program. Therefore, the resident did not receive his 12:00 p.m., drops as ordered. At the time of the survey, the facility failed to ensure Resident #3's Artificial Tears were administered as prescribed by the primary care physician.	I 473	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 May 29, 2012, through May 29, 2012. A sample of three residents was selected from a population of five men with various degrees intellectual disabilities. The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and one client, 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	The following constitutes the facility's response to the findings of the Department of Health and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies. This plan of correction is prepared as the facility's written credible plan of correction to address citations 3502.2(c), 3504.1, 3521.7(f), and 3522.4.	
1 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on observation, record review and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure that the modified diet for residents had been reviewed at least quarterly by a dietitian, for one of the three residents in the sample. (Resident #2) The finding includes: Observation of Resident #2's dinner meal on May 29, 2012, at 6:13 p.m., revealed the resident was served an 1800 calorie meal consisting bite size barbeque chicken, spinach, and a whole cornbread. However, the client did not eat his	1 043	Response to 3502.2(c) It is Metro Home's policy to ensure that all residents are provided timely annual and quarterly nutritional assessments. In the case when the survey team identified that a quarterly review of Resident #2's nutritional assessment was not on file, the QIDP contacted the dietitian and ensured that an updated document could be obtained. The dietitian agreed to perform a quarterly assessment to ensure that Resident #2's nutritional needs were being met.	7/6/2012

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER'S SIGNATURE



TITLE

COMPLIANCE OFFICER

(X6) DATE

6/18/12

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 043	Continued From page 1 cornbread. For his beverage he was served water. Record review of Resident #2's nutritional assessment dated July 11, 2011, on May 30, 2012, at 9:37 a.m., revealed that the resident was prescribed a 1800 calorie, high fiber diet. Further review failed to show evidence that the facility's nutritionist had reviewed Resident #2's diet on a quarterly basis. On May 31, 2012, at approximately 2:00 p.m., interview with the qualified intellectual disabilities professional (QIDP) confirmed that there was no evidence that the nutritionist conducted a quarterly after the residents' nutritional assessment. At the time of the survey, the GHMRP failed to have a nutrition review after the residents' assessment.	I 043		
I 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 facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was in an orderly manner, for five of the five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The findings include:	I 090		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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
1 090	Continued From page 2 1. The shed on the side of the house was full of broken equipment, trash, and debris. 2. In the kitchen the Venetian blinds at the rear door was broken. 3. The sink in the common bathroom appeared to be clogged. The water drained excessively slow and filled up rather quickly when the faucet was turned on. 4. In the laundry room area of the basement there was a wall socket where the wires were exposed and in need of a face plate. The staff indicated this was a pull station for the fire system that has not been repaired at the time of the survey. 5. The ceiling light globe in the basement is broken and in need of replacement. At approximately 4:50 p.m., the above deficiencies were discussed with the qualified intellectual disabilities (QIDP) professional and the agency maintenance personnel (MP) who had arrived at the facility and indicated that all of the above deficiencies would be abated.	1 090	Response to 3504.1 The facilities manager met with the QIDP and Residential Coordinator on 6/1/2012 and all work with the exception of Citation #1 was completed by 6/5/2012 and corrected as follows: 2. The venetian blinds were replaced. 3. The clog was removed and the drainage checked for proper flow. 4. A face plate was put in place and the exposed wires are no longer exposed. 5. The broken globe was replaced. The cleaning out of the shed will be delayed until the appropriate dumping grounds or a viable reclamation (green) resource is identified. The Residential Coordinator will ensure a monthly monitoring of the shed to ensure that it remains a clean and well organized storage option.	6/5/2012 7/6/2012
1 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by:	1 436		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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
1436	<p>Continued From page 3</p> <p>Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the two residents in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>On May 29, 2012, beginning at 5:00 p.m., Resident #3 was observed reading his book. When asked, the client stated he was reading an American university book. Interview with the qualified intellectual disabilities professional (QIDP) at approximately 4:30 p.m., indicated that the resident knew how to read. At 5:07 p.m., the resident went into the kitchen, and began to grease the muffin pan, then he poured the batter into the pan. After dinner at 6:28 p.m., the resident was observed helping the staff with the dishes. Observation of the medication administration beginning at 5:58 p.m., revealed the trained medication employee (TME) prepared Resident #3's medications. The TME punched Resident #3's medications into a medication cup. The TME then handed the resident his medications. At 6:02 p.m., the TME retrieved the resident's artificial tears then instilled one drop in each eye.</p> <p>Record review on May 29, 2012, beginning at 7:00 p.m., failed to reveal a self medication assessment for Resident #3.</p> <p>Interview with the TME on May 29, 2012, at approximately 6:30 p.m., revealed Resident #3 did not have a self medication assessment. Interview with the QIDP and the licensed practical nurse coordinator on May 31, 2012, at</p>	1436	<p>Response to 3521.7(f)</p> <p>The RN completed Resident #3's self-medication skills level assessment on 6/4/2012. A self-medication program was initiated for resident #3 the following day.</p> <p>The RN will also ensure that the self-medication assessments for all the other individuals residing in this home are re-evaluated to ensure all individuals are taking part in taking their medications to the fullest extent of the abilities. The re-evaluation of the self-medication assessments will be completed 7/1/2012.</p> <p>The facility's nursing staff will ensure the continuous re-assessments of all individuals' skill levels on a monthly basis and the RNs will also conduct a secondary evaluation every quarter.</p>	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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 436	Continued From page 4 approximately 4:20 p.m., confirmed that a self medication assessment was not completed for resident #3. The facility failed to assess and develop a self medication administration program for resident #3.	I 436		
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 verification, the Group Home for Persons with Intellectual Disability (GHPID) failed to report any irregularities to the Primary Care Physician (PCP) for one of three residents in the sample. (Resident #3) The finding includes: Observation of the medication administration on May 30, 2012, at 6:08 p.m., revealed Resident #3 received Artificial Tears. Interview with the trained medication employee (TME) at the same time revealed the eye drops were prescribed for the resident's dry eyes. At 6:54 p.m., review of the resident's May 2012 medication administration record (MAR) and current physician orders dated May 2012, revealed an order to administer the aforementioned eye drops four times a day. Continued review revealed the eye drops were only administered three times a day (Monday through Friday). Interview with the licensed practical nurse coordinator (LPNC) on May 31, 2012, at	I 473	Response to 3522.4 The Registered Nurse (RN) completed Resident #3's self-medication skills level assessment on 6/4/2012. A self-medication program was initiated for resident #3 the following day. The RN will also ensure that the self-medication assessments for all the other individuals residing in this home are re-evaluated to ensure all individuals are taking part in taking their medications to the fullest extent of the abilities. The re-evaluation of the self-medication assessments will be completed 7/1/2012. The facility's nursing staff will ensure the continuous re-assessments of all individuals' skill levels on a monthly basis and the RNs will also conduct a secondary evaluation every quarter.	7/6/2012

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, 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	
1473	Continued From page 5 approximately 4:15 p.m., revealed the aforementioned medication was not taken to the day program. Therefore, the resident did not receive his 12:00 p.m., drops as ordered. At the time of the survey, the facility failed to ensure Resident #3's Artificial Tears were administered as prescribed by the primary care physician.	1473			