

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

PRINTED: 03/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 4424 20TH STREET, NE WASHINGTON, DC 20019
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(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
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from February 24, 2014 through February 26, 2014. A sample of three clients was selected from a population of five men and women with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Group Home for Individuals with Intellectual Disabilities - GHIID Intermediate Care Facility - ICF Milligrams - MG Physical Therapy - PT Primary Care Physician - PCP Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN Trained Medication Employee - TME Urinary Tract Infection - UTI Day Program Staff-DPS Direct Support Professional-DSP Individual Support Plan-ISP</p>	W 000		
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by:</p>	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Emily J. Thomas* TITLE *Executive Director* (X6) DATE *3/21/14*

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 120	<p>Continued From page 1</p> <p>Based on observation, interview and record review, the facility failed to ensure that staff employed by outside services utilized each client's adaptive equipment effectively during ambulation, for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On February 24, 2014, at 6:21 p.m., DSP #1 in the home was observed escorting Client #3 from the client's bedroom to the dining room table. The client walked independently using a rolling walker. The client also wore a gait belt, which DSP #1 held loosely as she walked behind the client. Client #3 was again observed ambulating independently in the home the next morning (February 25, 2014) at 7:22 a.m. DSP #2 was observed using the same technique (loosely holding the client's gait belt) during ambulation. On occasions, the gait belt was placed around Client #3's waist.</p> <p>A different technique, however, was observed being used at Client #3's day program on February 25, 2014. At 12:20 p.m., the client was observed ambulating in the classroom. The client was using the rolling walker and his/her gait belt was observed to be placed around the upper chest and torso instead of the waist. DPS #1 was observed holding a loop on the back of the client's gait belt firmly and pulling upward on the belt. When asked, the day program supervisory case coordinator (DPS #2), who was present at the time, stated that the physical therapist from the home had trained all of their staff, including DPS #1, on the proper use of the gait belt and that it was acceptable for the belt to be secured around the chest.</p>	W 120	<p>W 120</p> <p>The day program staff have been re-inserviced on the use of the gait belt, and that the gait belt be placed around the waist, and not the chest area.</p> <p>SYSTEM: The staff at day program and residentially will be observed utilizing the gait belt.</p>	3/21/14 Ongoing	

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W 120	<p>Continued From page 2</p> <p>On February 26, 2014, at 2:09 p.m., the QIDP was asked about the positioning and use of Client #3's gait belt. The QIDP stated it should be placed around the waist and staff should hold it loosely, as a precaution (if the the client should lose his/her balance). The QIDP said the gait belt should never be placed around the chest, and staff should not pull on the belt as long as the client was ambulating independently with his/her walker.</p> <p>On February 26, 2014, at 2:21 p.m., review of Client #3's PT Evaluation dated September 18, 2013, revealed the client could ambulate with use of the walker "with contact guard assistance" and a "waist gait belt." At 3:09 p.m., the QIDP presented documentation showing that the physical therapist had provided training for day program staff on March 29, 2012, almost two years earlier. Review of the signature sheet revealed that both DPS #1 and DPS #2 had been in attendance. When asked about more recent training, the QIDP acknowledged that there had not been additional PT training provided for Client #3's day program staff since then.</p> <p>There was no evidence that the facility routinely monitored the ambulation supports that Client #3 received while at day program.</p>	W 120			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0149	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 4424 20TH STREET, NE WASHINGTON, DC 20018
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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from February 24, 2014 through February 26, 2014. A sample of three residents was selected from a population of five men and women with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews and review of resident and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Group Home for Individuals with Intellectual Disabilities - GHIID Intermediate Care Facility - ICF Milligrams - MG Physical Therapy - PT Primary Care Physician - PCP Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN Trained Medication Employee - TME Urinary Tract Infection - UTI Day Program Staff-DPS Direct Support Professional-DSP Individual Support Plan-ISP</p>	1 000		
1 095	<p>3504.6 HOUSEKEEPING</p> <p>Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to store poisonous agents in a locked cabinet and/or out of direct reach of each</p>	1 095	<p>1095</p> <p>The direct support professionals have been trained on the storage of poisonous agents being in a locked cabinet.</p> <p>SYSTEM:</p> <p>At least annually and as needed, staff will be re-inserviced on storage of poisonous chemicals.</p>	<p>3/12/14</p> <p>ongoing</p>

Health Regulation & Licensing Administration

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

TITLE

(X6) DATE

Ernie J. Thomas Executive Director

3/21/14

Health Regulation & Licensing Administration

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I 095	<p>Continued From page 1</p> <p>resident, for five of five residents of the facility. (Residents #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>During the environmental walk-thru on February 26, 2014, at 3:35 p.m., a bottle of Reeva Automatic Dishwashing Gel was observed in an unlocked cabinet beneath the kitchen sink. Review of the product label revealed the following: "Caution: Harmful if swallowed. Eye and skin irritant. Keep out of reach of children...Contains sodium silicate, sodium hydroxide and chlorine... If swallowed or gets in mouth, rinse mouth thoroughly, drink a large glass of water or milk. After providing first aid, call a poison control center or doctor immediately..."</p> <p>Observations during the survey had revealed all five residents were ambulatory and had access to the area.</p> <p>The QIDP, who was present at the time, removed the bottle immediately.</p>	I 095		