STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G162		04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from April 10, 2013 through April 12, 2013. A sample of three clients was selected from a population of three 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 three day programs, interviews with one client, 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 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients' prescribed diets were maintained confidentially for three of three sampled clients and two non-sample random clients. (Clients #1, #2, #3, #4 and #5) The finding includes: On April 10, 2013, at 6:13 p.m., a piece of paper was observed posted openly on the wall in the kitchen between the refrigerator and cabinet.	W 112	The QIDP removed the paper identifying the diets for individuals #1, #2, #3, #4, and #5. The QIDP will provide an accessible, but confidential place for individual's diets to ensure that staff are following diets per nutritional orders. SYSTEM: The QIDP developed a book for diets to remain accessible to staff, but maintain confidentiality for individuals #1, #2, #3, #4, and #5. All diets will be3 maintained in this book for all individuals residing at 4424 20th Street, NE Washington, DC. 20019.	4/10/12 4/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emily J Hamer — TITLE: Exec. Dir of Operations — (X6) DATE: 4/26/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 112	Continued From page 1 Review of the paper revealed that it included each client's first name and last initials and listed their prescribed diets. For example, Client #1 was prescribed an 1800 calorie reducing, low trans-fat, low cholesterol, high fiber, low starch, low carb and low fat diet. Client #2 was prescribed a 1200 Kcalorie, low fat, low cholesterol bite size diet. On April 12, 2013, at 1:10 p.m., the posting was brought to the attention qualified intellectual disabilities professional (QIDP1) during the inspection of the facility. QIDP1 stated that the dietary information placed on the wall was to ensure staff identified the appropriate diet for the clients. QIDP1 immediately removed the information from the kitchen wall. At the time of the survey, the facility failed to ensure an effective system was enacted to make certain clients' personal information was maintained confidential.	W 112		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially constituted committee failed to review and approve the incorporation of a restrictive intervention (door alarms) as part of a behavior support plan, for	W 262		

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W 262	Continued From page 2 one of three clients in the sample. (Client #1) The finding includes: Upon entrance to the facility on April 10, 2013, at 2:00 p.m., there was a loud alarm that sounded when the front door was opened. Interview with the residential coordinator (RC1) who entered the facility with the surveyor revealed that the alarm was in place due to Client #1's elopement behaviors. At 4:04 p.m. the clients were observed to enter the facility via the back door from the day program. Again, a loud alarm sounded when the back door was opened. Both alarms sounded each time staff was observed to enter or exit through the front/back doors throughout the remainder of the survey. On April 11, 2013, at 1:51 p.m., review of Client #1's behavior support plan (BSP) dated September 12, 2012, revealed the client had targeted behaviors of attempted elopement and elopement. Additionally, the BSP incorporated twenty-four (24) 1:1 supports at home and at the day program to prevent elopement and to ensure the client's health and safety. The BSP however, did not mention the use of door alarms. Interview with the qualified intellectual disabilities professional (QIDP1) on April 12, 2013, at 1:52 p.m., revealed that the alarm was placed on the door to address Client #1's targeted behaviors of attempted elopement and elopement. Further Interview with QIDP1 revealed that she thought the facility's human rights committee (HRC) had approved the use of the alarms. On April 12, 2013, at approximately 2:00 p.m., review of the HRC minutes from April 2012 to present revealed	W 262	The QIDP will request that the behavior support plan be updated to include the use of the door alarms for individual #1 by the current psychologist of record. The psychologist will include the door alarms as a restrictive measure in individual #1's behavior support plan. Furthermore, the QIDP generated an emergency approval form to all HRC members and received approval by the Human Rights committee.	5/5/13
			SYSTEM: The QIDP will at least annually and/or as needed present the all restrictions of rights to Human Rights Committee for approval for individual #1 and all individuals residing at 4424 20th Street NE Washington, DC 20019.	Ongoing

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W 262	Continued From page 3 there was no evidence of any HRC review for the door alarms. At approximately 2:10 p.m., QIDP1 confirmed that the HRC had not reviewed and approved the use of the door alarms.	W 262		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0149		04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 000	INITIAL COMMENTS A licensure survey was conducted from April 10, 2013 through April 12, 2013. A sample of three residents was selected from a population of three females and two males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and at three day programs, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 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 (GHIID) failed to maintain the interior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5 and) The findings include: Observation during the inspection of the environment on April 12, 2013, beginning 1:10 p.m., revealed two out of the six dining rooms	I 090	On 4/12/13, the QIDP contacted maintenance and requested replacement of all broken chairs immediately. SYSTEM: The Residential Coordinator will utilize the environmental quality assurance form to ensure that all furniture is in good condition, and that the environment is maintained in a safe, clean, orderly attractive and sanitary manner and be free from dirt, rubbish, and objectionable odors. Furthermore, if there is issues involving furniture or other problems identified in the home, the Residential Coordinator will input those repairs into the I MANAGE system, which is monitored daily by maintenance.	4/15/13 Ongoing

Health Regulation & Licensing Administration

Emily J. Horner Exec. Dir of Operations 4/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Health Regulation & Licensing Administration

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I 090	Continued From page 1 chairs wear torn and partially detached from the foundation which posed a safety risk. The house manager (HM) and qualified intellectual disabilities professional (QIDP) who were present during the inspection, confirmed the above findings. The QIDP stated that she would make maintenance aware of the problem immediately.	I 090		