

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2013
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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH 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
W 000	INITIAL COMMENTS A recertification survey was conducted from June 5, 2013 through June 7, 2013. A sample of three clients was selected from a population of four males and two females 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 at one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.	W 000		
W 159	[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.] 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the qualified intellectual disabilities professional failed to ensure a walking protocol was developed and implemented, for one of the three clients in the sample. (Client #1) The finding includes: On June 6, 2013, beginning at 12:25 p.m., Client #1 was observed seated in a recliner chair. At 12:33 p.m., Staff #2 assisted the client to a	W 159	W159 The QIDP #1 will develop a walking protocol for individual #1. The Physical Therapist will re-train staff #2 and all staff on the use of the gait belt for individual #1. SYSTEM: The QIDP will observe monthly and document on monthly progress note the observation and results of the staff assistance for individual #1. The QIDP will annually or as needed re-train on the walking protocol and gait belt.	7/12/13 7/19/13 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Emily J. Homan* TITLE *Exec Director of Operations* (X6) DATE *7/15/13*

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 159	<p>Continued From page 1</p> <p>standing position. Staff #2 then placed his hands on the client's waist and began to walk with him. At 12:35 p.m., the client became agitated and stopped walking. Staff #2 asked the client to sit in his wheelchair but he continued to scream and shake his body. At 12:41 p.m., Client #3 sat in his wheelchair after he became calm.</p> <p>On June 6, 2013, at approximately 2:00 p.m., review of Client #1's record revealed a physical therapy assessment dated January 18, 2013. The assessment revealed a recommendation for a gait belt to be used during ambulation. Further review revealed a recommendation for the client to use his wheelchair as needed in the home and in the community.</p> <p>On June 7, 2013, at approximately 1:00 p.m., interview with the qualified intellectual disabilities professional (QIDP) #1 revealed a gait belt was purchased for Client #1. Interview with Staff #2 at 4:15 p.m., revealed he did not use the gait belt because Client #1 does not like it.</p> <p>On June 7, 2013, at 3:37 p.m., review of the in-service training records revealed all staff received training on the physical therapy assessment on May 21, 2013. The physical therapy assessment however, did not include how to use the client's gait belt. Review of Client's records on June 6, 2013, beginning at approximately 1:30 p.m., failed to reveal a walking protocol with the use a gait belt.</p> <p>At the time of survey, QIDP #1 failed to ensure that staff was trained on how to use a gait belt while walking with Client #1.</p>	W 159			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189			

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W 189	<p>Continued From page 2</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 effectively trained to manage the provisions outlined in each client's physical therapy assessment, for one of the three clients in the sample. (Client #3)</p> <p>The findings include:</p> <p>The facility failed to prompt or encourage Client #3 to sit in a arm chair during dinner in accordance with the physical therapy assessment, as evidenced below:</p> <p>On June 5, 2013, beginning at 4:06 p.m., Client #3 was observed sitting in a wheelchair. At 7:12 p.m., Client #3 was observed eating dinner while seated in his wheelchair. Observation at the day program on July 6, 2013, beginning at 11:57 a.m., revealed Client #3 was eating lunch while seated in his wheelchair.</p> <p>On June 7, 2013, at 1:38 p.m., review of Client #3's physical therapy assessment dated April 30, 2012, recommended that the client use a regular chair with arms during mealtime. At 3:38 p.m., review of the staff in-service training records revealed that all staff had received training on Client #3's physical therapy assessment on May 21, 2013. Observations on June 5, 2013,</p>	W 189	<p>W189 Staff will be re-trained by the QIDP on prompting and encouraging individual #3 to sit in a armchair during dinner according to the physical therapy assessment. Staff will be trained on transferring from the wheelchair to the arm chair. SYSTEM: The QIDP will monthly observe at least 2 meal times to ensure proper use of the arm chair and transferring from wheelchair to armchair during mealtimes. The QIDP will document observation on monthly progress notes.</p>	7/19/13	Ongoing

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W 189	Continued From page 3 however, indicated that the training was not effective.	W 189			
W 247	On June 7, 2013, at 4:43 p.m., Interview with Staff #3 revealed that she was trained on the client's physical therapy assessment. Further interview revealed that the client usually sits in his arm chair but did not sit in his arm chair on June 5, 2013. 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing staff failed to ensure client self-management during the medication administration process, for two of three clients in the sample. (Client #2 and #3) The finding includes: On June 5, 2013, beginning at 5:42 p.m., trained medication employee (TME) #1 was observed to stir Client #2's medications with apple sauce and spoon feed her, using a coated spoon. TME #1 then placed a cup of water to Client #2's mouth. However, during dinner observations beginning at 7:06 p.m., Client #2 was observed eating dinner independently using a coated spoon, high sided section plate, and a cup with a built in straw. Similarly, on June 5, 2013, beginning at 6:38 p.m., TME #1 was observed to stir Client #3's medication (crushed) with apple sauce and spoon	W 247	W 247 The Registered Nurse will re-train TME #1 and all TME's on the opportunity for the use of adaptive equipment during medication administration, as well as all opportunities. TME #1 and all staff will be re-trained on informal opportunities pertaining to active engagement. SYSTEM: The QIDP will re-train at least annually or as needed on informal opportunities and active engagement.	7/19/13 Ongoing	

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W 247	Continued From page 4 feed him, using a regular teaspoon. However, during dinner observations beginning at 7:06 p.m., Client #3 was observed eating dinner independently using a coated spoon, high sided section plate, and a cup with a built in straw. On March 26, 2013, at 4:10 p.m., interview with TME #1 revealed that Client #3 could feed herself after set up. Further interview revealed that a small bowl can be provided to give the client the opportunity to feed herself.	W 247	W 368 The delegating Registered Nurse will re-train TME #1 on administering all medications in accordance with the physicians orders. The delegating RN will re-train TME #1 on the administering of enulose, cold medicine and ear drops as prescribed for individual #2 and #6.	7/15/13
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 Enulose, cold medicine and ear drops were administered as prescribed, for two of three clients in the facility. (Clients #2 and #6) The findings include: 1. On June 5, 2013, beginning at 5:33 p.m., the trained medication employee (TME) #1 began to prepare Client #2's medication. At 5:42 p.m., TME #1 administered Calcium, Keppra, Sucralfate, Rifampin, Ducosate, Clarithromycin, Fish oil, Cranberry Fruit, Deep Sea spray, and Mineral oil, to Client #2. TME #1 then placed the aforementioned medications in the closet. TME #1 indicated that the medication administration was completed for Client #2.	W 368	SYSTEM: The delegating Registered Nurse will observe medication administration every 6 months for TME #1 and all TME's at Metro Homes, Inc.	Ongoing

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W 368	<p>Continued From page 5</p> <p>On June 5, 2013, at 7:50 p.m., review of the client's medication administration review (MAR) and physician's order sheets (POS) dated June 1, 2013, revealed an order to administer Enulose in the evening.</p> <p>Interview with TME #1 on June 6, 2013, at approximately 4:00 p.m., revealed she thought she had administered the Enulose with the aforementioned medications.</p> <p>At the time of survey, the facility failed to administer Client #2's Enulose as prescribed.</p> <p>2. On June 5, 2013, beginning at 4:50 p.m., Client #2 was observed coughing and drooling. The qualified intellectual disabilities professional (QIDP) #1 then handed the client a napkin and asked Client #2 to wipe her mouth and the mucus from her nose. QIDP #1 also told her "its ok you will get your medicine soon." At 4:53 p.m., QIDP #1 placed a cup of tea in front of Client #2. Observation of the medication administration at 5:33 p.m., revealed the TME #1 administered Calcium, Keppra, Sucralfate, Rifampin, Ducusate, Clarithromycin, Fish oil, Cranberry Fruit, Deep Sea spray, and Mineral oil, to Client #2. Continued observation revealed Client #2 coughed and clean the mucus from her nose intermittently throughout the survey.</p> <p>On June 6, 2013, at approximately 1:00 p.m., review of the client's medical record revealed a written order dated June 3, 2013. The order stated to administer "Tussin every six hours as needed for cough."</p>	W 368			

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W 368	Continued From page 6 Interview with TME #1 on June 6, 2013, at approximately 4:00 p.m., revealed the facility did not have any more cold medicine. Further interview indicated that the pharmacy later delivered the cold medicine and another TME administered it after she left at twelve midnight. At the time of survey, the facility failed to administer Client #2's Tussin as prescribed. 3. On June 5, 2013, beginning at 6:07 p.m., TME #1 administered five drops of Eardrops (Generic Debrox) in Client #6's right ear and four drops in the left ear. Observation of the medication label revealed the client was supposed to receive 5 drops of Eardrops in each ear. This was also in accordance with the client's medication administration record (MAR) and physician's orders for June 2013.	W 368		
W 369	Interview with TME #1 on June 6, 2013, at approximately 4:15 p.m., revealed she administered five drops of Eardrops in each ear. 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 Enulose and ear drops were administered without error, for two of three clients in the facility. (Clients #2 and #6) The findings include:	W 369		

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W 371	<p>Continued From page 9</p> <p>On June 6, 2013, at 4:10 p.m., interview with TME #1 revealed the clients was required to throw their cups away.</p> <p>On June 6, 2013, at 3:00 p.m. and 3:16 p.m., respectively, review of Clients #2 Individual program plan (IPP) dated May 18, 2013, and review of Client #3's IPP dated April 1, 2013, revealed that both clients had self-medication training programs. The programs revealed that given verbal prompts, the clients will identify a medication and state the purpose.</p> <p>On June 6, 2013, at 4:10 p.m., interview with TME #1 revealed the clients was required to throw their cups away. Interview with registered nurse #1 revealed the clients were required to identify a medication and state the purpose.</p>	W 371			

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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from June 5, 2013 through June 7, 2013. A sample of three residents was selected from a resident population of four males and two females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process</p> <p>The findings of the survey were based on observations in the home and one day program, interviews with one resident, direct support staff, nursing and administrative staff, 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>	1 000		
1 090	<p>3604.1 HOUSEKEEPING</p> <p>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.</p> <p>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 and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for six of six residents residing in the facility (Residents #1, #2, #3 #4 #5 and #6)</p> <p>The findings include:</p>	1 090	<p>1090</p> <p>The closet has been cleared of clutter. SYSTEM: The Residential Coordinator will on a monthly basis do an environmental checklist to include observing to ensure that closets are free from clutter.</p>	<p>7/13/13</p> <p>ongoing</p>

Health Regulation & Licensing Administration

Emily J. Danner, Exec. Director of Operations
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

7/15/13

Health Regulation & Licensing Administration

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I 090	Continued From page 1 Observation during the inspection of the environment on June 7, 2013, beginning 3:00 p.m., revealed the closet in the basement was cluttered with paint cans, paint brushes, shoes, boxes, buckets and an ironing board. Interview with house manager #1 on June 7, 2013, at approximately 3:30 p.m., revealed the facility will clean the closet immediately.	I 090		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all health care professionals had current health certificates on file, for one of four registered nurses (RN). (RN #2). The finding includes: On June 7, 2013, beginning at approximately 2:30 p.m., review of the personnel records for all employees, including licensed professionals, revealed there was no evidence of a current physician's health inventory/certificate for RN #2. Interview with the qualified intellectual disabilities professional (QIDP #1) and the house manager	I 206	1206 The physicians current health certificate has been retrieved for the RN #2 and filed in her personnel file. SYSTEM: Human Resources will retrieve Health Certificates for all staff that are required to have this, including all health professionals.	7/13/13 Ongoing

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I 206	Continued From page 2 (HM #1) on the same day at approximately 4:30 p.m., revealed they will retrieve the aforementioned document.	I 206		
I 474	<p>3522.5 MEDICATIONS</p> <p>Each GHMRP shall maintain an individual medication administration record for each resident.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with Intellectual disabilities (GHID's) nursing staff failed to ensure that each residents' Enulose, cold medicine and ear drops were administered as prescribed, for two of three residents in the sample. (Resident #2 and #6)</p> <p>The findings include:</p> <p>1. On June 5, 2013, beginning at 5:33 p.m., the trained medication employee (TME) #1 began to prepare Resident #2's medication. At 5:42 p.m., TME #1 administered Calcium, Keppra, Sucralfate, Rifampin, Ducusate, Clarithromycin, Fish oil, Cranberry Fruit, Deep Sea spray, and Mineral oil, to Resident #2. TME #1 then placed the aforementioned medications in the closet. TME #1 indicated that the medication administration was completed for Resident #2.</p> <p>On June 5, 2013, at 7:50 p.m., review of the resident's medication administration review (MAR) and physician 's order sheets (POS) dated June 1, 2013, revealed an order to administer Enulose in the evening.</p> <p>Interview with TME #1 on June 6, 2013, at approximately 4:00 p.m., revealed she thought</p>	I 474	<p>1474</p> <p>Cross Reference with W 368 and W 369</p>	

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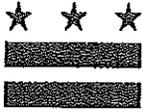
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1474	<p>Continued From page 3</p> <p>she had administered the Enulose with the aforementioned medications.</p> <p>At the time of survey, the facility failed to administer Resident #2's Enulose as prescribed.</p> <p>2. On June 5, 2013, beginning at 4:50 p.m., Resident #2 was observed coughing and drooling. The qualified intellectual disabilities professional (QIDP) #1 then handed the resident a napkin and asked Resident #2 to wipe her mouth and the mucus from her nose. QIDP #1 also told her "its ok you will get your medicine soon." Observation of the medication administration at 5:33 p.m., revealed the TME #1 administered Calcium, Keppra, Sucralfate, Rifampin, Ducusate, Clarithromycin, Fish oil, Cranberry Fruit, Deep Sea spray, and Mineral oil, to Resident #2. Continued observation revealed Client #2 coughed and clean the mucus from her nose intermittently throughout the survey.</p> <p>On June 6, 2013, at approximately 1:00 p.m., review of the resident's medical record revealed a written order dated June 3, 2013. The order stated to administer "Tussin every six hours as need for cough."</p> <p>Interview with TME #1 on June 6, 2013, at approximately 4:00 p.m., revealed the facility did not have any more cold medicine. Further interview indicated that the pharmacy later delivered the cold medicine and another TME administered it after she left at twelve midnight.</p> <p>At the time of survey, the facility failed to administer Resident #2's Tussin as prescribed.</p> <p>3. On June 5, 2013, beginning at 6:07 p.m., TME</p>	1474		
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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2013
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1474	Continued From page 4 #1 administered five drops of Eardrops (Generic Debrox) in Resident #6's right ear and four drop in the left ear. Observation of the medication label revealed the resident was supposed to receive 5 drops of Eardrops in each ear. This was also in accordance with the resident's medication administration record (MAR) and physician's orders for June 2013. Interview with TME #1 on June 6, 2013, at approximately 4:15 p.m., revealed she administered five drops of Eardrops in each ear.	1474			



Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration



Intermediate Care Facilities Division

Sent Via Email and US Mail

JUL 3 2013

Maxwell Asenso
Executive Director
Metro Homes, Inc.
6856 Eastern Avenue, N.W., Suite 376
Washington, DC 20012

Re: 929 55th Street, N.E.

Dear Mr. Asenso:

You will find enclosed Statement of Deficiency reports for federal and local licensure. The reports enumerate deficiencies found as a result of a survey completed on June 7, 2013. You are required to respond to each deficiency. Although a reasonable period of time may be allowed for actual correction of these deficiencies, it is imperative that your plan be signed with a specific date for anticipated completion and returned to this office prior to **July 13, 2013**. Since these reports are subject to public disclosure, it is necessary that the responses be indicated on the original forms (and not on an attachment, except if submitting a copy of a policy change). NOTE: "Corrected" is not an accepted reply. The plan MUST also include the following.

- **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**
- **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**
- **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and**
- **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented.**

PLEASE NOTE: Plans of Correction not adhering to the above requirements will not be considered acceptable. Also, failure to submit acceptable plans, within the specified time frame, MAY result in the loss of Medicaid reimbursement.

If you have any questions or concerns regarding the above, please contact Laura A. Hunte, Supervisory Health Services Program Specialist, Intermediate Care Facilities Division on (202) 724-8800.

Sincerely,



Sharon H. Mebane
Program Manager

Enclosures

cc: Jared Thomas
Chief Quality Enhancement Unit
Department on Disability Services