

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

PRINTED: 06/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                      |  |
|--|---|--|--|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G155 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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<br><br>A recertification survey was conducted from May 22, 2013 through May 24, 2013. A sample of three clients was selected from a population of five males with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process.<br><br>The findings of the survey were based on observations in the home and 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 368  | [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]<br>483.460(k)(1) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that each client's medications were administered in accordance with physician's orders, for two of five clients residing in the facility. (Clients #2 and #3)<br><br>The findings include:<br><br>I. On May 22, 2013, at 7:08 a.m., a trained medication employee (TME, Staff #6) was observed administering 30 milliliters (ml) of Enulose stool softener to Client #3. Review of the | W 368  | The supervising RN will re-train staff #6 on the measuring and administering of enulose stool softener for individual #3. Additionally, staff #6 will be re-trained on the administration of flonase. The supervising RN will re-train staff #5(LPN) on that upon determination of a medication error, that the LPN should have administered the additional spray of Flonase herself.<br><br>SYSTEM: The supervising RN will do quarterly observations to ensure proper administration of medications by all TME's, and document results.<br><br>S | 6/20/13              | Ongoing                                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Emily J. Hower* TITLE: *Executive Director Of Operations* (X6) DATE: *6/18/13*

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: 06/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G155 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|--|--|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 1</p> <p>label on the Enulose bottle revealed that the order was for the client to receive 15 ml of the medication. His physician's order sheets (POS) dated May 1, 2013, and medication administration record (MAR) for May 2013 also reflected an order for 15 ml Enulose.</p> <p>II. On May 22, 2013, at 7:29 a.m., Staff #6 was observed administering one spray Flonase in each of Client #2's nostrils. The label on the box revealed the client was to be administered 2 sprays in each nostril. After Staff #6 indicated that he had completed the medication administration process, at 8:00 a.m., he and his supervisor, the licensed practical nurse (LPN) coordinator, (Staff #5) were informed of the observation. Upon examination of Client #2's POS, Staff #5 was observed to instruct Staff #6 to administer another spray in each nostril. At 8:06 a.m., Staff #6 said goodbye and left the facility. At 8:19 a.m., Staff #5 did not see evidence that Staff #6 had administered the second spray. She immediately telephoned Staff #6; he informed her that he had not administered more Flonase before signing out from his shift. At the time, Client #2 and his peers were observed seated in a van with staff in front of the facility. At 8:20 a.m., the LPN Coordinator (Staff #5) was observed to leave the facility and speak with the van driver. A moment later, the van drove away from the facility. No additional Flonase had been administered.</p> <p>On May 22, 2013, at approximately 9:45 a.m., the morning medication administration observations were shared with the facility's director of nursing (and acting supervisory registered nurse, Staff #3). She informed Staff #5, who was present at the time that she should have administered the</p> | W 368 |  |  |
|-------|--|-------|--|--|

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

PRINTED: 06/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G155 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|--|--|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 2<br>second dose of Flonase to Client #2, once she had determined that the TME had failed to do so.<br><br>It should be noted that evening observations of Clients #2 and #3 in the facility on May 22, 2013, and interviews with staff who had accompanied them to day program (Staff #7 and #8, respectively, at approximately 4:10 p.m.) revealed that neither client had shown any signs or symptoms of a negative outcome following the medication administration errors observed on that morning.   | W 368         |   |                        |
| W 369              | This is a repeat deficiency. See Federal Deficiency Report dated May 31, 2012.<br>483.460(k)(2) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and record review, the facility failed to ensure that each client's prescribed drugs were administered without error, for two of five clients residing in the facility. (Clients #2 and #3)<br><br>The findings include:<br><br>[Cross-reference to W368]<br><br>I. On May 22, 2013, at 7:08 a.m., a trained medication employee (TME, Staff #6) was observed administering 30 milliliters (ml) of Enulose stool softener to Client #3. The client's physician's order sheets (POS) dated May 1, | W 369         | The supervising RN will re-train staff #6 on the measuring and administering of enulose stool softener for individual #3. Additionally, staff #6 will be re-trained on the administration of Flonase nasal spray. The supervising RN will re-train staff #5(LPN) on that upon determination of a medication error that the LPN should have administered the additional spray of Flonase herself. SYSTEM: The supervising RN will do quarterly observations to ensure proper administration of medication by all TME's and document results. | 6/20/13<br><br>Ongoing |

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

PRINTED: 06/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G155 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|--|--|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2288 SUDBURY ROAD, NW<br>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 3<br>2013, and medication administration record (MAR) for May 2013 reflected the order was for 15 ml Enulose.<br><br>II. On May 22, 2013, at 7:29 a.m., Staff #6 was observed administering one spray Flonase in each of Client #2's nostrils. Client #2's POS, dated May 1, 2013, and MARs reflected he was to receive 2 sprays Flonase in each nostril. Even though the medication error was brought to a nurse's attention (Staff #5) while Client #2 was at the facility that morning, the client left for day program without receiving the second spray of Flonase to each nostril, as ordered.   | W 369 |  |  |
| W 455 | 483.470(l)(1) INFECTION CONTROL<br><br>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure effective infection control procedures (hand washing/sanitizing) was implemented during medication administrations, for four of five clients residing in the facility. (Clients #1, #2, #4 and #5)<br><br>The finding includes:<br><br>The morning medication administration was observed on May 22, 2013, beginning at 6:50 a.m. A trained medication employee (TME, Staff #6) washed his hands prior to administering medications to Client #3 and again before Client #4. Continued observations, however, revealed the TME failed to wash his hands before | W 455 |  |  |

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

PRINTED: 06/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G155 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|--|--|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 455              | <p>Continued From page 4</p> <p>administering medications to Clients #2, #1 and #5. While administering medications to the other clients, the TME was observed to use a key to lock and unlock the medication closet, touch the closet door, touch various documents such as the medication administration records and touch the bottles and blister packs of medications being administered.</p> <p>At 8:00 a.m., Staff #6 and his supervisor, the licensed practical nurse (LPN) coordinator, (Staff #5) were informed of the observation. Staff #6 confirmed the observation. Staff #5 stated that washing hands and/or using sanitizing gel before pouring each client's medications (and more frequently, as needed) was included in the TME training curriculum.</p> <p>Review of the in-service training records on May 24, 2013, beginning at 2:05 p.m., revealed that all staff including Staff #6 received training on Infection control on February 7, 2013. Observations on May 22, 2013, however, revealed the training had not been effective.</p> <p>It should be noted that the LPN coordinator (Staff #5) documented having re-trained four TME's, including Staff #6, on the morning of May 24, 2013. Washing hands throughout the medication administration process was reflected on the agenda.</p> | W 455         | <p>Staff #6 will be re-inserviced on proper hand washing/sanitizing procedures during medication administration for individual #2, #1, and #5, and all individuals residing in 2268 Sudbury Rd. NW WDC.</p> <p>SYSTEM: The staff will be re-inserviced as needed on the proper procedure of hand washing during medication administration. The supervising RN will observe quarterly medication administration and document results.</p> | <p>6/20/13</p> <p>Ongoing</p> |

Health Regulation & Licensing Administration

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0131 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|---|--|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 | <p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from May 22, 2013 through May 24, 2013. A sample of three residents was selected from a population of five males with varying degrees of intellectual disabilities.</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 |  |  |
| 1 058 | <p><b>3502.16 MEAL SERVICE / DINING AREAS</b></p> <p>A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by:<br/>Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that modified diets were reviewed at least quarterly by the consulting dietitian, for one of three residents in the sample. (Resident #3)</p> <p>The findings include:</p> <p>On May 22, 2013, at 6:39 a.m., a trained medication employee (TME, Staff #6) used a</p> | 1 058 |  |  |

Health Regulation & Licensing Administration

*Emily J. Hamer*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Executive Director of Operations*  
TITLE

6/18/13 (X6) DATE

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0131                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 058  | Continued From page 1<br><br>finger stick to test Resident #3's fasting blood glucose. He said the resident had diabetes and his blood sugar was tested every Monday, Wednesday and Friday morning. At 7:03 a.m., the TME administered Metformin 500 milligram (mg) with other medications and the resident ate breakfast shortly thereafter.<br><br>I. On May 23, 2013, at approximately 10:15 a.m., review of Resident #3's nutrition records revealed an assessment dated April 28, 2012, at which time his diet order was an 1800 calorie weight reducing, high fiber diet. The next assessment by the nutritionist was documented on December 20, 2012 (8 months later). The assessment reflected the new diagnosis of Diabetes Melitus Type 2 and included the following recommendation: "discontinue 1800 calorie weight reducing, high fiber diet. Start 1800 calorie diabetic high fiber diet."<br><br>II. Resident #3's nutrition records failed to show evidence that the nutritionist had re-assessed his dietary status in the five months since December 20, 2012. | I 058  | The QIDP will be re-trained by the Program Director on the criteria for review of nutritionist. The nutritionist has updated the quarterly report. QIDP has been trained on case management and coordination of services.<br><br>SYSTEM: The Program Director will conduct drop in visits on a quarterly basis to ensure compliance of all review of individuals services. | 6/19/13<br><br>Ongoing                       |
| I 206  | 3509.6 PERSONNEL POLICIES<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the group  | I 206  | The facility received for staff #8 the current health certificate annually as required dated 8/09/12.<br><br>SYSTEM: The facility will require that all staff turn in a health certificate annually.   | 8/9/12<br><br>Ongoing                        |

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0131                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 206  | Continued From page 2<br>home for individuals with intellectual disabilities (GHIID) failed to ensure that all employees had current health certificates on file, for 1 of 17 employees. (Staff #8)<br><br>The finding includes:<br><br>On May 24, 2013, at 12:40 p.m., review of the personnel records revealed no evidence of a physician's health inventory/certificate for Staff #8. The finding was shared during the Exit conference held later that afternoon, beginning at 3:08 p.m.; however, no additional information was made available for review.  | I 206  |   |  |
| I 226  | 3510.5(c) STAFF TRAINING<br><br>Each training program shall include, but not be limited to, the following:<br><br>(c) Infection control for staff and residents;<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all staff received effective training on infection control, for 1 out of 17 employees. (Staff #6)<br><br>The finding includes:<br><br>The morning medication administration was observed on May 22, 2013, beginning at 6:50 a.m. A trained medication employee (TME, Staff #6) washed his hands prior to administering medications to Resident #3 and again before Resident #4. Continued observations, however, revealed the TME failed to wash his hands or use | I 226  | The supervising RN will train staff #6 and all TME's on washing hands and infection control for individuals #2, #1, and #4 and all individuals residing at 2268 Sudbury Rd. NW WDC.<br><br>SYSTEM: The staff will be trained at least annually or as needed on hand washing procedures as it relates to infection control and/or medication administration. | 6/18/13<br><br>Ongoing                       |

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0131                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 226  | Continued From page 3<br><br>hand sanitizer before administering medications to Residents #2, #1 and #5. While administering medications to the other residents, the TME was observed to use a key to lock and unlock the medication closet, touch the closet door, touch various documents such as the medication administration records and touch the bottles and blister packs of medications being administered.<br><br>At 8:00 a.m., Staff #6 and his supervisor, the licensed practical nurse (LPN) coordinator, (Staff #5) were informed of the observation. Staff #6 confirmed the observation. Staff #5 stated that washing hands and/or using sanitizing gel before pouring each resident's medications (and more frequently, as needed) was included in the TME training curriculum.<br><br>Review of the in-service training records on May 24, 2013, beginning at 2:05 p.m., revealed that all staff including Staff #6 received training on infection control on February 7, 2013. Observations on May 22, 2013, however, revealed the training had not been effective.<br><br>It should be noted that the LPN coordinator (Staff #5) documented having re-trained four TME's, including Staff #6, on the morning of May 24, 2013. Washing hands throughout the medication administration process was reflected on the agenda. | I 226  |   |  |
| I 261  | 3512.2 RECORDKEEPING: GENERAL PROVISIONS<br><br>Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies.  | I 261  |   |  |

Health Regulation & Licensing Administration

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0131 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|---|--|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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) | (X6) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

|       |  |       |   |                               |
|-------|--|-------|---|-------------------------------|
| I 261 | <p>Continued From page 4</p> <p>This Statute is not met as evidenced by:<br/>Based on interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to ensure that (1) records of registered nurse (RN) oversight and, (2) the training provided for trained medication employees (TME's) were available for inspection by personnel of the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA).</p> <p>The finding includes:</p> <p>[Cross-reference I500]<br/>On May 22, 2013, at 7:08 a.m., a trained medication employee (TME, Staff #6) was observed administering 30 milliliters (ml) of Enulose stool softener to Resident #3. The resident's physician's order sheets (POS) dated May 1, 2013, and medication administration record (MAR) for May 2013 reflected the order was for 15 ml Enulose.</p> <p>Similarly, at 7:29 a.m., Staff #6 was observed administering one spray Flonase in each of Resident #2's nostrils. Resident #2's POS, dated May 1, 2013, and MARs reflected he was to receive 2 sprays Flonase in each nostril. Even though the medication error was brought to a nurse's attention (Staff #5) while Resident #2 was at the facility that morning, the resident left for day program without receiving the second spray of Flonase to each nostril, as ordered.</p> <p>On May 23, 2013, at approximately 1:30 p.m., the licensed practical nurse (LPN) coordinator (Staff #5) and the program director (Staff #9) agreed to retrieve records of all training received by TME's as well as documentation of RN oversight of TME's. Said records reportedly were maintained</p> | I 261 | <p>Going forward, the TME's records are stored at the home.</p> <p>SYSTEM: All records will be stored to ensure availability for inspection by personnel of the Department of Health, Health Regulation, and Licensing Administration (DOH/HRLA).</p> | <p>6/20/13</p> <p>Ongoing</p> |
|-------|--|-------|---|-------------------------------|

Health Regulation & Licensing Administration

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0131</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br><b>05/24/2013</b> |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>METRO HOMES</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2268 SUDBURY ROAD, NW<br/>WASHINGTON, DC 20012</b> |
|--|--|

| (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     |
|--------------------|---|---------------|--|------------------------|
| 1261               | Continued From page 5<br><br>at the corporate office, for each of the supervisory RN's. A second request was made on May 24, 2013, at 10:02 a.m. The facility, however, failed to make available for review the aforementioned documentation before the survey ended on May 24, 2013, at 3:08 p.m.<br><br>At the time of the survey, the GHIP failed to ensure that records of RN oversight of TME's were maintained and made available for DOH/HRLA inspection and review.   | 1261          |  |                        |
| 1379               | 3519.10 EMERGENCIES<br><br>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.<br><br>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 individuals with intellectual disabilities (GHID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the five residents of the facility. (Resident #2)<br><br>The finding includes: | 1379          | The QIDP will be re-trained on the reporting procedure for DOH/HRLA by the Program Director.<br>SYSTEM: The QIDP's will be re-trained annually and as needed the reporting protocol. | 6/17/13<br><br>Ongoing |

Health Regulation & Licensing Administration

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0131 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|--|---|--|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 6<br><br>On May 22, 2013, at 11:40 a.m., review of the facility's incident reports revealed that Resident #2 was taken to a hospital emergency room on May 3, 2013, at approximately 6:00 p.m. after he showed signs and symptoms of abdominal distress. The hospital discharge papers indicated the findings: "fecal impaction and hyponatremia." Continued review of the incident report revealed that a message reportedly had been left at DOH/HRLA on May 4, 2013, at 5:00 p.m. Pre-survey review of incident notifications had not, however, reflected any ER visits reported within the past month.<br><br>On May 23, 2013, at 2:25 p.m., interview with the qualified intellectual disabilities professional (Staff #1) revealed that she was the staff that called and left a message. Further interview, however, revealed that she had called a telephone number that was no longer used by DOH/HRLA. Staff #1 then acknowledged that the facility had not submitted written notification within 24 hours or the next business day, in accordance with this regulation. | I 379         |   |                    |
| I 500              | 3523.1 RESIDENT'S RIGHTS<br><br>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.<br><br>This Statute is not met as evidenced by:<br>Based on observations, interviews and record review, the group home for individuals with intellectual disabilities (GHIID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly  | I 500         | Cross Reference with W368   |                    |

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0131                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 500  | <p>Continued From page 7</p> <p>called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for two of five residents residing in the facility. (Residents #2 and #3)</p> <p>The findings include:</p> <p>[483.420(a)(7)] The GHIID failed to ensure Residents #2 and #3s' right to receive medications in accordance with physician's orders and without error, as follows:</p> <p>I. On May 22, 2013, at 7:08 a.m., a trained medication employee (TME, Staff #6) was observed administering 30 milliliters (ml) of Enulose stool softener to Resident #3. Review of the label on the Enulose bottle revealed that the order was for the resident to receive 15 ml of the medication. His physician's order sheets (POS) dated May 1, 2013, and medication administration record (MAR) for May 2013 also reflected the order for 15 ml Enulose.</p> <p>II. On May 22, 2013, at 7:29 a.m., Staff #6 was observed administering one spray Flonase in each of Resident #2's nostrils. The label on the box revealed the resident was to be administered 2 sprays in each nostril. After Staff #6 indicated that he had completed the medication administration process, at 8:00 a.m., he and his supervisor, the licensed practical nurse (LPN) coordinator, (Staff #5) were informed of the observation. Upon examination of Resident #2's POS, Staff #5 was observed to instruct Staff #6 to administer another spray in each nostril. At 8:06 a.m., Staff #6 said goodbye and left the facility. At 8:19 a.m., Staff #5 did not see evidence that Staff #6 had administered the second spray. She</p> | I 500  |   |  |

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0131                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>05/24/2013 |
|--|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>METRO HOMES  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2268 SUDBURY ROAD, NW<br>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 500  | <p>Continued From page 8</p> <p>Immediately telephoned Staff #6; he informed her that he had not administered more Flonase before signing out from his shift. At the time, Resident #2 and his peers were observed seated in a van with staff in front of the facility. At 8:20 a.m., the LPN Coordinator (Staff #5) was observed to leave the facility and speak with the van driver. A moment later, the van drove away from the facility. No additional Flonase had been administered.</p> <p>On May 22, 2013, at approximately 9:45 a.m., the morning medication administration observations were shared with the facility's director of nursing (and acting supervisory registered nurse, Staff #3). She informed Staff #5, who was present at the time that she should have administered the second dose of Flonase to Resident #2, once she had determined that the TME had failed to do so.</p> <p>It should be noted that evening observations of Residents #2 and #3 in the facility on May 22, 2013, and interviews with staff who had accompanied them to day program (Staff #7 and #8, respectively, at approximately 4:10 p.m.) revealed that neither resident had shown any signs or symptoms of a negative outcome following the medication administration errors observed on that morning.</p> <p>This is a repeat deficiency. See Federal Deficiency Report dated May 31, 2012.</p> | I 500  |   |  |