

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

PRINTED: 03/03/2009
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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>INITIAL COMMENTS</p> <p>A follow-up survey was conducted on February 17, 2009, to assess the facility's level of compliance with the condition level deficiencies cited during the recertification survey completed on January 7, 2009. A random sample of three clients was selected from a residential population of five clients (three females and two males) with mental retardation and other disabilities. The results of the survey were based on observations, staff interviews, as well as a review of client and administrative records, including unusual incident reports.</p> <p>The survey findings determined that the facility was in compliance with the condition of Active Treatment, however, standard level deficiencies were cited.</p>	{W 000}		
{W 159}	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation interview and record verification, the Qualified mental Retardation Professional (QMRP) failed to ensure the coordination of services for four of the four clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>1. The QMRP failed to ensure recommendations from consultants were addressed for Client #1.</p> <p>On February 17, 2009 at approximately 6:10 PM,</p>	{W 159}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Gusman J. Sloan VP - Operations TITLE
(X6) DATE **3/16/09**

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: 03/03/2009
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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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 159}	<p>Continued From page 1</p> <p>Client #1 was observed eating her dinner. The meal consisted of carrots, potatoes and chicken. The chicken was noted to be in chunks on the plate.</p> <p>The Client #1 required verbal prompts to slow her eating pace. The staff also directed the client to drink at intervals during the meal. The client was also noted to spill the liquid as she drank. Additionally, the client was observed eating with her face very close to the plate. At times, the staff were observed providing hand over hand assistance to ensure the client did not put too much food on the spoon. Staff further were observed assisting Client #1 to an upright position.</p> <p>Review of the Nutritional assessment dated February 17, 2009 at approximately 6:59 PM revealed the following recommendations:</p> <ul style="list-style-type: none"> - "Input from Occupational Therapist (OT) regarding the use of a plate elevator; - A cup with a lid for an alternative techniques to manage food and fluid spillage; and - sitting in an upright position." <p>Interview with the QMRP on the same day at 7:00 PM failed to evidence the she was aware of the recommendation. In addition, there was no evidence that the Primary Care Physician and OT were made aware of the recommendation.</p> <p>At the time of the re-visit, the facility failed to ensure Client #1 was evaluated by the OT as recommended.</p>	{W 159}	<p>W 159</p> <ol style="list-style-type: none"> 1. Client #1 was seen by the OT on 2/18/09 and a cup with a lid and a plate elevator was recommended. All staff were in serviced on the adaptive equipment. 2. All staff were in serviced on client's mealtime protocol and texture. 3. Self medication program was re written and the TMEs have been in serviced. 4. Client's IPPs were include on their individual activity schedules. <p>In the future the QMRP and the RN Supervisor will ensure that client's active treatment, program and medical compliance is integrated and coordinated with their management oversight. See attached – OT note, IPP incorporated on Activity schedule, Staff in service records, Self medication program</p> <p>All QMRPs complete a monthly QA of the ISP and IPP records to ensure that client's programs are implemented and staff receive the necessary training and supports necessary.</p>	2/28/09
---------	---	---------	---	---------

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

PRINTED: 03/03/2009
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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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 159}	Continued From page 2 2. The QMRP failed to ensure staff were trained to prepare Client #1's meat in the texture prescribed. [See W474] 3. The facility's QMRP failed to ensure that an objective was developed to address self medication training program needs as identified by the interdisciplinary team (IDT) in the comprehensive assessment. [See W227] 4. The facility's QMRP failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules. [See W250]	{W 159}		
{W 194}	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The finding includes: The facility failed to ensure effective training in the preparation of meals requiring special food textures. [See W474]	{W 194}	W 194 All staff were re trained in the mealtime protocol. In the future the QMRP and the RN Supervisor will ensure that client's active treatment, program and medical compliance is integrated and coordinated with their management oversight. See attached staff in service on mealtime protocol	2/28/09
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs,	W 227	All QMRPs complete a monthly QA of the ISP and IPP records to ensure that client's programs are implemented and staff receive the necessary training and supports necessary.	

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

PRINTED: 03/03/2009
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 R 02/17/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 227	Continued From page 3 as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that an objective was developed to address self medication training program needs identified by the interdisciplinary team (IDT), for one of the four clients in the sample. (Client #4) The finding includes: On February 17, 2009 at 4:41 PM, Client #4 was observed being administered his medications. Client #4 was observed punching medications from a blister package of medications and pouring a cup of water with physical assistance. Interview with the Registered Nurse on February 17, 2009 at 5:15 PM indicated that the client participated in a self medication program by punching out his medications but staff were not documenting on a data sheet. Review of the self medication assessment dated September 20, 2008 on February 17, 2009 at 5:20 PM indicated that the client was capable of self-administering medication with assistance and under close supervision. The assessment further indicated that client was recommended for a self medication program. Review of the Individual Program Plan (IPP) dated October 23, 2009 revealed no program goal or objective for the client to receive training in self medication.	W 227	W 227 The self medication program has been re written to incorporate the goal. In the future the QMRP and the RN Supervisor will ensure that client's active treatment, program and medical compliance is integrated and coordinated with their management oversight. See attached self medication program All QMRPs complete a monthly QA of the ISP and IPP records to ensure that client's programs are implemented and staff receive the necessary training and supports necessary.	2/28/09
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION	{W 249}		

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

PRINTED: 03/03/2009
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 R 02/17/2009
--	---	--	--

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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 249}	<p>Continued From page 4</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment, for one of the three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Observation on February 17, 2009 at 5:03 PM revealed Client #2 participated in a community walk from 5:03 PM until 5:10 PM. Interview with the Qualified Mental Retardation Professional (QMRP) on February 17, 2009 at 6:48 PM indicated that Client #2 had a program to workout at the local recreation center. Further interview revealed that Client #2 did not start her gym program because she "just" paid for it. She also indicated that she was trying to figure out an appropriate time schedule.</p> <p>Record review on February 17, 2009 at 6:55 PM revealed that Client #2 had a program to go to the gym three times a week. There was no evidence that Client #2 participated in this program. Further review of the records revealed that Client #2's gym membership was paid on February 4, 2009.</p>	{W 249}	<p>W 249</p> <p>The program for cardio vascular conditioning has been started and at this time she will go once a week and progress towards increasing the frequency of participation.</p> <p>See attached – program and inservice record and February'09 documentation record.</p> <p>All QMRPs complete a monthly QA of the ISP and IPP records to ensure that client's programs are implemented and staff receive the necessary training and supports necessary.</p>	2/28/09
---------	--	---------	---	---------

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

PRINTED: 03/03/2009
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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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 249}	Continued From page 5	{W 249}		
W 250	<p>There was no evidence that Client #2 was given the opportunity to participate in her individual program plan objectives.</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules, for one of the four clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on February 17, 2009 at approximately 12:05 PM revealed that Client #1's IPP goals and objectives were approved at her ISP meeting on January 16, 2009. The client's habilitation records were reviewed on the same day at approximately 12:30 PM to determine if the records contained an activity schedule. Although the records revealed a schedule, the clients' IPP or training programs were not included in the schedule. The QMRP was made aware on the same day that the activity schedule lacked information regarding the days and timeframe for the implementation of the client's IPP goals.</p>	W 250	<p>W 250</p> <p>Client's activity schedules were revised to incorporate the individual's training programs. In the future the QMRP and the RN Supervisor will ensure that client's active treatment, program and medical compliance is integrated and coordinated with their management oversight. See attached activity schedules</p> <p>All QMRPs and RNs complete a monthly QA of the ISP and IPP records to ensure that client's programs are implemented and staff receive the necessary training and supports necessary.</p>	2/28/09
W 474	483.480(b)(2)(iii) MEAL SERVICES	W 474		

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

PRINTED: 03/03/2009
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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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 474	<p>Continued From page 6</p> <p>Food must be served in a form consistent with the developmental level of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve foods in a form consistent with prescribed textures, for one of the three clients (Clients #1) in the sample.</p> <p>The finding includes:</p> <p>On February 17, 2009 at approximately 6:10 PM, Client #1 was observed eating her dinner. The meal consisted of carrots, potatoes and chicken. The chicken was noted to be in chunks on the plate.</p> <p>The Client #1 required verbal prompts to slow her eating pace. The staff also directed the client to drink at intervals during the meal. The client was also noted to spill the liquid as she drank. Additionally, the client was observed eating with her face very close to the plate. At times, the staff were observed providing hand over hand assistance to ensure the client did not put too much food on the spoon. Staff further were observed assisting Client #1 to an upright position.</p> <p>The direct care staff that prepared the meal was interviewed at approximately 6:16 PM to ascertain how Client #1's meat was prepared. She indicated that the client's meat was chopped with a knife. The nurse was asked to observe the client's meal at approximately 6:27 PM. The nurse acknowledged that the meat was not finely chopped as prescribed in the client's diet.</p>	W 474	<p>W 474</p> <p>All staff were re trained in the mealtime protocol.</p> <p>In the future the QMRP and the RN Supervisor will ensure that client's active treatment, program and medical compliance is integrated and coordinated with their management oversight. See attached staff in service on mealtime protocol</p> <p>All QMRPs complete a monthly QA of the ISP and IPP records to ensure that client's programs are implemented and staff receive the necessary training and supports necessary.</p>	2/28/09

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

PRINTED: 03/03/2009
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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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 474	Continued From page 7 Review of the mealtime protocol on that was placed in front of the client during mealtime revealed the client diet order was low fat, low cholesterol, high fiber with finely chopped meats and bite size other foods. The protocol further indicated that the client eats at a rapid pace and tends to overload the utensil. Review of the physician's orders concurred with the nutritionist's diet.	W 474		
-------	---	-------	--	--

Health Regulation 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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{R 000}	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from January 5, 2009 through January 7, 2009. A random sample of three clients was selected from a residential population of three females and two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and a review of records, including unusual incident reports.</p>	{R 000}		
---------	---	---------	--	--

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Susan V. Gleason*

TITLE: *Operations*

(X6) DATE: *3/16/09*

STATE FORM 6899 OK0712 If continuation sheet 1 of 1

Health Regulation 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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{1 000}	<p>INITIAL COMMENTS</p> <p>A follow-up licensure survey was conducted on February 17, 2009, to assess the facility's level of compliance with the condition level deficiencies cited during the recertification survey completed on January 7, 2009. A random sample of three clients was selected from a residential population of five clients (three females and two males) with mental retardation and other disabilities. The results of the survey were based on observations, staff interviews, as well as a review of client and administrative records, including unusual incident reports.</p> <p>The survey findings determined that the facility was in compliance with the condition of Active Treatment, however, standard level deficiencies were cited.</p>	{1 000}		
I 229	<p>3510.5(f) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>The findings include:</p>	I 229	<p>I 229</p> <p>Client #1 was seen by the OT on 2/18/09 and a cup with a lid and a plate elevator was recommended. All staff were in serviced on the adaptive equipment. All staff were in serviced on client's mealtime protocol and texture. In the future the QMRP and the RN Supervisor will ensure that client's active treatment, program and medical compliance is integrated and coordinated with their management oversight.</p>	2/28/09

Health Regulation Administration

Swan T. Swan (Signature) VP - Operations (Title) 3/16/09 (Date)

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

Health Regulation 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 R 02/17/2009	
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 229	<p>Continued From page 1</p> <p>On February 17, 2009 at approximately 6:10 PM, Resident #1 was observed eating her dinner. The meal consisted of carrots, potatoes and chicken. The chicken was noted to be in chunks on the plate.</p> <p>The Resident #1 required verbal prompts to slow her eating pace. The staff also directed the resident to drink at intervals during the meal. The resident was also noted to spill the liquid as she drank. Additionally, the resident was observed eating with her face very close to the plate. At times, the staff were observed providing hand over hand assistance to ensure the resident did not put too much food on the spoon. Staff further were observed assisting Resident #1 to an upright position.</p> <p>The direct care staff that prepared the meal was interviewed at approximately 6:16 PM to ascertain how Resident #1's meal was prepared. She indicated that the resident's meat was chopped with a knife. The nurse was asked to observe the resident's meal at approximately 6:27 PM. The nurse acknowledged that the meat was not finely chopped as prescribed in the resident's diet.</p> <p>Review of the Resident #1's mealtime protocol on that was placed on the table in front of the resident during mealtime revealed the diet order: low fat, low cholesterol, high fiber with finely chopped meats and bite size other foods. The protocol further indicated that the resident eats at a rapid pace and tends to overload the utensil. Review of the physician's orders concurred with the nutritionist's diet.</p>	I 229	<p>All QMRPs complete a monthly QA of the ISP and IPP records to ensure that client's programs are implemented and staff receive the necessary training and supports necessary.</p>	
{ I 422 }	3521.3 HABILITATION AND TRAINING	{ I 422 }		

Health Regulation 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 R 02/17/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
{ I 422 }	Continued From page 2 Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for one of the four residents included in the sample. (Resident #2) The finding includes: Observation on February 17, 2009 at 5:03 PM revealed Resident #2 participated in a community walk from 5:03 PM until 5:10 PM. Interview with the Qualified Mental Retardation Professional (QMRP) on February 17, 2009 at 6:48 PM indicated that Resident #2 had a program to workout at the local recreation center. Further interview revealed that Resident #2 did not start her gym program because she " just" paid for it. She also indicated that she was trying to figure out an appropriate time schedule. Review of Resident #2's record on February 17, 2009 at 6:55 PM revealed that the resident had a program to go to the gym three times a week. There was no evidence that Resident #2 participated in this program. Further review of the records revealed that the resident's gym membership was paid on February 4, 2009. There was no evidence that Resident #2 was given the opportunity to participate in her individual program plan objectives.	{ I 422 }	I 422 The program for cardio vascular conditioning has been started and at this time she will go once a week and progress towards increasing the frequency of participation. See attached – program and inservice record and February'09 All QMRPs complete a monthly QA of the ISP and IPP records to ensure that client's programs are implemented and staff receive the necessary training and supports necessary.	2/28/09
I 436	3521.7(f) HABILITATION AND TRAINING	I 436		

Health Regulation 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 R 02/17/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 436	<p>Continued From page 3</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(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);</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that its residents were afforded the opportunity to learn how to take part in their self medication program as required by this section and as evidenced below, for one of the four residents included in the sample. (Resident #4)</p> <p>The finding includes:</p> <p>On February 17, 2009 at 4:41 PM, Resident #4 was observed being administered his medications. Resident #4 was observed punching medications from a blister package of medications and pouring a cup of water with physical assistance. Interview with the Registered Nurse on February 17, 2009 at 5:15 PM indicated that the resident participated in a self medication program by punching out his medications, but staff were not documenting on a data sheet.</p> <p>Review of the self medication assessment dated September 20, 2008 on February 17, 2009 at 5:20 PM indicated that the resident was capable of self-administering medication with assistance and under close supervision. The assessment further indicated that resident was recommended for a self medication program.</p>	I 436	<p>I 436</p> <p>The self medication program has been re written to incorporate the goal.</p> <p>In the future the QMRP and the RN Supervisor will ensure that client's active treatment, program and medical compliance is integrated and coordinated with their management oversight. See attached self medication program</p>	2/28/09

Health Regulation 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 R 02/17/2009
--	---	--	--

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 436	Continued From page 4 Review of the Individual Program Plan (IPP) dated October 23, 2009 revealed no program goal or objective for the resident to receive training in self medication.	I 436		