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

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING ____ B. WING ____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from April 29, 2008 through May 1, 2008. The survey was initiated utilizing the fundamental survey process. A random sample of three clients was selected from a population of four male and two female clients with varying degrees of mental retardation. Additionally, a focus review was conducted for two of the remaining three clients. The findings of the survey were based on observations at the group home and three day programs. Also the findings were based on interviews with three clients and direct care staff and management in both the group home and the day programs, as well as a review of habilitation and administrative records, to include the review of the facility's unusual incident management system.	W 000	2008 MAY 21 P 5:06 RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that the clients' rights for privacy during the medication administration were protected for one of three clients included in the sample. (Client #1) The finding includes: The facility failed to ensure that Client#1 received privacy during the evening medication administration as evidenced below:	W 130	W 130 TME was in serviced on client's rights and privacy. TME was in serviced on Medication Administration Safety principles and Policy and Procedure. In the future the Delegating RN Supervisor will monitor the TME pass medications at least quarterly. See the attached in service records for medication administration P&P, clients' rights and TME monitoring record.	5/10/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan T. Shoan, RN, BSN, MA TITLE: VP Operations (X6) DATE: 5/20/08

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.

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 130	Continued From page 1 During the evening medication administration observation on 4/29/08 at 6:42 PM, the Trained Medication Employee (TME) was observed to administer Client #1 his medication in the kitchen. Further observations revealed direct care staff in the kitchen preparing dinner and two other clients were sitting in the kitchen at the time Client #1 received his PM medications.	W 130		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of prompt notification of parents or guardians of a significant incident which was potentially harmful for each client residing in the facility. The findings include: Interview with the QMRP and review of the facility's unusual incident reports and investigations on April 30, 2008, at 1:00 PM, failed to show evidence that each clients' family and/or guardian was notified immediately of the following significant incidents; a. On November 5, 2007, Client #1 received an injury to his forehead. b. On July 15, 2007, Client #1 substained an	W 148	W 148 The QMRP was in serviced on the Agency's Incident Management Policy and Procedure. All staff was also in serviced on Incident Management and Reporting. In the future the QMRP will ensure that the procedures for incident reporting are completed as per policy. The Incident management coordinator will monitor that all incident reports are completed as per policy. See attached in service records for Incident Management P&P	5/10/08

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

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 148	Continued From page 2 injury to his left hand and finger. c. On March 25, 2008, Client #1's nose was bleeding after taking his evening shower. d. On March 5, 2008, Client #1's toe was observed bleeding after staff took off his shoes. e. On January 14, 2008, Client #1 was observed with a bruise area on his upper thigh when changing his protective garments at the day program.	W 148		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) The findings include: The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on April 30, 2008 at 1:30 PM, revealed the facility failed to report the following incident(s) to the governmental agency:	W 153	W 153 The QMRP was in serviced on the Agency's Incident Management Policy and Procedure. All staff was also in serviced on Incident Management and Reporting. In the future the QMRP will ensure that the procedures for incident reporting are completed as per policy. The Incident management coordinator will monitor that all incident reports are completed as per policy. See attached in service records for Incident Management P&P	5/10/08

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

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 153	Continued From page 3 a. An unusual incident report, dated March 25, 2008, revealed Client #1 nose was bleeding after taking his evening shower. b. An unusual incident report, dated March 5, 2008, revealed that upon a direct care staff's removal of the client shoes observed that Client #1's toe on the left foot was bleeding. Reportedly direct staff were not aware as to how the client had injured his toe. c. An unusual incident report, dated January 14, 2008, Client #1 reportedly was observed with a bruise area on his thigh when changing his protective garments at the day program.	W 153		
W 159	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 interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The finding include: The QMRP failed to ensure that the facility held evacuation drills under varied conditions. [See W441]	W 159	W 159 Cross refer to W 441	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with	W 189		

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

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 189	Continued From page 4 initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include: 1. The facility failed to ensure that current training for direct care staff was effective on using all method of egresses during fire drills as evidenced below: Review of the facility's fire drill records on 4/29/08 at 3:54 PM revealed that most of the fire drills were conducted via the front door exit. Further review revealed that staff failed to document method of egrees on the fire drill forms. Observations of the environmental walk-thru and interview with the House Manager and Qualified Mental Retardation Professional (QMRP) on 5/1/08 at approximately 2:00 PM revealed fire exits through all six clients bedrooms. Further review of the fire drill record revealed that the these exits had not been used at least quarterly on each shift. Review of the staff in service training records on 5/1/08 revealed that all staff received fire drill training on 3/22/08. There was no evidence that training was effective. 2. The facility failed to ensure that Trained Medication Employees training on securing	W 189	W 189 1. All staff was re trained in Fire Drill and Safety. An in service by Inspector Madison has been scheduled. In the future the QMRP / House Manager and staff will ensure that all egresses are used during a fire drill and not just the front door. The fire drill form has been modified to include the bedroom egresses. 2. The TME has been re trained in Medication Administration Policy and Procedure. In the future the Delegating RN Supervisor will monitor the TME pass medications at least quarterly. 3. All staff was re trained on Ted Hose stockings. The nurse and the TME will ensure that the documentation for monitoring the stockings are worn daily is completed in the MAR. See the attached in service records for medication administration P&P, Ted Hose stocking training, and Fire Safety and Drill training.	5/10/08

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

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 189	Continued From page 5 medications was effective as evidenced below: On 4/29/08 at approximately 6:05 PM, the Trained Medication Nurse (TME) was observed to drop a pill while removing it from the blister pack. The TME picked the pill up off the floor, placed it in a cup, and put it aside until she finished administering the other medications to Client #1. The TME was then observed to leave the medication area to call the nursing staff at 6:30 PM while the medications cabinet was wide open. Medications that required double locks and other medications were left on the table in front of the surveyor. At 6:39 PM the TME punched another pill from the blister pack and administered the medication to Client #1, who was in the kitchen with direct care staff and peers. At 6:41 PM, the medication cabinet remained open and medications were still on the table in front of the surveyor. Interview with the TME at 6:50 PM acknowledged that she should have secured the medications. 3. On April 30, 2008 at approximately 11:00 PM interview with the day program nurse and review at Client #1's day program records revealed that he did not wear his prescribed ted hose to the day program. According to the physician orders dated March 2008, the client was to wear the ted hose in the morning to decrease swelling in his lower extremities. Interview with the group home nurse and QMRP revealed that staff were to monitor Client #1's usage of the ted support hose daily; however, the monitoring system failed to be effective. According to the QMRP the direct care staff were trained on each client's support needs to included the importance of the Ted hose on 1/14/08.	W 189		

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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 DEFICIEI	(X5) COMPLETION DATE
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure programs that incorporate restrictive techniques had been reviewed, approved and monitored by its specially constituted committee prior to implementation, for two of six clients residing in the facility. (Client #2 and #5) The findings include: Observation during an environmental walk-through on May 1, 2008 and interview with the QMRP and Residential Director revealed that Client #2 and #5 use bed rails at night for their safety. Interview with the Director of Nursing revealed that the agency's practice was to completed a Bed Mobility Assessment for a hospital bed/rails. Once the determination has been made, the results was required to presented to the Human Rights Committee for approval. Review of Client #2's medical records did not evidence a Bed Mobility Assessment had been completed and forwarded to the HRC. Review of Client #5's Bed Mobility Assessment dated 7/14/07 revealed that he was in need of bed rails in order to assist him in changing position in the bed at night; however, review of the HRC minutes did not evidence that the committee had	W 262	W 262 The QMRP will present the Bedside rails to the HRC this month . In the future the QMRP and the Nurse will make sure all adaptive equipment is presented to the HRC for approval on an annual basis.	5/23/08

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 262	Continued From page 7 approved the facility's usage of the rails.	W 262		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services in accordance with their needs for two of six clients residing in the facility. (Client #1 and #4) The findings include: 1. On May 1, 2008 at approximately 10:00 AM, interview with the nurse and review of Client #4's medical recommendation from the client's hospitalization in February 2008, revealed that his Health Management Care Plan (HMCP) was to have been modified to include an area of risk for Influenzae. Review of the HMCP dated 2/8/08 did not revealed that the HMCP was amended to includes this risk area as recommended. 2. On May 1, 2008 at approximately 10:15 PM, interview with the QMRP and a review medical record revealed that Client #4 was to have had a Physical Therapy consult to investigate if the client needed adaptive modification/adjustments to his wheelchair to assist with facilitating swallowing needs. Review off the Modified Barium Swallowing/Videofluoroscopy of Swallow Study completed on 2/19/08 revealed the following recommendations included that Client #4 needs to turn his head to the left to swallow down to the right. There was no evidence that the physical	W 331	W 331 1. HMCP has been revised to include the high risk for Influenza. In the future the RN Supervisor will make sure all investigative - medical and nursing recommendations are completed in a timely manner. 2. The Physical Therapist has been scheduled to complete an assessment of positioning and swallowing. In the future the QMRP will ensure that all recommendations are completed promptly. 3. Cross refer W 189 4. Cross refer W 189 & W 381 See attached HMCP, PT assessment and TME training record on Medication Administration Policy and Procedure, PT assessment	5/23/08

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

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 331	Continued From page 8 therapist assessed the client's wheelchair to identify if any modification could be made to assist with his swallowing concerns. 3. The nursing staff failed to ensure direct care staff provided Client #1 with prescribed adaptive supports daily. [See W189] 4. The nursing staff failed to ensure that the TME's secured medication as required by the agency nursing policies and procedures. [See W189 and W381]	W 331		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to store drugs under proper conditions of security. The finding includes: The facility failed to ensure that each client's medications were secured during the medication administration as evidence below: On 4/29/08 at approximately 6:05 PM, the Trained Medication Nurse (TME) was observed to drop a pill while removing it from the blister pack. The TME picked the pill up off the floor, placed it in a cup, and put it aside until she finished administering the other medications to Client #1. The TME was then observed to leave the medication area to call the nursing staff at 6:30 PM while the medications cabinet was wide open.	W 381	W 381 The TME was in serviced on Medication Administration Safety Principles and Policy and Procedure. In the future the Delegating RN Supervisor will monitor the TME pass medications at least quarterly. See attached In service record on Medication Policy and Procedures.	5/23/08

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

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 381	Continued From page 9 Medications that required double locks and other medications were left on the table in front of the surveyor. At 6:39 PM the TME punched another pill from the blister pack and administered the medication to Client #1, who was in the kitchen with direct care staff and peers. At 6:41 PM, the medication cabinet remained open and medications were still on the table in front of the surveyor. Interview with the TME at 6:50 PM acknowledged that she should have secured the medications.	W 381		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to furnish adaptive and safety equipment for one of four clients in the sample . (Client #1) The finding include: The facility failed to ensure that the staff ensure that Client #1 was provided his ted hose daily as prescribed. [See W189]	W 436	W 436 Cross refer to W 189	
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.	W 441		

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

PRINTED: 05/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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) COMPLETION DATE
W 441	Continued From page 10 This STANDARD is not met as evidenced by: Based on observations, staff interview, and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: Review of the facility's fire drill records on 4/29/08 at 3:54 PM revealed that most of the fire drills were conducted via the front door exit. Further review revealed that staff failed to document method of egrees on the fire drill forms. Observations of the environmental walk-thru and interview with the House Manager and Qualified Mental Retardation Professional (QMRP) on 5/1/08 at approximately 2:00 PM revealed fire exits through all six clients bedrooms. Further review of the fire drill record revealed that the these exits had not been used at least quarterly on each shift. There was no evidence that evacuation drills were held under varied conditions.	W 441	W 441 All staff was re trained in Fire Drill and Safety. An in service by Inspector Madison has been scheduled. In the future the QMRP / House Manager and staff will ensure that all egresses are used during a fire drill and not just the front door. The fire drill form has been modified to include all the bedroom egresses.	5/23/08

PRINTED: 05/09/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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
I 000	INITIAL COMMENTS A licensure survey was conducted from April 29, 2008 through May 1, 2008. A random sample of three clients was selected from a resident population of four male and two female clients with varying degrees of mental retardation. Additionally, a focus review was conducted for two of the remaining three clients. The findings of the survey were based on observations at the group home and three day programs. Also the findings were based on interviews with three clients and direct care staff and management in both the group home and the day programs, as well as a review of habilitation and administrative records, to include the review of the facility's unusual incident management system.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Observations of the GHMRP 's environment on 4/25/08 beginning at 11:15 AM revealed the	I 090	I 1090 Interior: 1. The wooden door molding has been fixed. 2. The handle has been replace on the drawer. 3. The door molding has been secured and the nails removed. 4. The door molding has been secured.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Suzanne L. Evans, BSN, MA TITLE VP-Operations (X6) DATE 5/20/08

PRINTED: 05/09/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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
I 090	Continued From page 1 following: Interior 1. The wooden door molding was loose and could pose a potential hazard for wheelchair existing from Client #3 and #4 bedroom. 2. Client #1's chest of drawer was missing a handle. 3. The wooden door molding in Clients' #1 and #5 bedroom was observed to be loose and to have exposed nails. 4. The wooden door molding in Clients' #2 and #6 bedroom was observed to be loose. 5. The refrigerator freezer located in the basement was dirty. 7. The stove drawer was off track and presented a ptential safety hazard.. Exterior 1. Liter bottle crates, milk crates, boxes and a large basket were observed stacked near and around the trash containers in the rear of the facility. 2. The front door was observed swinging back and forth in the front of the facility. No support cylinder for closure has been placed on the door in order for the door to close on it onw when being opened. 3. The gutters on the driveway side of the facility was exposing large loose support nails.	I 090	The freezer has been cleaned. The stove drawer was fixed. Exterior: 1. The litter has been removed. 2. The front door hinge has been fixed. 3. The gutters on the driveway have been fixed and the nails have been removed. 4. The gutter at the back of the facility has been fixed. In the future the QMRP will make sure that a monthly environmental QA – audit is completed and maintenance is informed of the repairs that need to be done. The House Manager was in serviced on the procedure of an environmental audit and will complete weekly environmental checks and report that to the QMRP. See attached – Environmental QA – monthly and weekly audits, Inservice record.	5/23/08

PRINTED: 05/09/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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
I 090	Continued From page 2 4. The gutter down spout near the ramp in the rear of the faicility was dented and the support brakets were loose.	I 090		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation the GHMRP failed to lock caustic agents being stored. The findings include: Observations of the environmental walk-through on 5/1/08 at approximately 11:30 PM revealed that caustic agent were being store in the kitchen cabinet unlocked.	I 095	I 095 All chemical agents have been removed from under the sink. All staff has been in serviced on MSDS and OSHA safety practices. In the future the QMRP and the House Manager will ensure that the environmental audits are conducted at least weekly to prevent any chemicals being exposed to potentially endanger the clients. In service record on OSHA safety.	5/23/08
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on observations, staff interview, and record verification, the GHMRP failed to hold evacuation drills under varied conditions. The finding includes: There was no evidence that evacuation drills were held under varied conditions as evdienced below:	I 135		

PRINTED: 05/09/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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
I 135	Continued From page 3 Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's fire drill records on 4/29/08 at 3:54 PM revealed that most of the fire drills were conducted via the front door exit. Further record review revealed that staff failed to document each method of egress on the fire drill forms. The environmental walk-thru and further interview with the (QMRP) on 5/1/08 at approximately 2:00 PM revealed exits through each of the clients bedrooms. Neither of the fire drill forms revealed that the Client's bedrooms had been used as a method of egress durrng any of the fire drills.	I 135	I 135 Cross refer W441	
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on 4/15/08 at 11:20 AM, revealed that GHMRP failed to provide evidence of current signed job descriptions for four (4) direct care staff [redacted]	I 203	I 203 Attached job descriptions of mentioned employees. The Agency has revised the job descriptions and all employees have signed these. In the future the QMRP will ensure that all employees sign on the job descriptions at the time of hiring and with the annual performance appraisal. Attached signed job descriptions	5/23/08
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	I 206		

PRINTED: 05/09/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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
I 206	Continued From page 4 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 GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform their required duties. The findings include: Interview with the QMRP and review of the GHMRP's personnel files on 4/15/08 at 2:00 PM, revealed the GHMRP failed to provide evidence that current health certificates were on file four (4) direct staff [redacted] and two (2) consultants (Nutrition and Psychologist).	I 206	I 206 Attached are is the Health Certificates for the mentioned staff. 1 staff is traveling overseas and will not be on the schedule for the next 2 mths. However she will have to have a PE prior to employment. 2 employees will have their PE completed by 5/23/08 In the future the QMRP will ensure that the necessary certifications are updated as needed when a monthly audit of personnel files is completed. The Agency has hired an HR Coordinator to develop a data base and a tickler system to avoid expired certifications.	5/23/08
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The finding includes: See Federal Deficiency Report Citation W189	I 222	I 222 Cross refer to W 189	

PRINTED: 05/09/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G215	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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
I 379	3519.10 EMERGENCIES 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. This Statute is not met as evidenced by: Based on record review the facility failed to report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: 1. The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on April 30, 2008 at 1:30 PM, revealed the facility failed to report the following incident(s) to the appropriate authorities: a. An unusual incident report, dated March 25, 2008, revealed Client #1's nose was bleeding after taking his evening shower. b. An unusual incident report, dated March 5, 2008, revealed that Client #1 was discovered with a injuried toe. c. An unusual incident report, dated January 14,	I 379	I 379 Cross refer to W 148	

PRINTED: 05/09/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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
I 379	Continued From page 6 2008, Client #1 reportedly was observed with a bruise area on his thigh. 2. Also See Federal Deficiency Report Citation - Citation W148	I 379		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services in accordance with their needs for two of six clients residing in the facility. (Client #1and #4) The findings include: 1. On May 1, 2008 at approximately 10:00 AM, interview with the nurse and review of Client #4's medical recommendation from the client's hospitalization in February 2008, revealed that his Health Management Care Plan (HMCP) was to have been modified to include an area of risk for Influenzae. Review of the HMCP dated 2/8/08 did not revealed that the HMCP was amended to includes this risk area as recommended,	I 395	I 395 Cross refer to W 189	

PRINTED: 05/09/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G216	A. BUILDING _____ B. WING _____	05/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	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
I 395	Continued From page 7 2. On May 1, 2008 at approximately 10:15 PM, interview with the QMRP and a review medical record revealed that Client #4 was to have had a Physical Therapy consult to investigate if the client needed adaptive modification/adjustments to his wheelchair to assist with facilitating swallowing needs. Review off the Modified Barium Swallowing/Videofluoroscopy of Swallow Study completed on 2/19/08 revealed the following recommendations included that Client #4 needs to turn his head to the left to swallow down to the right. There was no evidence that the physical therapist assessed the client's wheelchair to identify if any modification could be made to assist with his swallowing concerns. 3. The nursing staff failed to ensure direct care staff provided Client #1 with prescribed adaptive supports daily. [See W189]	I 395		