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 ______	04/15/2014

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 14, 2014 through April 15, 2014. A sample of three clients was selected from a population of four males and two females with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations, interviews and review of client and administrative records. Note: The below are abbreviations that may appear within the body of this report. Director of Nursing - DON Physician's Orders - POS Individual Support Plan ISP Interdisciplinary Team - IDT Residential Coordinator - RC Qualified Intellectual Disabilities Professional - QIDP Direct Support Professional - DSP Licensed Practical Nurse Coordinator - LPNC Rehabilitation Equipment Professional - REP	W 000	RECEIVED MAY 07 2014 BY: .... Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
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:	W 436		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emily A. Homer
TITLE
(X6) DATE: 5/5/14

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

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W 436	Continued From page 1 Based on observation, interview and record review, the facility failed to furnish and maintain in good repair hospital beds and a chest harness identified as needed by the IDT, for three of the six clients residing in the facility. (Clients #6, #4, and #3) The findings include: 1. The facility failed to ensure Client #6's prescribed hospital bed was maintained in good repair, as evidenced below: On April 15, 2014, at 2:05 p.m., the QIDP and the RC accompanied the surveyor to observe the environment in Client #6's bedroom. The observation revealed a hospital bed with side rails, equipped with an electrically operated remote control. When the surveyor attempted to raise and lower the head of the bed using the remote control, the head of the bed did not move in either direction. On April 15, 2014, at 2:07 p.m., interview with the facility's QIDP and RC, revealed they were unaware of how long the remote control for Client #6's hospital had been broken. The QIDP stated that the client enjoyed pressing buttons and may have broken the remote control for the bed. On April 15, 2014, at 5:10 p.m., review of Client #6's annual medical assessment dated May 14, 2013 revealed diagnoses including chronic pneumonitis, aspiration risk, calcified chest mass, and density within the left lower lobe. Review of the current POS, dated March 2014 prescribed a hospital bed with side rails. According to Client #6's ISP health service summary dated May 15, 2013, a hospital bed with rails was included as	W 436	W 436 1. The hospital bed remote for individual #6 has been repaired. 2. The hospital bed plug for the remote control for individual #4 has been repaired. 3. The chest harness for individual #3 has been replaced. SYSTEM: The QIDP will immediately report to the appropriate consultant and/or durable medical equipment provider to needed repairs and provide weekly follow up until resolution.	Ongoing

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W 436	Continued From page 2 supportive adaptive equipment. At the time of the survey, the facility failed to ensure that Client #6's recommended hospital bed was maintained operational. Additionally, there was no evidence the client was trained, to the extent of his capability, to minimize the risk of damage to the remote control during unsupervised time. 2. The facility failed to ensure Client #4's hospital bed remote control device was maintained in good repair, as evidenced below: On April 15, 2014, at 2:08 p.m., observation of Client #4's hospital bed revealed the attached remote control was not operable. Continued observations of the bed revealed the power cord attached to the remote control lacked the two metal prongs required to connect it to an electrical outlet. The QIDP and the RC were interviewed on April 15, 2014, at approximately 2:10 p.m., to ascertain why the power cord attached to the remote control for Client #4's hospital bed had no prongs. According to the QIDP, on the morning of April 15, 2014, a DSP reported that the metal prongs were no longer attached to the remote control of the client's hospital bed. On April 15, 2014, at 3:42 p.m., the LPNC revealed that Client #4 was provided with 1:1 direct supervision 24 hours daily for safety due to the risk of sudden seizure activity. It should be noted that, the LPNC revealed that a hospital bed was to be used with side rails and that the bed was to be kept in a low position when the client was in bed.	W 436		

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W 436	Continued From page 3	W 436		

On April 15, 2014, at 5:10 p.m., review of current POS dated March 2014, revealed a "hospital bed with side rails was prescribed as an ongoing order. Client #4's ISP health service summary dated September 17, 2013, included diagnoses of parasagittal tumor, left side hemiparesis, high risks for falls, and noted a slowly declining health status. It should be noted that a hospital bed with rails was included as supportive adaptive equipment.

3. The facility failed to ensure that Client #3's chest harness was properly fitted, as evidenced below:

On April 14, 2014, at 11:27 a.m., observation conducted at Client #3's day program revealed a butterfly style chest harness was attached to the client's wheelchair. Continued observations of the chest harness revealed there were several knots tied bilaterally at the back of the wheelchair to reduce the length of the straps. The positioning of the knots caused the shoulder straps of the harness to rest against the client's upper arms and caused the harness to fit loosely even when all buckles were fastened. At 11:25 a.m., interview with the day program case manager revealed that he/she could not recall exactly how the chest harness straps had been tied in that manner.

On April 15, 2014, at 10:39 a.m., review of Client #3's POS dated March 2014 revealed prescribed adaptive equipment included a chest harness for safety.

During a discussion with the QIDP on April 15, 2014, at 1:21 p.m., it was revealed that, the REP

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W 436	Continued From page 4 came to the facility and made adjustments to Client #3's wheelchair on February 24, 2014. Further interview with the QIDP revealed that the REP evaluated Client #3 for a new chest harness at that time. However, due to Client #3's small size, it was necessary to order a smaller chest harness to fit the client properly. The QIDP stated that the client was still waiting for the smaller chest harness to arrive. At 1:42 p.m., interview with the LPNC confirmed the QIDP interview regarding the new chest harness. On April 15, 2014, at 1:55 p.m., review of a nursing progress note dated February 24, 2014, also confirmed that the REP came to the home to evaluate Client #3, and parts were ordered. When further queried regarding the new chest harness, neither the QIDP nor the LPNC could provide additional information. It should be noted that on April 15, 2014, at approximately 3:40 p.m., the QIDP revealed that he/she had just corresponded with the REP, who stated that the chest harness would be delivered to Client #3 by 6:00 p.m. that evening. At the time of the survey exit at 6:15 p.m., the chest harness had not arrived to the facility.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly, for two of the five shift of duty reviewed (Weekday 8:00	W 440		

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W 440	Continued From page 5 a.m. - 4:00 p.m. and Weekend 8:00 p.m. - 8:00 a.m.). The finding includes: On April 15, 2014, at 12:22 p.m., interview with the QIDP revealed that there were five designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.) for the weekend (Saturday/Sunday). Review of the facility's fire drill records on April 15, 2014, beginning at 12:25 p.m., revealed that no drills were held during the weekday shift (8:00 a.m. - 4:00 p.m.) from October 2013 through December 2013 and weekend shift (8:00 p.m. - 8:00 a.m.) from July 2013 through September 2013. At 2:50 p.m., the RC reviewed the fire drill reports located in the records and on the computer and confirmed that no drills were conducted during the aforementioned time periods. The RC then stated that he would re-train all staff immediately on the importance of conducting fire drills four times a year during each shift. At the time of the survey, the facility failed to conduct simulated fire drills quarterly for each shift of personnel.	W 440	W 440 The Residential Coordinator has been re-inserviced on the requirement for reviewing drills to ensure required completion. Additionally, staff were re-inserviced on the requirement to conduct drills as scheduled to ensure that all staff from each shift are conducting drills as scheduled. SYSTEM: The Residential Coordinator will review fire drills on a monthly basis to ensure that staff are conducting drills as scheduled.	4/26/14 Ongoing

Health Regulation & Licensing Administration

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	HFD03-0235	A. BUILDING: ______ B. WING ______	04/15/2014

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 14, 2014 through April 15, 2014. A random sample of three residents was selected from a population of four males and two females with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews, and review of resident and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. Director of Nursing - DON Physician's Orders - POS Interdisciplinary Team - IDT Residential Coordinator - RC Qualified Intellectual Disabilities Professional - QIDP Direct Support Professional - DSP Licensed Practical Nurse Coordinator - LPNC Rehabilitation Equipment Professional - REP	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to ensure that exterior (downspout, ramp, siding, and wires, and beds) were maintained, as required. The findings include:	I 090		

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I 090	Continued From page 1 On April 15, 2014, beginning at at 12:05 p.m., the surveyor was accompanied by Maintenance Worker #1 to conduct observation of the external environment. The following concerns were identified: 1. A black wire was observed hanging approximately twelve inches below the top of the exit door leading from the bedroom of Residents #4 and #6. Maintenance Worker #1 indicated that the wire appeared to be a cable wire, and should be secured to prevent the possibility of staff bumping into it. (Note: All residents of the facility were observed to be wheelchair dependent for mobility.) 2. Observations of the exterior environment revealed there was water dripping from above the generator, which was located on the left side of the GHIID. Further observations revealed the water was coming from a round hole in the gutter. Maintenance Worker #1 indicated that a downspout should be in the hole to divert water from the roof away from the area where the generator was located. 3. A piece of siding was observed hanging below the roof on the second level of the GHIID. Maintenance Worker #1 indicated that the damage may have been caused by wind. Maintenance Worker #1 stated that no one had not reported the concern to him for repair. 4. A large broken area was observed in the wooden board at the corner of the ramp located at the back of the GHIID. Maintenance Worker #1 revealed that the board on the ramp was broken when it was struck by the trash truck.	I 090	1090 1. The black wire hanging twelve inches below the top of the door leading from the bedroom of individual #4 and #6 has been fixed. 2. The gutter has been repaired. 3. The siding on the second level has been repaired. 4. The ramp has been repaired. SYSTEM: The Residential Coordinators will at least monthly inspect all homes environmentally, and submit any issues to IMANAGE maintenance section for review by the administrative assistant and assignment to maintenance.	5/2/14 5/2/14 5/2/14 5/2/14

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I 135	Continued From page 2	I 135	The residential Coordinator has been re-inserviced on the requirements for reviewing drills to ensure required completion. Additionally, staff were re-iserviced on the requirements to conduct drills, as scheduled, to ensure that all staff from each shift are conducting drills as scheduled.	4/26/14
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 interview and record review, the GHIID failed to hold evacuation drills at least four times a year, for two of the five shift of duty reviewed. (Weekday 8:00 a.m. - 4:00 p.m. and Weekend 8:00 p.m. - 8:00 a.m.) The finding includes: On April 15, 2014, at 12:22 p.m., interview with QIDP revealed that there were five designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.) for the weekend (Saturday/Sunday). Review of the GHIID's fire drill records on April 15, 2014, beginning at 12:25 p.m., revealed that no drills were held during the weekday shift (8:00 a.m. - 4:00 p.m.) from October 2013 through December 2013 and weekend shift (8:00 p.m. - 8:00 a.m.) from July 2013 through September 2013. At 2:50 p.m., the RC reviewed the fire drill reports located in the records and on the computer and confirmed that no drills were conducted during the aforementioned time periods. The RC then stated that he would re-train all staff immediately on the importance of conducting fire drills four times a year during each shift.	I 135	SYSTEM: The Residential Coordinator will review the fire drills on a monthly basis to ensure that staff are conducting drills as scheduled.	Ongoing

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I 135	Continued From page 3 At the time of the survey, the GHIID failed to conduct simulated fire drills at least four times (4) a year for each shift.	I 135		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to ensure that all employees and health care professionals had current health certificates on file, for five (5) of sixteen (16) non-licensed employees and two (2) of nine (9) consultants. (Employees #3, #4, #5, #12, #16 and Consultants #6 and #7) The findings include: On April 15, beginning at 2:20 p.m., review of the personnel records for all employees including consultants revealed the following: 1. There was no evidence of a physician's health inventory/certificate for Employees #3, #4, #5, #12 and #16), who provided direct care services to six of the six residents residing residing in the facility.	I 206		