

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

I 000 INITIAL COMMENTS I 000

A licensure survey was conducted from April 4, 2012 through April 5, 2012. A sample of three residents was selected from a population of two men and three women with various degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and at three day programs, interviews with direct support staff, administrative staff and one resident, as well as a review of resident and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

*Received  
May 2 2012*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
600 North Capitol St., N.E.  
Washington, D.C. 20002

I 042 3502.2(b) MEAL SERVICE / DINING AREAS I 042

Modified diets shall be as follows:

(b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and...

This Statute is not met as evidenced by:  
Based on observation, staff interview and record review, the facility failed to ensure all residents received their meals in the form and consistency prescribed, for three of the three residents in the sample. (residents #1, #2 and #3)

The findings include:

The facility failed to ensure that Residents #1, #2 and #3 were served each food in the prescribed texture in accordance with their assessed developmental needs, as evidenced below:

I 042  
a,b&c. Metro Homes, Inc. has a meal observation record and the QDDP, RN and House Manager monitor the individuals' mealtime at least weekly.  
In the future all staff will be trained to ensure that the individuals receive the correct diet and texture.

All staff has been in serviced on the individuals' food texture and portions.

See attached in service record

4/20/12

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Susan I. Sloan* TITLE: *VP Operations* (X6) DATE: *4/30/12*

STATE FORM 6899 JBNQ11 If continuation sheet 1 of 6

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 042	Continued From page 1  a. On April 4, 2012, beginning at 6:38 p.m., observations of the dinner meal revealed resident #1 was served green beans, noodles, ground turkey with tomato sauce and toasted garlic bread for dinner. Further observations revealed that the resident's toasted garlic bread was served in its whole form. The garlic bread was observed to be approximately two (2) inches thick and approximately five (5) inches wide.  On April 5, 2012, at approximately 9:20 a.m., review of Resident #1's current physician orders (POs) dated March 2012, revealed the resident was prescribed a regular bite size portion of meat and hard foods diet.  Interview with Staff #1 who served the dinner meal on the same day at approximately 7:05 p.m. revealed that she did not cut Resident #1's toasted garlic bread into bite size pieces as prescribed.  b. On April 4, 2012, at 11:20 a.m., observations conducted at Resident #2's day program revealed the resident was missing her top and bottom teeth. On April 4, 2012, beginning at 6:41 p.m., observation of the dinner meal revealed Resident #2 was served finely chopped green beans, bite size noodles, ground turkey with tomato sauce and toasted garlic bread for dinner. Further observations revealed that the resident's toasted garlic bread was served in its whole form. The garlic bread was observed to be approximately two (2) inches thick and approximately three (3) inches wide.  On April 5, 2012, at approximately 9:00 a.m., review of Resident #2's current physician orders (POs) dated March 2012, revealed the resident was prescribed a 1000 calorie, low fat, low	I 042			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
I 042	<p>Continued From page 2</p> <p>cholesterol, bite size diet.</p> <p>Interview with Staff #1 who served the dinner meal on the same day at approximately 7:05 p.m. revealed that she did not cut Resident #2's toasted garlic bread into bite size pieces as prescribed.</p> <p>c. On April 4, 2012, at 11:02 a.m., observations conducted out in the community revealed Resident #3 was observed to be missing several front teeth. On April 4, 2012, beginning at 6:38 p.m., observation of the dinner meal revealed resident #3 was served green beans, noodles, ground turkey with tomato sauce and toasted garlic bread for dinner. Further observations revealed that the resident's toasted garlic bread was served in its whole form. The garlic bread was observed to be approximately two (2) inches thick and approximately three (3) inches wide.</p> <p>On April 5, 2012, at approximately 10:00 a.m., review of Resident #3's current physician orders (POs) dated March 2012 revealed the resident was prescribed a 1500 reducing, high fiber, low cholesterol, bite size diet.</p> <p>Interview with Staff #1 who served the dinner meal on the same day at approximately 7:05 p.m. revealed that she did not cut Resident #3's toasted garlic bread into bite size pieces as prescribed.</p> <p>At the time of the survey, there was no evidence the facility ensured that Residents #1, #2 and #3 received their food in a bite size texture at all times, as prescribed.</p>	I 042	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 043	Continued From page 3	I 043		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS  Modified diets shall be as follows:  (c) Reviewed at least quarterly by a dietitian.  This Statute is not met as evidenced by: Based on observation, record review and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the modified diet for resident's had been reviewed at least quarterly by dietitian, for one of the three residents in the sample. (Resident #2)  The finding includes:  On April 4, 2012, at 11:20 a.m., observations conducted at Resident #2's day program revealed the resident was missing her top and bottom teeth. On April 4, 2012, beginning at 6:41 p.m., observation of the dinner meal revealed Resident #2 was served finely chopped green beans, bite size noodles, ground turkey with tomato sauce and toasted garlic bread for dinner. Further observations revealed that the resident's toasted garlic bread was served in its whole form. The garlic bread was observed to be approximately two (2) inches thick and approximately three (3) inches wide. Interview with Staff #1 who served the dinner meal on the same day at approximately 7:05 p.m. revealed that she did not cut Resident #2's toasted garlic bread into bite size pieces.  Review of Resident #2's nutritional assessment dated October 4, 2011, on April 4, 2012, at 4:12 p.m., revealed that the resident was prescribed a 1000 calorie, low fat, low cholesterol, bite size diet.	I 043	I 043  This individual was seen by the Dietician on 1/4/12 and a quarterly assessment was completed. However the report was not available. In the future the QDDP will ensure that the individual is seen by the dietician quarterly and an assessment is received.  See attached nutritional assessment	4/20/12

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
I 043	Continued From page 4  Further review failed to show evidence that the facility's nutritionist had reviewed Resident #2's diet on a quarterly basis.  On April 5, 2012, at approximately 2:00 p.m., interview with the qualified intellectual disabilities professional (QIDP) confirmed that there was no evidence that the nutritionist conducted a quarterly after the residents' nutritional assessment.  At the time of the survey, the GHMRP failed to have a nutrition review after the residents' assessment.	I 043	
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 group home for persons with intellectual disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for five of the five residents residing in the GHPID. (Residents #1, #2, #3, #4 and #5)  The finding includes:  The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:  On April 4, 2012, beginning at 9:41 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three 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	I 135	I 135 Metro Homes, Inc. has a system which requires all staff to complete a fire drill on each shift per month. We have met with the Fire Marshall and are in the process of redesigning the form to include the weather along with mock situations such as bomb threat, earthquake and tornado drills.  See attached in service record on conducting a fire drill appropriately.  4/20/12

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
I 135	<p>Continued From page 5</p> <p>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).</p> <p>Review of the GHPID's fire drill log records on April 4, 2012, beginning at approximately 9:45 a.m., revealed that no drills were held during the weekday first shift (8:00 a.m. - 4:00 p.m.) from April 2011 through December 2011. Further review revealed there were no fire drills held during the weekend first shift (8:00 a.m. - 8:00 p.m.) from October 2011 through December 2011.</p> <p>Interview with the QIDP on April 4, 2012, at 2:43 p.m., revealed that she was aware that fire drills were not conducted during the aforementioned timeframes listed above. The QIDP stated that she was in the process of retraining all staff on conducting fire drills.</p>	I 135	

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

PRINTED: 04/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from April 4, 2012 through April 5, 2012. A sample of three clients was selected from a population of two men and three women with various degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and at three day programs, interviews with direct support staff, administrative staff and one client, as well as a review of client and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS

W 154

The facility must have evidence that all alleged violations are thoroughly investigated.

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to thoroughly investigate an allegation of neglect, for one of the five clients residing in the facility. (Client #4)

The finding includes:

Review of the facility's incident reports, including available corresponding investigative reports, on April 4, 2012, beginning at 9:20 a.m., revealed that on October 18, 2011, Client #4 eloped from the facility. Review of the investigation report

W 154

In this particular incident the hospital could not reveal where this particular individual's whereabouts were prior to him bring brought to the hospital. He was arrested at the CVS stealing some food items and the police took him to the hospital. The IMC has been re trained on Incident Management reporting.

4/20/12

See attached in service record

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Gwan J. Sloan*

TITLE

*VP Operations*

(X6) DATE

*4/30/12*

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 154 Continued From page 1  
dated October 20, 2011, revealed that the incident management coordinator (IMC) substantiated the allegation of neglect; however, the report failed to revealed when and where Client #4 was found.

W 154

On April 4, 2012, at approximately 2:30 p.m., interview with the qualified intellectual disabilities professional (QIDP) confirmed that the IMC failed to include when and where Client #4 was found after his elopement.

The facility failed to show evidence that Client #4's elopement from the facility was thoroughly investigated.

W 247 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN

W 247

The individual program plan must include opportunities for client choice and self-management.

This STANDARD is not met as evidenced by:  
Based on observation and interview, the facility staff failed to ensure client choice during meals, for three of the three clients included in the sample. (Clients #1, #2 and #3)

The finding includes:

On April 4, 2012, beginning at 6:38 p.m., observations of the dinner meal revealed Staff #1 was observed to place the clients' plates on the dining table, which included green beans, noodles, ground turkey with tomato sauce and toasted garlic bread. Further observations revealed Staff #1 poured the clients water and milk into their cups and placed them on the dining

W 247

In the future the QDDP and House Manager will ensure that staff encourages the individuals to exercise their independence and choice.

4/20/12

See attached in service record – on Metro Homes, Inc. 'mission statement'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 247 Continued From page 2  
table. At approximately 6:45 p.m., all clients were observed eating independently without the use of adaptive eating equipment. At approximately 7:00 p.m., Staff #1 was then observed to remove each client's plate from the dining table to the sink after completing their dinner meal.

W 247

Interview with Staff #1 who prepared the meal on the same day at approximately 7:05 p.m., revealed all clients were more than capable of serving themselves, pouring their beverage and taking there plates to the kitchen sink. Further interview revealed that she should have encouraged the clients to participate in the serving of their dinner meal.

At the time of the survey, the facility's staff failed to allow clients to exercise their independence and allow options of choice.

W 440 483.470(i)(1) EVACUATION DRILLS

W 440 W 440

The facility must hold evacuation drills at least quarterly for each shift of personnel.

Metro Homes, Inc. has a system which requires all staff to complete a fire drill on each shift per month. We have met with the Fire Marshall and are in the process of redesigning the form to include the weather along with mock situations such as bomb threat, earthquake and tornado drills.

4/20/12

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4 and #5)

The finding includes:

The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:

See attached in service record on conducting an evacuation drill at least quarterly and appropriately.

On April 4, 2012, beginning at 9:41 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 440 Continued From page 3  
interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three 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).

W 440

Review of the facility's fire drill log records on April 4, 2012, beginning at approximately 9:45 a.m., revealed that no drills were held during the weekday first shift (8:00 a.m. - 4:00 p.m.) from April 2011 through December 2011. Further review revealed there were no fire drills held during the weekend first shift (8:00 a.m. - 8:00 p.m.) over an 8 month time frame (October 2011 through December 2011).

Interview with the QIDP on April 4, 2012, at 2:43 p.m., revealed that she was aware that fire drills were not conducted during the aforementioned timeframes listed above. The QIDP stated that she was in the process of retraining all staff on conducting fire drills.

W 474 483.480(b)(2)(iii) MEAL SERVICES

W 474

Food must be served in a form consistent with the developmental level of the client.

This STANDARD is not met as evidenced by:  
Based on observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency prescribed, for three of the three clients in the sample. (Clients #1, #2 and #3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 474 Continued From page 4

The findings include:

The facility failed to ensure that Clients #1, #2 and #3 were served each food in the prescribed texture in accordance with their assessed developmental needs, as evidenced below:

a. On April 4, 2012, beginning at 6:38 p.m., observations of the dinner meal revealed Client #1 was served green beans, noodles, ground turkey with tomato sauce and toasted garlic bread for dinner. Further observations revealed that the client's toasted garlic bread was served in its whole form. The garlic bread was observed to be approximately two (2) inches thick and approximately five (5) inches wide.

On April 5, 2012, at approximately 9:20 a.m., review of Client #1's current physician orders (POs) dated March 2012, revealed the client was prescribed a regular bite size portion of meat and hard foods diet.

Interview with Staff #1 who served the dinner meal on the same day at approximately 7:05 p.m. revealed that she did not cut Client #1's toasted garlic bread into bite size pieces as prescribed.

b. On April 4, 2012, at 11:20 a.m., observations conducted at Client #2's day program revealed the client was missing her top and bottom teeth. On April 4, 2012, beginning at 6:41 p.m., observation of the dinner meal revealed Client #2 was served finely chopped green beans, bite size noodles, ground turkey with tomato sauce and toasted garlic bread for dinner. Further observations revealed that the client's toasted

W 474

W 474

a,b&c. Metro Homes, Inc. has a meal observation record and the QDDP, RN and House Manager monitor the individuals' mealtime at least weekly.

In the future all staff will be trained to ensure that the individuals receive the correct diet and texture.

All staff has been in serviced on the individuals' food texture and portions.

See attached in service record

4/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 474 Continued From page 5

W 474

garlic bread was served in its whole form. The garlic bread was observed to be approximately two (2) inches thick and approximately three (3) inches wide.

On April 5, 2012, at approximately 9:00 a.m., review of Client #2's current physician orders (POs) dated March 2012, revealed the client was prescribed a 1000 calorie, low fat, low cholesterol, bite size diet.

Interview with Staff #1 who served the dinner meal on the same day at approximately 7:05 p.m. revealed that she did not cut Client #2's toasted garlic bread into bite size pieces as prescribed.

c. On April 4, 2012, at 11:02 a.m., observations conducted out in the community revealed Client #3 was observed to be missing several front teeth. On April 4, 2012, beginning at 6:38 p.m., observation of the dinner meal revealed Client #3 was served green beans, noodles, ground turkey with tomato sauce and toasted garlic bread for dinner. Further observations revealed that the client's toasted garlic bread was served in its whole form. The garlic bread was observed to be approximately two (2) inches thick and approximately three (3) inches wide.

On April 5, 2012, at approximately 10:00 a.m., review of Client #3's current physician orders (POs) dated March 2012 revealed the client was prescribed a 1500 reducing, high fiber, low cholesterol, bite size diet.

Interview with Staff #1 who served the dinner meal on the same day at approximately 7:05 p.m. revealed that she did not cut Client #3's toasted

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

PRINTED: 04/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4424 20TH STREET, NE WASHINGTON, DC 20019</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 474 Continued From page 6  
garlic bread into bite size pieces as prescribed.

W 474

At the time of the survey, there was no evidence the facility ensured that Clients #1, #2 and #3 received their food in a bite size texture at all times, as prescribed.