

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from April 26, 2012 through April 27, 2012. A sample of three clients was selected from a population of two men and four women with various degrees 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 two day program, interviews with direct support staff, administrative staff and two clients, 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 140 483.420(b)(1)(i) CLIENT FINANCES

W 140

The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.

This STANDARD is not met as evidenced by:  
Based on record review and staff interview, the facility failed to maintain a complete accounting of all clients' funds for three of the three sampled clients. (Clients #1, #2 and #3)

The findings include:

Record review on 4/27/2012, at approximately 2:30 p.m., revealed the facility failed to ensure an accurate accounting of clients' expenditures as evidenced below:

*Received 5/18/12*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
800 North Capitol St., N.E.  
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE  <i>Gwan J. Gwan</i>	TITLE  <i>VP Operations</i>	(X6) DATE  <i>5/15/12</i>
--	-----------------------------------	---------------------------------

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>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

W 140 Continued From page 1

W 140

1. Client #1 had \$200.00 withdrawn from his account on September 9, 2011. Review of the receipts on hand totaled \$161.74. Interview with the facility's qualified intellectual disabilities professional (QIDP) on April 27, 2012, at approximately 4:05 p.m., revealed she could not account for the missing funds. The QIDP also tabulated the receipts on hand and validated the survey team's total of \$161.74. Further interviews with the facility's accounting office on the same day at approximately 4:20 p.m. revealed the receipts in question were unaccounted for.

2. Client #2 had \$150.00 withdrawn from her account on November 23, 2011. Review of the receipts on hand totaled \$126.89. Interview with the QIDP on April 27, 2012, at approximately 4:30 p.m., revealed she could not account for the missing funds. The QIDP also tabulated the receipts on hand and validated the survey team's total of \$126.89. Further interviews with the facility's accounting office on the same day at approximately 4:25 p.m. revealed the receipts in question were unaccounted for.

3. Client #3 had \$20.00 withdrawn from her account on two separate occasions on October 12, 2011. There was no evidence presented or on file at the time of survey to substantiate the withdrawal. Interview with the QIDP on April 27, 2012, at approximately 4:40 p.m., revealed she could not account for the missing funds. The QIDP also reviewed the record and revealed the receipts were missing. Further interviews with the facility's accounting office on the same day at approximately 4:35 p.m. revealed the receipts in question were unaccounted for.

W 140

All individuals' financial records were audited and Metro Homes, Inc reconciled and balanced all the accounts. Checks were deposited into the individuals' accounts to cover the deficits. The financial policy was updated and a system of monthly reconciliation and audit has been instituted for each individual.

5/10/12

See attached copies of checks deposited into individuals' accounts, financial policy and audit record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

W 153

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 interview and review of client records, including incident reports and investigations, the facility failed to ensure that an alleged allegation of neglect was reported immediately to the Department of Health (DOH), Health Regulation and Licensing Administration (HRLA), for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)

The finding includes:

On April 26, 2012, beginning at 3:15 p.m., review of the facility's incident/investigation reports revealed that on August 18, 2011, the Department on Disability Services (DDS) received an email from an undisclosed source alleging that clients' were being neglected at their current home by staff. Continued review of the report revealed the following allegations.

- Staff were not providing proper or adequate care;
- Staff were not providing adequate supervision;
- Failure to provide some basic necessities;

W 153

The QDDP assigned to this home is not currently employed wit the company.  
All staff was in serviced on Incident Management policy and procedure.

See attached in service record

5/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

W 153	Continued From page 3 -Failure to follow prescribed diet orders;  -Failure to have a functioning air conditioner;  -There were theft of the clients' food and;  -There was theft of clients' personal belongings.	W 153		
-------	--	-------	--	--

It should be noted that a pre-survey review of incidents reported to the State agency had not indicated an alleged allegation on neglect reported for the six clients.

Interview with the qualified intellectual disabilities professional (QIDP) on April 27, 2012, at approximately 4:35 p.m., verified that the allegation was not forwarded to the DOH. The QIDP stated that the allegation should have been forwarded to the DOH upon receipt of notification.

At the time of the survey, there was no evidence the facility reported the alleged allegation of neglect to DOH.

W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS	W 156		
-------	--	-------	--	--

The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident, for six of the six clients residing in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

W 156 Continued From page 4  
facility. (Clients #1, #2, #3, #4, #5 and #6)

W 156

The findings include:

Review of the facility's incident reports and corresponding investigation reports on April 26, 2012, beginning at 3:15 p.m., revealed the following investigations that were not reported to the administrator within five working days:

1. An incident (allegation of verbal abuse) report dated June 16, 2011, documented that Client #2 was refusing to come out of the van after returning from the day program. Client #2 told another staff member that two other staff were verbally abusing her by calling her a "mother fucker". Review of the corresponding investigative report dated June 20, 2011, revealed the incident management coordinator (IMC) completed the investigation on June 24, 2012. Further review revealed the administrator reviewed and signed the investigative report on June 24, 2012.

2. An incident (allegation of neglect) report dated August 18, 2011, documented that the Department on Disability Services (DDS) received an email from an undisclosed source alleging that clients' were being neglected at their current home by staff. The report revealed that staff was not providing proper or adequate care, proper supervision, failure to provide some basic necessities, failure to follow prescribed diet orders, theft of the client's food and theft of clients' personal belongings.

Review of the corresponding investigative report dated September 9, 2011, on April 26, 2012, at

W 156

5/10/12

The QDDP assigned to this home is not currently employed wit the company.  
All staff was in serviced on Incident Management policy and procedure.

See attached in service record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

W 156 Continued From page 5  
approximately 3:20 p.m., revealed the incident management coordinator (IMC) completed the investigation on October 3, 2011. Further review revealed the administrator reviewed and signed the investigative report on October 3, 2011.

W 156

Interview with the qualified intellectual disabilities professional (QIDP), on April 27, 2012, at approximately 4:20 p.m., verified that the results for the aforementioned incidents were not reviewed and signed off by the facility's administrators within five working days.

W 426 483.470(d)(3) CLIENT BATHROOMS

W 426

The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

This STANDARD is not met as evidenced by:  
Based on observation and staff interview, the facility failed to ensure water temperatures did not exceed 110 degrees Fahrenheit to ensure the health and safety, for of six of the six clients residing in the facility. (Client #1, #2, #3, #4, #5 and #6)

The finding includes:

On April 27, 2012, at approximately 2:15 p.m., this surveyor noted that the hot water temperature located on the main hallway felt a little warmer at the hand sink than on April 26, 2012.

Further inspection of the water temperature with

W426

All staff was in serviced in appropriate procedure to take water temperature. A new water temperature thermometer was purchased. The maintenance manager has adjusted the temperature thermostat and water temperatures are checked every shift and are below 110degrees.

5/10/12

See attached in service record, water temperature logs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

W 426 Continued From page 6

the qualified intellectual disabilities professional (QIDP) on April 27, 2012, at approximately 2:55 p.m., revealed the water temperature measured 116 degrees Fahrenheit. The QIDP confirmed the 116 degree water temperature and indicated she would contact the maintenance manager (MM) to address the elevated temperature. At approximately 4:00 p.m., on April 27, 2012, the MM arrived on site and indicated he lowered the temperature on the thermometer to get the water temperature down below 110 F.

On April 27, 2012, at 6:30 p.m., the surveyor and the QIDP rechecked the hot water temperature and it measured 109 degrees Fahrenheit.

At the time of the survey, there was no evidence that the facility had ensured that the temperature of the water did not exceed 110 degrees Fahrenheit at all times.

W 426

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

I 000 INITIAL COMMENTS

I 000

A licensure survey was conducted from April 26, 2012 through April 27, 2012. A sample of three residents was selected from a population of two men and four women with various degrees intellectual disabilities.

The findings of the survey were based on observations in the home and at two day program, interviews with direct support staff, administrative staff and two residents, 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.]

I 090 3504.1 HOUSEKEEPING

I 090

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 facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was in an orderly manner, for six of the six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6)

The finding includes:

The sink in Bathroom #2 appeared to be clogged. The water drained excessively slow and pooled rather quickly when the faucet was turned on.

I 090

The sink drain has been fixed. In the future the QDDP will ensure that the monthly environmental audits are completed and the issues are resolved.

5/10/12

Health Regulation & Licensing Administration

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

*Gwan J. Gwan*

TITLE

*VP Operations*

(X6) DATE

*5/17/12*

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

I 189 3508.7 ADMINISTRATIVE SUPPORT

I 189

Each GHMRP shall maintain records of residents' funds received and disbursed.

This Statute is not met as evidenced by:  
Based on record review and staff interview, the facility failed to maintain a complete accounting of all residents' funds for three of three sampled residents. (Residents #1, #2 and #3)

The findings include:

Record review on April 27, 2012, at approximately 2:30 p.m., revealed the facility failed to ensure an accurate accounting of residents' expenditures, as evidenced below:

1. Resident #1 had \$200.00 withdrawn from his account on September 9, 2011. Review of the receipts on hand totaled \$161.74. Interview with the facility's qualified intellectual disabilities professional (QIDP) on April 27, 2012, at approximately 4:05 p.m., revealed she could not account for the missing funds. The QIDP also tabulated the receipts on hand and validated the survey team's total of \$161.74. Further interviews with the facility's accounting office on the same day at approximately 4:20 p.m. revealed the receipts in question were unaccounted for.

2. Resident #2 had \$150.00 withdrawn from her account on November 23, 2011. Review of the receipts on hand totaled \$126.89. Interview with the QIDP on April 27, 2012, at approximately 4:30 p.m. revealed she could not account for the missing funds. The QIDP also tabulated the receipts on hand and validated the survey team's total of \$126.89. Further interviews with the facility's accounting office on the same day at approximately 4:25 p.m. revealed the receipts in

I 189

5/10/12

All individuals' financial records were audited and Metro Homes, Inc reconciled and balanced all the accounts. Checks were deposited into the individuals' accounts to cover the deficits. The financial policy was updated and a system of monthly reconciliation and audit has been instituted for each individual.

See attached copies of checks deposited into individuals' accounts, financial policy and audit record

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>
--	--

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

I 189	Continued From page 2 question were unaccounted for.	I 189		
-------	---	-------	--	--

3. Resident #3 had \$20.00 withdrawn from her account on two separate occasions on October 12, 2011. There was no evidence presented or on file at the time of survey to substantiate the withdrawal. Interview with the QIDP on April 27, 2012, at approximately 4:40 p.m., revealed she could not account for the missing funds. The QIDP also reviewed the record and revealed the receipts were missing. Further interviews with the facility's accounting office on the same day at approximately 4:35 p.m. revealed the receipts in question were unaccounted for.

I 227	3510.5(d) STAFF TRAINING	I 227		
-------	--------------------------	-------	--	--

Each training program shall include, but not be limited to, the following:

(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;

This Statute is not met as evidenced by:  
Based on staff interview and record review, the facility failed to ensure that staff was received training in CPR and maintained a current CPR certificate to ensure the health and safety of six of six residents residing in the facility. (Resident #1, #2, #3, #4, #5 and #6)

The findings include:

The facility failed to ensure four of fourteen staff received ongoing training in CPR, as identified below:

I 227	Staff did receive their CPR certification but inadvertently the record was not filed in the personnel file. HR Department has a new computer system – 'Imanage' to monitor/audit personnel files to prevent future staff deficiencies  See attached CPR certification			5/10/12
-------	--	--	--	---------

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/27/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>METRO HOMES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8020 EASTERN AVENUE, NW WASHINGTON, DC 20012</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
I 227	<p>Continued From page 3</p> <ol style="list-style-type: none"> <li>Staff #3's CPR certification expired on March 13, 2012.</li> <li>Staff #6's CPR certification expired on April 13, 2012.</li> <li>Staff #9's CPR certification expired on April 3, 2012.</li> </ol> <p>Interview with the facility's qualified intellectual disabilities professional (QIDP) on April 27, 2012, at approximately 10:30 a.m., revealed all staff on the active work schedule was required to have their CPR training completed and current. The QIDP indicated she would work with the human resources department to address this oversight.</p>	I 227		