

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

PRINTED: 08/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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

W 000

A recertification survey was conducted from July 19, 2011 through July 20, 2011. A sample of three clients was selected from a population of five men and women with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process.

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

Received 8/16/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

W 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES

W 120

The facility must assure that outside services meet the needs of each client.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that outside services meet the needs of each client, for one of the three clients in the sample. (Client#3)

The findings include:

1. The facility failed to ensure that Client #3's day program used adaptive drinking equipment, as prescribed.

Observations at the day program on July 19, 2011, at 12:35 p.m., revealed the day program staff held a folded paper towel under Client #3's mouth, and then placed the Styrofoam cup with grape juice in his mouth. After the client drank his juice, the staff wiped his mouth with the paper

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan J. Sloan</i>	TITLE <i>VP Operations</i>	(X6) DATE <i>8/12/11</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: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 120 Continued From page 1
towel.

On July 19, 2011, review of the physician's order dated July 1, 2011, at 10:45 a.m., revealed a sport cup was prescribed for Client #3.

Interview with the house manager on July 20, 2011, at 11:28 a.m., revealed the day program was provided with Client #3's adaptive feeding equipment. The house manager stated that Client #3 should have used his sport cup to drink his juice.

2. The facility failed to ensure that the day program implemented Client #3's meal time protocol.

On July 19, 2011, at 12:35 p.m., the day program staff was observed feeding Client #3 pureed roast pork, green beans, mash potatoes and pudding with a built up handle spoon. In an interview at 12:41 p.m., the day program staff stated, she usually feeds him with hand over hand assistance to make him as independent as possible.

Review of the meal time protocol dated June 22, 2011 on July 20, 2011, at 10:35 a.m., revealed staff is required to provide verbal prompts for the client to begin eating. If the client does not begin to eat; place his spoon in his hand and provide hand over hand assistance to initiate feeding. If the client resist after five attempts with hand over hand assistance then the staff should feed him.

Interview with the house manager on July 20, 2011, at 11:30 a.m., revealed the day program was provided with Client #3's mealtime protocol.

W 120

W120

1. Staff at the day program were in-serviced on the individual's drinking adaptive utensil. 8/13/11
2. Staff at the day program were in-serviced on the individual's mealtime protocol.
3. Staff at the day program were in-serviced on the individual's adaptive equipment – eye glasses.

Metro Homes, Inc. has a system in place – QDDP, RN or LPN visit day programs monthly and document progress / assessment of continuity of care etc.

In the future the QDDP, RN and house manager will ensure that their monthly day program visits are consistent and areas of adaptive equipment and mealtime protocol is monitored and documented closely.

See attached – in service records from day program – adaptive eating utensils, eyeglasses and mealtime protocol

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

PRINTED: 08/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 120 Continued From page 2

3. The facility staff failed to ensure consistent use of Client #3's eyeglasses as evidence below:

Observation at Client #3's day program on July 19, 2011, at approximately 12:00 p.m., revealed Client #3 sitting in his wheelchair in his classroom. At 12:06 p.m., the client propelled his wheelchair into another client. The day program staff pushed the client back to the table then locked the brakes. A few minutes later the client unlocked his brakes then began to propel his wheelchair. As he propelled his wheelchair, he ran into another client. At 5:06 p.m., Client #3 arrived home. Further observation revealed the client wearing eyeglasses. Observation at the day program on the same day beginning at approximately 12:00 p.m., revealed Client #3 did not have his glasses.

Interview with the house manager on July 20, 2011, at 11:40 a.m., revealed Client #3 wore his glasses to school. The house manager also stated that the client "actually likes to wear his glasses."

W 120

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

PRINTED: 08/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 120	Continued From page 3	W 120	
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the Qualified Intellectual Disabilities Professional (QIDP), for three of three sampled clients. (Clients #1, #2, #3)</p> <p>The findings include:</p> <p>The facility's QIDP failed to ensure adaptive equipment (hospital beds) were furnished, monitored and maintained as recommended, for Clients #1, #2 and #3. (See W436)</p>	<p>W 159</p> <p>W159 Metro Homes, Inc. has a system in place to check all adaptive equipment on a daily basis. All 3 individuals have had the hospital beds fixed/purchased and a hospital bed assessment has been completed. In the future the QDDP and nurses will ensure that all individuals have the appropriate beds and that all beds are in working condition. See attached – in service record on adaptive equipment maintenance and daily monitoring record.</p>	<p>8/12/11</p>
W 391	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that all prescribed medications had pharmacy labels, for one of the five clients in the facility. (Client #4)</p>	W 391	

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

PRINTED: 08/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 391 Continued From page 4

The findings include:

On July 19, 2011, at approximately 6:25 a.m., the Trained Medication Employee (TME) was observed to remove a packaged ampule of medication from a plastic bag without a pharmacy label on it from the medication cabinet. Further observation revealed the TME poured the contents of the ampule into a jet nebulizer chamber. During a face to face interview with the TME on July 19, 2011, at approximately 6:26 a.m., it was revealed the packaged ampule contained a single dose of Budesonide 0.25 mg/2 ml nebulizer inhalation suspension for Client #4. In an interview with the TME, Licensed Practical Nurse (LPN) and Registered Nurse (RN) on July 19, 2011, at approximately 8:00 a.m., it was acknowledged the pharmacy label on the plastic bag containing the single dose packaged ampules of Budesonide 0.25 mg/2 ml nebulizer inhalation suspension was missing, and that the medication belonged to Client #4. Review of Client #4's July Medication Administration Record (MAR) and physician order sheet (POS) dated June 1, 2011, at approximately 8:15 a.m. confirmed Client #4 was prescribed the aforementioned medication.

There was no observable evidence the facility ensured that all prescribed medications had pharmacy labels.

W 426 483.470(d)(3) CLIENT BATHROOMS

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

W 391

W391

The TME was in serviced on Medication Administration Policy and Procedure. In the future the RN Supervisor will ensure that there is all TMEs are supervised and monitored regularly as per policy. See attached in service record

8/13/11

W 426

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR 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	<p>Continued From page 5 exceed 110 degrees Fahrenheit.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, and record review, the facility failed to ensure that the temperature of the water did not exceed 110 degrees Fahrenheit for five of five clients residing in the facility. (Clients #1, #2, #3, #4, and #5)</p> <p>The finding includes:</p> <p>On July 19, 2011, at 4:25 p.m., the surveyor noted that the hot water temperature felt very warm to touch during hand washing in bathroom #1. The residential coordinator (RC) was notified immediately. The surveyor and the residential coordinator then measured the hot water temperatures, and determined that they read 120 degrees Fahrenheit in bathroom #1, and 119 degrees Fahrenheit in bathroom #2. The surveyor notified the Qualified Intellectual Disabilities Professional (QIDP), who immediately contacted maintenance, and the Director of Residential Services (DRS). At 5:10 p.m., a maintenance staff arrived at the facility to "check the water temperature."</p> <p>On July 19, 2011, at 5:15 p.m., interview with the maintenance staff confirmed that the hot water temperature exceeded 110 degrees Fahrenheit in the clients' bathrooms. He stated that the temperatures was usually less than 110 degrees Fahrenheit. According to the maintenance staff, he "turned down" the setting on the hot water heater, although he was unable to determine a reason why the hot water temperatures were elevated. At 6:25 p.m., a follow-up measurement</p>	W 426	<p>W426 The facility Maintenance Manager has resolved the water temperature issue. Staff has been monitoring the water temp. at least 3 times a day and the documentation shows the hot water temps. are maintained below 110 degrees. Metro Homes, Inc. will continue with the current system in place – daily monitoring of water temperatures and notify the Maintenance manager if the temperatures run above 110 degrees. See attached in service record</p>	8/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 426 Continued From page 6

W 426

of the water temperatures revealed that they remained at 120 degrees Fahrenheit. The DRS was again notified and informed the surveyor that maintenance would return to the facility to further adjust the water temperature setting, and continue to monitor it to ensure that it was corrected to 110 degrees Fahrenheit.

On July 20, 2011, at 7:30 a.m., review of the hourly temperature monitoring log revealed hot water temperatures were 107 (BR#1) and 106 (BR #2) Fahrenheit, respectively on July 19, 2011, at 10:00 p.m.

On July 20, 2011, at 7:35 a.m., the surveyor checked the hot water temperature and it measured 80 degrees in both bathroom #1 and #2.

Interview with the overnight staff on July 20, 2011, at 7:43 a.m., revealed that water temperatures remained cool during the third shift and that water was heated to make it warmer for morning baths. Interview with the QIDP revealed that maintenance was scheduled to come back to the facility to further adjust the water temperature.

On July 20, 2011, at 12:15 p.m., the surveyor and the RC observed that the hot water temperatures measured 100 degrees Fahrenheit in both bathrooms. At 3:00 p.m., the hot water temperatures read 107 Fahrenheit (BR #1) and 108 degrees Fahrenheit (BR #2).

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

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

PRINTED: 08/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 436 483.470(g)(2) SPACE AND EQUIPMENT W 436

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 the record review, the facility failed to furnish and maintain in good repair, adaptive equipment identified as needed by the interdisciplinary team, for three of three clients in the sample. (Clients #1, #2, and #3).

The findings include:

1. The facility failed to ensure Client #1's hospital bed was maintained in good repair, as evidenced below:

On July 20, 2011, at approximately 3:30 p.m., observation of Client #3's hospital bed revealed that when pressed, the buttons on the remote control functioned in the opposite direction. For example, the foot controls raised and lowered the head of the bed. The controls for the head of the bed raised and lowered the foot of the bed. Additionally, the buttons on the control identified to lower the bed raised it. Interview with the facility staff during this time revealed they were not able to determine how long the remote control of the client's bed had been malfunctioning.

Record review on July 20, 2011, at 4:01 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 436	<p>Continued From page 8</p> <p>revealed Client #3 had a current physician's order dated June 1, 2011, for a hospital bed with side rails. Additionally, the physician's orders prescribed to "elevate both feet, if possible." At the time of the survey, there was no evidence that the remote control for the client's recommended hospital bed was maintained in good repair.</p> <p>2. The facility failed to ensure Client #1's hospital bed was maintained in good repair, as evidenced below:</p> <p>On July 20, 2011, at approximately 3:30 p.m., observation of Client #1's hospital bed frame revealed that the protective molding had separated from the foot of the bed on the right side, and was protruding outward. The Qualified Intellectual Disabilities Professional (QIDP) was in the client's bedroom during the observation and acknowledged the finding.</p> <p>Record review on July 20, 2011 at 3:47 p.m. revealed Client #1 had a current physician's order dated June 1, 2011, for a hospital bed with side rails. At the time of the survey, there was no evidence the facility ensured that the client's recommended hospital bed was maintained in good repair.</p> <p>3. The facility failed to ensure a hospital bed was provided for Client #2 as prescribed, as evidenced below:</p> <p>On July 20, 2011, at approximately 12:39 p.m., observation of Client #2's room revealed he had a double regular bed.</p> <p>Interview with the residential coordinator (RC)</p>	W 436	<p>W436 1, 2, & 3 - Metro Homes, Inc. has a system in place to check all adaptive equipment on a daily basis. All 3 individuals have had the hospital beds fixed/purchased and a hospital bed assessment has been completed. In the future the QDDP and nurses will ensure that all individuals have the appropriate beds and that all beds are in working condition. See attached – in service record on adaptive equipment maintenance and daily monitoring record.</p> <p>8/13/11</p>

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

PRINTED: 08/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 436 Continued From page 9
during the observation revealed Client #2 already had the bed when she began working at the facility in February 2011. Interview with the QIDP revealed the client had the bed for "some time." Interview with the RN on July 20, 2011, at approximately 4:30 p.m., revealed that she would review the record to determine who recommended the bed, and when it was approved for the client's use.

W 436

Record review on July 20, 2011, at 3:52 p.m., revealed Client #1's physical therapy assessment dated March 24, 2011, recommended an adjustable hospital bed. Further record review revealed that the client had a physician's order dated June 1, 2011, that documented a diagnosis of chronic pneumonitis and prescribed a hospital bed with side rails. At the time of the survey, there was no evidence that the client was provided a hospital bed as prescribed.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
1 000	INITIAL COMMENTS A licensure survey was conducted from July 19, 2011 through July 20, 2011. A sample of three residents was selected from a population of five men and women with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with staff and residents in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	1 000	
1 090	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 Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the interior and exterior of the GHPID were maintained in a safe and sanitary manner to meet the needs of five of five residents in the GHPID (Residents #1, #2, #3, #4, and #5) The findings include: 1. On July 20, 2011, beginning at 12:02 p.m., the surveyor conducted observations of the external environment with the maintenance supervisor. The following concerns were identified: a. The handrail on the right side of the stairs,	1 090	

Health Regulation & Licensing Administration

Swan T. Sloan
LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

VP Operations
TITLE

(X6) DATE
8/12/11

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1</p> <p>exiting from the basement to the back yard, was observed to not be secured tightly in the ground, causing it to move when pressure was applied.</p> <p>b. Approximately 1" of the shanks of several nails, which secured the gutters to the roof, were visible on both the right and left side of the GHPID.</p> <p>c. There were several warped boards on the railing of the ramp, which lead from the exit doors of Residents #2, #3 and #5's bedrooms. The ramp was located at the rear of the GHPID.</p> <p>2. On July 20, 2011, beginning at 12:25 p.m., the residential coordinator (RC) accompanied the surveyor to conduct observations of the interior environment.</p> <p>The following concerns were identified:</p> <p>a. The ceiling fan in bathroom #2 was not operable.</p> <p>b. Two of four lights in bathroom #2, were observed to have sockets without light bulbs.</p> <p>c. A television (TV) was observed on top of Resident #4's chest of drawers. Interview with the RC revealed that the TV belonged to the resident and that it was operable. The surveyor's attempt to operate the TV revealed it did not come on. Further discussion with the RC revealed the TV did not come on because there was no electrical outlet available to operate it.</p> <p>d. A lamp was observed on the table beside Resident #4's bed. Interview with the RC revealed that the lamp belonged to the resident and was operable. Further discussion with the RC</p>	I 090	<p>I 090</p> <p>1. a – The hand rail has been tightened. b – The nails have been fixed on the gutters. c – The warped boards have been replaced</p> <p>2. a – The ceiling fan has been fixed b - The lights have been fixed c – There is an electrical outlet in place now and the TV is functioning. d - There is an electrical outlet in place now and the lamp is functioning. e – The tracs on the chest of drawers has is fixed f – The freezer has a functioning thermometer</p> <p>3. The facility Maintenance Manager has resolved the water temperature issue. Staff has been monitoring the water temp. at least 3 times a day and the documentation shows the hot water temps. are maintained below 110 degrees. Metro Homes, Inc. will continue with the current system in place – daily monitoring of water temperatures and notify the Maintenance manager if the temperatures run above 110 degrees.</p> <p>In the future the QDDP and the QA Manager will ensure that monthly environmental audits are completed appropriately and comprehensively. See attached in service record</p> <p>8/13/11</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CDDE 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 revealed the lamp did not come on because all of the electrical outlets were already in use. The shade was missing from Resident #2's table lamp. e. One of the tracts (drawer #2) was broken in Resident #4's chest of drawers, which was used to store her clothing. Resident #3's chest of drawers had the tract missing from the bottom of drawer #4. f. The thermometer in the refrigerator section of the refrigerator measured 20 degrees Fahrenheit. Closer observation revealed that none of the foods in the refrigerator were frozen, therefore the 20 degrees was not an accurate temperature. There was no thermometer in the refrigerator located in the basement. 3. The GHPID failed to ensure that the temperature of the water did not exceed 110 degrees, as evidenced below: On July 19, 2011, at 4:25 p.m., the surveyor noted that the hot water temperature felt very warm to touch during hand washing in bathroom #1. The residential coordinator (RC) was notified immediately. The surveyor and the residential coordinator then measured the hot water temperatures, and determined that they read 120 degrees Fahrenheit in bathroom #1, and 119 degrees Fahrenheit in bathroom #2. The surveyor notified the qualified intellectual disabilities professional (QIDP), who immediately contacted maintenance, and the Director of Residential Services (DRS). At 5:10 p.m., a maintenance	I 090	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)	
I 090	<p>Continued From page 3</p> <p>staff arrived at the GHPID to "check the water temperature."</p> <p>On July 19, 2011, at 5:15 p.m., interview with the maintenance staff confirmed that the hot water temperature exceeded 110 degrees Fahrenheit in the residents' bathrooms. He stated that the temperatures was usually less than 110 degrees Fahrenheit. According to the maintenance staff, he "turned down" the setting on the hot water heater, although he was unable to determine a reason why the hot water temperatures were elevated. At 6:25 p.m., a follow-up measurement of the water temperatures revealed that they remained at 120 degrees Fahrenheit. The DRS was again notified and informed the surveyor that maintenance would return to the GHPID to further adjust the water temperature setting, and continue to monitor it to ensure that it was corrected to 110 degrees Fahrenheit.</p> <p>On July 20, 2011, at 7:30 a.m., review of the hourly temperature monitoring log revealed hot water temperatures were 107 (BR#1) and 106 (BR #2) Fahrenheit, respectively on July 19, 2011, at 10:00 p.m.</p> <p>On July 20, 2011, at 7:35 a.m., the surveyor checked the hot water temperature and it measured 80 degrees in both bathroom #1 and #2.</p> <p>Interview with the overnight staff on July 20, 2011, at 7:43 a.m., revealed that water temperatures remained cool during the third shift and that water was heated to make it warmer for morning baths. Interview with the QIDP revealed that maintenance was scheduled to come back to the GHPID to further adjust the water temperature.</p>	I 090		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 4 On July 20, 2011, at 12:15 p.m., the surveyor and the RC observed that the hot water temperatures measured 100 degrees Fahrenheit in both bathrooms. At 3:00 p.m., the hot water temperatures read 107 Fahrenheit (BR #1) and 108 degrees Fahrenheit (BR #2). At the time of the survey, however, there was no evidence that the GHPID had ensured that the temperature of the water did not exceed 110 degrees Fahrenheit at all times.	I 090	
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative support to efficiently meet the needs of three of three residents, as required by their habilitation plans. (Residents #1, #2 and #3) The finding includes: The GHPID failed to ensure adaptive equipment (hospital beds) were furnished, monitored and maintained as recommended, for Residents #1, #2 and #3. (See Federal Deficiency Report - Citation W436)	I 180	I 180 1, 2, & 3 - Metro Homes, Inc. has a system in place to check all adaptive equipment on a daily basis. All 3 individuals have had the hospital beds fixed/purchased and a hospital bed assessment has been completed. In the future the QDDP and nurses will ensure that all individuals have the appropriate beds and that all beds are in working condition. See attached -- in service record on adaptive equipment maintenance and daily monitoring record. 8/13/11
I 484	3522.11 MEDICATIONS	I 484	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 484	<p>Continued From page 5</p> <p>Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectually Disabilities (GHPID) nursing staff failed to remove from use, medications that had a missing label, for one of five residents in the facility. (Resident #4)</p> <p>The finding includes:</p> <p>On July 19, 2011, at approximately 6:25 a.m., the Trained Medication Employee (TME) was observed to remove a packaged ampule of medication from a plastic bag without a pharmacy label on it from the medication cabinet. Further observation revealed the TME poured the contents of the ampule into a jet nebulizer chamber. During a face to face interview with the TME on July 19, 2011, at approximately 6:26 a.m., it was revealed the packaged ampule contained a single dose of Budesonide 0.25 mg/2 ml nebulizer inhalation suspension. In an interview with the TME, Licensed Practical Nurse (LPN) and Registered Nurse (RN) on July 19, 2011, at approximately 8:00 a.m., it was acknowledged the pharmacy label on the plastic bag containing the single dose packaged ampules of Budesonide 0.25 mg/2 ml nebulizer inhalation suspension was missing, and that the medication and belonged to Resident #4. Review of Resident #4's July Medication Administration Record (MAR) and physician order sheet (POS) dated June 1, 2011, on July 19, 2011, at approximately 8:15 am confirmed Resident #4 was prescribed the aforementioned medication.</p>	I 484	<p>I 484</p> <p>The TME was in serviced on Medication Administration Policy and Procedure. In the future the RN Supervisor will ensure that there is all TMEs are supervised and monitored regularly as per policy. See attached in service record</p>	8/13/11

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 484	Continued From page 6 There was no observable evidence the facility removed from use, all medications that had a missing label.	I 484		
-------	--	-------	--	--