

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011
--------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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

An recertification survey was conducted from August 30, 2010 through September 1, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of five females with various levels of mental retardation and disabilities.

W 000

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

W 120

The findings of the survey were based on observations at the group home and three day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.

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

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

The finding includes:

Client #3 was observed at his day program on August 30, 2010, beginning at 1:15 p.m. At 1:25 p.m., review of the client's day program active treatment program book, revealed no individual program plans (IPP) for Client #3. Interview with the day program staff at the same time, confirmed that there was no goals and objectives in place for the client. Further interview revealed that the client enjoys arts and crafts and making jewelry.

W120
This individual had her 30 day review on 9/22/10 9/7/10 and her IPP was developed and staff working with her at her day program was in-serviced.
In the future the QMRP and the Day Program case manager will ensure that IPP development is completed and implemented within 30 days of admission.
See attached – IPP and in-service record

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

SEP 23 2010

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

TITLE

(X6) DATE

Swan J. Sloan

VP Operations

9/22/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011	
(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 Interview with the case manager (CM) on the same day, at 1:43 p.m., revealed that Client #3 started the day program on July 14, 2010. Continued interview revealed that a thirty day review meeting was scheduled for August 18, 2010, however the meeting was cancelled. The CM stated that once the meeting takes place with the service coordinator, Client #3's IPP will be developed and implemented. Interview with the qualified mental retardation professional (QMRP) on September 1, 2010, at approximately 2:30 p.m., confirmed that Client #3 had not had a 30 day review and did not have an IPP goals and objectives at her day program. There was no evidence that the facility's QMRP ensured that Client #3's IPP was developed.	W 120		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an effective system to protect the clients' right for privacy during medication administration and while clients were resting in their beds, for two of the five clients residing in the facility. (Clients #3 and #5) The findings include: 1. Observations during medication administration on August 30, 2010, from 4:35 p.m. until 5:00 p.m., revealed Client #5 administering her	W 130	W 130 – 1&2 The staff was in-serviced on client's rights and privacy. In the future the QMRP and management staff will be vigilant to ensure that staffs observe rights and privacy of our individuals. See in-service record – Client rights and privacy	9/22/10

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 130	<p>Continued From page 2</p> <p>medications with assistance from the licensed practical nurse (LPN). The maintenance man was observed walking between the client and the LPN during the medication administration, five times. Inquiry was made to the LPN, during the medication administration, "are staff allowed to walk through the area while you are administrating medications?" The LPN replied, "No" and then informed the maintenance man that she needed privacy during the medication administration. Seconds later, the maintenance man was observed walking through them one last time.</p> <p>Review of the facility's training record on September 1, 2010, at approximately 11:13 a.m., revealed a training titled, "Client's Rights dated July 17, 2010." Further review revealed no evidence that the maintenance man's name was on the signed agenda.</p> <p>2. On August 30, 2010, at 4:30 p.m., Client #1 was overheard informing staff that she wanted to go to her bedroom and rest. At 4:37 p.m., a direct care staff was observed escorting the client to her bedroom and assisting her in the bed. At 4:45 p.m., the maintenance man was observed entering the client's bedroom (from the outside) and walking through her bedroom, four times. On the fourth time, the maintenance man stated, "I will be out of your room so you can rest, shortly." Minutes later, the LPN confirmed that the maintenance man was observed walking back and forth in Client #1's bedroom, while she was resting.</p>	W 130			
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be</p>	W 159			

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011	
(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 159	<p>Continued From page 3</p> <p>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 the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for one of three clients included in the sample. (Clients #3)</p> <p>The finding include:</p> <p>On August 30, 2010, at 5:01 p.m., the direct support staff placed a plate of grapes in front of Client #3. The client was observed putting grapes and her mouth at a fast pace while chewing. At no time did the direct support staff encouraged Client #3 to slow down.</p> <p>On September 1, 2010, at 10:00 a.m., review of Client #3's speech and language assessment dated August 22, 2010, revealed the client maintains a rapid eating pace while engaged in dietary intake. Further review revealed the client required supervision and assistance from staff to maintain a slower rate of intake and to modulate the amount of food she places in her mouth while eating.</p> <p>Interview with the QMRP on September 1, 2010, at approximately 2:45 p.m., confirmed that staff is required to ensure that Client #3 does not stuff her mouth with food.</p> <p>The QMRP failed to ensure that Client #3 did not eat at a rapid pace as recommended by the speech and language pathologist.</p>	W 159	<p>W 159</p> <p>All staff was in-serviced on this individual's mealtime protocol – emphasis on bite size and pace of eating. In the future the QMRP and the nutritionist will monitor the staff during the mealtimes to ensure that staff is following the mealtime protocol. See in-service record – mealtime protocol</p>	9/22/10

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011	
(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 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to provide continuous active treatment, for two of the three clients included in the sample. (Client #1 and #3)</p> <p>The findings include:</p> <p>1. On August 30, 2010, at 6:24 p.m., Client #3 was observed using profanity and telling the staff to shut up. One minute later the client raised her hand to hit the staff. The staff told the client to drink her water and eat her dinner. At 6:27 p.m., the client told the staff to shut up and get out then began to use profanity. The staff replied and said "the food is good". At 6:29 p.m., the client raised her hand to hit the staff then continued to eat her dinner. At 7:02 p.m., the direct care staff was observed rubbing Client #3's back after the client hit her on the arm. Interview with the staff shortly after revealed that she told the client not to hit her.</p> <p>On August 30, 2010, at 7:13 p.m., review of Client #3's behavior support plan (BSP) dated April 6, 2010, revealed "physical aggression, verbal aggression, SIB and disrobing." were challenging</p>	W 249	<p>W 249 – 1,2&3</p> <p>The staff was in-serviced on the BSP, and the nurse was in-serviced on the self medication programs.</p> <p>In the future the QMRP and the RN Supervisor will ensure that all programs are implemented and individuals receive continuous active treatment and interventions to support and achieve their objectives.</p> <p>The QMRP and RN will through direct observation and documentation monitor this.</p> <p>See attached - in-service record – BSP and self medication programs</p>	9/22/10

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(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 249	<p>Continued From page 5</p> <p>maladaptive behaviors identified in the BSP. Further review revealed that staff is required to firmly, verbally direct her to discontinue the aggressive behavior. If the Client does not respond to the verbal prompt to stop, escort her to a quiet area of the home and allow her to calm down. At no time did the direct support staff firmly direct the client to stop her aggressive behavior.</p> <p>In an interview with the QMRP on September 1, 2010, at approximately 3:00 p.m., revealed that the staff ignored the client aggressive behaviors.</p> <p>2. Observation of the medication administration on August 30, 2010, beginning at 6:25 p.m., revealed the licensed practical nurse (LPN) went into the bathroom to wash her hands. Further observations revealed the LPN prepared Client #1's medications by punching the medication into the cup and mixing the medication into applesauce. The LPN was then observed to spoon feed the client her medications and held the cup up to the client's mouth as the client drank the water. The LPN was observed to place the cup into the trash can. At no time did the LPN encourage the client to participate in the self-medication administration. Interview with LPN on the same day at approximately 5:38 p.m., revealed that the client does not participate in a self medication program.</p> <p>Review of Client #1's Individual Program Plan (IPP) dated May 4, 2010, on August 31, 2010, at 1:00 p.m., revealed a program objective which stated, "[the client] will complete the steps to take her medications with 50% verbal prompts for three consecutive months. Further review indicated Client #1's self-medication program was</p>	W 249			

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011	
(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 249	<p>Continued From page 6 outlined as follows:</p> <ul style="list-style-type: none"> - wash her hands; - obtain medications; - will swallow medications; and - will throw cup in the trash. <p>Review of Client's #1 program documentation record on August 31, 2010, at approximately 2:30 p.m., and interview with the facility's qualified mental retardation professional (QMRP) confirmed that Client #1's self-medication was not implemented.</p> <p>3. Observation of the medication administration on August 30, 2010, beginning at 5:45 p.m., revealed the licensed practical nurse (LPN) went into the bathroom to wash her hands. Further observations revealed the LPN prepared Client #1's medications by punching the medication into the cup and mixing the medication into applesauce. The LPN was then observed pouring the pills and liquid medications into the client's mouth. The LPN was observed to place the medication cup into the trash can. The LPN gave the client a cup of water and she consumed the water independently. At no time did the LPN encourage the client to participate in the self-medication administration. Interview with LPN on the same day at approximately 5:38 p.m., revealed that the client does not participate in a self medication program.</p> <p>Review of Client #3's Individual Program Plan (IPP) dated April 6, 2010, on August 31, 2010, at 2:15 p.m., revealed a program objective which stated, "[the client] will take her medications with 50% verbal prompts for three consecutive months. Further review indicated Client # 3's</p>	W 249		

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010	
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(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 249	Continued From page 7 self-medication program was outlined as follows: - wash her hands; - pour water in cup; - will swallow medications; and - will throw cup in the trash. Review of Client's #1 program documentation record on August 31, 2010, at approximately 2:45 p.m., and interview with the facility's qualified mental retardation professional (QMRP) confirmed that Client #3's self-medication program was not implemented.	W 249		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for two of three clients included in the sample. (Clients #1 and #3) The findings include: 1. Observation of the medication administration on August 30, 2010, beginning at 6:25 p.m., revealed the licensed practical nurse (LPN) went into the bathroom to wash her hands, punched the medication into a cup of applesauce and spoon fed the client her medications. The LPN	W 371	W 371 – 1&2 The nurse was in-serviced on the self medication programs. In the future the RN Supervisor will ensure that the LPN is monitored at least on a quarterly basis to ensure Medication Policy and Procedure and IPPs are being implemented. See attached – in-service record – Medication Administration Policy and Procedure and in-service on self medication IPPs	9/22/10

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(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 371	<p>Continued From page 8</p> <p>then held the cup up to the client's mouth as the client drank the water. When finished, the LPN placed the cup into the trash can. At no time did the LPN encourage the client to participate in the self-medication administration. Interview with LPN on the same day at approximately 5:38 p.m., revealed that the client does not participate in a self medication program.</p> <p>Review of Client #1's Individual Program Plan (IPP) dated May 4, 2010, on August 31, 2010, at 1:00 p.m., revealed a program objective which stated, "[the client] will complete the steps to take her medications with 50% verbal prompts for three consecutive months. Further review indicated Client #1's self-medication program was outlined as follows:</p> <ul style="list-style-type: none"> - wash her hands; - obtain medications; - will swallow medications; and - will throw cup in the trash. <p>Review of Client's #1 program documentation record on August 31, 2010, at approximately 2:30 p.m., and interview with the facility's qualified mental retardation professional (QMRP) confirmed that Client #1's self-medication was not implemented.</p> <p>2. Observation of the medication administration on August 30, 2010, beginning at 5:45 p.m., revealed the licensed practical nurse (LPN) went into the bathroom to wash her hands. Further observations revealed the LPN prepared Client #1's medications by punching the medication into the cup and mixing the medication into applesauce. The LPN was then observed pouring the pills and liquid medications into the</p>	W 371		

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010	
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(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 371	<p>Continued From page 9</p> <p>client's mouth. The LPN was observed to place the medication cup into the trash can. The LPN gave the client a cup of water and she consumed the water independently. At no time did the LPN encourage the client to participate in the self-medication administration. Interview with LPN on the same day at approximately 5:38 p.m., revealed that the client does not participate in a self medication program.</p> <p>Review of Client #3's Individual Program Plan (IPP) dated April 6, 2010, on August 31, 2010, at 2:15 p.m., revealed a program objective which stated, "[the client] will take her medications with 50% verbal prompts for three consecutive months. Further review indicated Client # 3's self-medication program was outlined as follows:</p> <ul style="list-style-type: none"> - wash her hands; - pour water in cup; - will swallow medications; and - will throw cup in the trash. <p>Review of Client's #1 program documentation record on August 31, 2010, at approximately 2:45 p.m., and interview with the facility's qualified mental retardation professional (QMRP) confirmed that Client #3's self-medication program was not implemented.</p>	W 371		
W 455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure proper infection</p>	W 455		

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011	
(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 455	Continued From page 10 control procedures were implemented, for five of the five clients in the sample. (Clients #1, #2, #3, #4 and #5) The finding includes: Observation on August 30, 2010, at 4:20 p.m., revealed the direct support staff sitting in the living room and dining room engaging the clients with their active treatment programs. At 4:57 p.m., the direct support staff was observed going outside with Clients #3 and #4. At 4:58 p.m., the direct support staff and Client #5 began to set the table for snacks. At 5:01 p.m., Client #1, #2, #3, #4, and #5 were observed eating their snacks without washing or sanitizing their hands. Review of the training records on September 1, 2010, at 11:13 a.m., revealed that staff were trained on infection control on July 17, 2010. Interview with the qualified mental retardation professional on September 1, 2010, at approximately 2:00 p.m., revealed all clients are required to wash their hands before eating. There was no evidence that proper infection control procedures were implemented before the clients ate their snack.	W 455	W 455 All staff was in-serviced on Infection Control. In the future the QMRP and RN will ensure that mealtime observations are monitored at least weekly to ensure that the staffs implement Infection Control practices. See attached in-service record – hand washing and Infection Control	9/22/10
W 472	483.480(b)(2)(i) MEAL SERVICES Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that food portions were served in accordance with prescribed diets for one of three clients in the	W 472		

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011
--------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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 472	<p>Continued From page 11 sample. (Clients #3)</p> <p>The finding includes:</p> <p>Observation on August 30, 2010, at 6:20 p.m., revealed that Client #3 received potatoes and spinach. Prior to that the client informed the staff that she did not want fish for dinner.</p> <p>Interview with the qualified mental retardation professional on September 1, 2010, at approximately 11:45 p.m., revealed that the direct support staff was required to substitute the fish for another meat. At the same time, review of the substitution menu revealed that staff is required to substitute a meat for a meat. At no time did the direct support staff offer another meat to Client #3.</p>	W 472	<p>W 472</p> <p>All staff was in-serviced on meal menu / food preparation / and substitution. In the future the QMRP, Nutritionist and RN will ensure that staff are monitored at least weekly during mealtimes to ensure that diets are served in accordance to their individual prescription. See attached in-service record – Diet/food prep/substitution</p>	9/22/10
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011
--------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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	<p>INITIAL COMMENTS</p> <p>An licensure survey was conducted from August 30, 2010, through September 1, 2010. A random sample of three residents was selected from a population of five females with various levels of mental retardation and disabilities.</p> <p>The findings of the survey were based on observations at the group home and three day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports.</p>	I 000		
I 090	<p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors for four of four clients residing in the facility. (Clients #1, #2, #3, #4 and #5).</p> <p>The findings include:</p> <ol style="list-style-type: none"> In bathroom #2 the faucet was loose to touch the water drained slowly. In the living room, the center window had broken Venetian blind blades. <p>These deficiencies were acknowledged by the</p>	I 090	<p>I 090</p> <ol style="list-style-type: none"> BR faucet has been fixed Venetian blind has been replaced <p>In the future the QMRP and RC will ensure that at least monthly QA of environment is completed and documented.</p>	9/22/10

Health Regulation Administration

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

STATE FORM

Swan J. Sloan

VP Operations

TITLE

(X6) DATE

9/22/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010	
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 1 coordinator (RC) during the walk through.	I 090		
I 092	<p>3504.3 HOUSEKEEPING</p> <p>Each GHMRP shall be free of insects, rodents and vermin.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the environment was free of insects, rodents and vermin to ensure the health and safety, for five of five residents. (Residents #1, #2, #3, #4, and #5.).</p> <p>The finding includes:</p> <p>On August 30, 2010, at approximately 10:30 a.m., it was revealed by the survey team that roaches were observed crawling on the kitchen counter top. Again at 1:45 p.m., baby roaches were observed crawling on the kitchen counter top and in the kitchen cabinets. At 6:45 p.m., fruit flies were observed flying around the vegetable bin located in the kitchen. Further observations revealed an apple that had been cut and left sitting in the vegetable bin. At 6:50 p.m., the qualified mental retardation professional (QMRP) was informed that the roaches and fruit flies were in the kitchen area.</p> <p>Interview with the qualified mental retardation professional (QMRP) at 6:55 p.m., revealed that the contracted exterminator was in the facility in August 2010. The visitor's sign-in log confirmed that the exterminator was in the facility on August 20, 2010.</p> <p>During the environmental inspection on August</p>	I 092	<p>I 092</p> <p>Metro Homes had the pest control specialist complete a thorough assessment of the environment and submit a schedule for the appropriate extermination process. The QMRP will ensure that the Exterminator will follow the prescribed schedule to ensure the environment is free of all rodents and insects.</p>	9/22/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011
--------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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 092	Continued From page 2 30, 2010, at approximately 2:45 p.m., surveyors reported observing a mouse crawling on the kitchen counter and roaches were seen in the same area. Interview with the qualified mental retardation professional on the same day who provided the surveyor with an invoice of the facilities most recent extermination. Also provided was a copy of the facility's contract with a pest control company. The same day the facility had another contractor come to the facility and provide pest control services. The facility failed to ensure an insect free environment as required by this section. The QMRP acknowledged these findings this same day.	I 092		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all employees had current health certificates, for one of sixteen staff (Staff #8), and two of ten consultants (Psychiatrist and Pharmacist). The finding includes: On August 31, 2010, beginning at approximately	I 206	I 206 Both health certificates were on file -- inadvertently the surveyor did not see them. Metro Homes has a data base and a tracking system for personnel folders See attached - health certificates	9/22/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 3 1:30 p.m., review of the personnel records revealed the GHMRP failed to provide evidence that current health certificates were on file for staff #8 and the psychiatrist and the pharmacist. The qualified mental retardation professional (QMRP), acknowledged the findings at approximately 3:00 p.m.	I 206		
I 231	3510.5(h) STAFF TRAINING Each training program shall include, but not be limited to, the following: (h) Orientation programs for each new employee which shall include philosophy, organization, programs, practices and goals of the GHMRP as well as a review of applicable laws, regulations and agreements important to the operation of the GHMRP for the care and treatment of persons with mental retardation in the District of Columbia; and... This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure all new staff received orientation training to include care and treatment for persons with mental retardation, for two of the five residents residing in the facility. (Residents #3 and #5) The findings include: 1. Observations during medication administration on August 30, 2010, from 4:35 p.m. until 5:00 p.m., revealed Resident #5 administering her medications with assistance from the licensed practical nurse (LPN). The maintenance man was observed walking between the resident and	I 231	I 231 The staff was in-serviced on client's rights and privacy. In the future the QMRP and management staff will be vigilant to ensure that staffs observe rights and privacy of our individuals. See in-service record – Client rights and privacy	9/22/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(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 231	Continued From page 4 the LPN during the medication administration, five times. Inquiry was made to the LPN, during the medication administration, "are staff allowed to walk through the area while you are administrating medications?" The LPN replied, "No" and then informed the maintenance man that she needed privacy during the medication administration. Seconds later, the maintenance man was observed walking through them one last time. Review of the facility's training record on September 1, 2010, at approximately 11:13 a.m., revealed a training titled, "Resident's Rights" dated July 17, 2010. Further review revealed no evidence that the maintenance man's name was on the signed agenda. 2. On August 30, 2010, at 4:30 p.m., Resident #1 was overheard informing staff that she wanted to go to her bedroom and rest. At 4:37 p.m., a direct care staff was observed escorting the resident to her bedroom and assisting her in the bed. At 4:45 p.m., the maintenance man was observed entering the client's bedroom (from the outside) and walking through her bedroom, four times. On the fourth time, the maintenance man stated, "I will be out of your room so you can rest, shortly." Minutes later, the LPN confirmed that the maintenance man was observed walking back and forth in Resident #1's bedroom, while she was resting.	I 231		
I 405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers,	I 405		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011	
(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 405	<p>Continued From page 5</p> <p>including both public and private agencies and individual practitioners.</p> <p>This Statute is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that outside services met the needs of residents, for one of the three sampled clients. (Resident #3)</p> <p>The finding includes:</p> <p>Resident #3 was observed at his day program on August 30, 2010, beginning at 1:15 p.m. At 1:25 p.m., review of the resident's day program active treatment program book, revealed no individual program plans (IPP) for Resident #3. Interview with the day program staff at the same time, confirmed that there was no IPP in place for the resident. Further interview revealed that the resident enjoyed arts and crafts and making jewelry.</p> <p>Interview with the case manager (CM) on the same day, at 1:43 p.m., revealed that Resident #3 started the day program on July 14, 2010. Continued interview revealed that a thirty day review meeting was scheduled for August 18, 2010, however the meeting was cancelled. The CM stated that once the meeting takes place with the service coordinator, Resident #3's IPP will be developed and implemented.</p> <p>Interview with the qualified mental retardation professional on September 1, 2010, at approximately 2:30 p.m., confirmed that Resident #3 did not have an IPP at her day program.</p> <p>There was no evidence that the facility ensured that Resident #3's IPP was developed.</p>	I 405	<p>I 405</p> <p>This individual had her 30 day review on 9/7/10 and her IPP was developed and staff working with her at her day program was in-serviced.</p> <p>In the future the QMRP and the Day Program case manager will ensure that IPP development is completed and implemented within 30 days of admission.</p> <p>See attached – IPP and in-service record</p> <p>9/22/10</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011
--------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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 500	Continued From page 6	I 500		
I 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure an effective system to protect the Residents' right for privacy during medication administration and while Residents were resting in their beds, for two of the five Residents residing in the facility. (Residents #3 and #5)</p> <p>The findings include:</p> <p>1. Observations during medication administration on August 30, 2010, from 4:35 p.m. until 5:00 p.m., revealed Resident #5 administering her medications with assistance from the licensed practical nurse (LPN). The maintenance man (agency employee) was observed walking between the Resident and the LPN during the medication administration, five times. Inquiry was made to the LPN, during the medication administration, "are staff allowed to walk through the area while you are administering medications?" The LPN replied, "No" and then informed the maintenance man that she needed privacy during the medication administration. Seconds later, the maintenance man was observed walking through them one last time.</p> <p>Review of the (GHMRP) facility's training record on September 1, 2010, at approximately 11:13</p>	I 500	<p>I 500</p> <p>The staff was in-serviced on client's rights and privacy.</p> <p>In the future the QMRP and management staff will be vigilant to ensure that staffs observe rights and privacy of our individuals.</p> <p>See in-service record – Client rights and privacy</p>	9/22/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011		
(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 500	Continued From page 7 a.m., revealed a training titled, "Resident's Rights dated July 17, 2010." Further review revealed no evidence that the GHMRP's maintenance man's name was on the signed agenda. 2. On August 30, 2010, at 4:30 p.m., Resident #1 was overheard informing staff that she wanted to go to her bedroom and rest. At 4:37 p.m., a direct care staff was observed escorting the Resident to her bedroom and assisting her in the bed. At 4:45 p.m., the maintenance man was observed entering the Resident's bedroom (from the outside) and walking through her bedroom, four times. On the fourth time, the maintenance man stated, "I will be out of your room so you can rest, shortly." Minutes later, the LPN confirmed that the maintenance man was observed walking back and forth in Resident #1's bedroom, while she was resting.	I 500		