

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
E0000	Initial Comments A recertification survey was conducted at this facility from 08/24/2026 through 08/26/2026. A sample of three clients was selected from a census of six. The survey was conducted utilizing the focused fundamental survey process. The survey findings were based on observations, interviews, and reviews of client and administrative records.	E0000	Please start typing your responses here:		
W0000	INITIAL COMMENTS A recertification survey was conducted at this facility from 08/24/2026 through 08/26/2026. A sample of three clients was selected from a census of six. The survey was conducted utilizing the focused fundamental survey process. The survey findings were based on observations, interviews, and reviews of client and administrative records.	W0000			
E0007	EP Program Patient Population CFR(s): 483.475(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. **	E0007			

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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
E0007	Continued from page 1 *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This STANDARD is NOT MET as evidenced by: Based on observations, interview, and record reviews, the facility failed to ensure that each resident's Personal Emergency Preparedness Plan (PEPP) included documentation of the resident's current medications for three of the three clients in the sample (Client #1, #2, and #3). Findings included: A review of Client #1's PEPP dated 11/20/2025 showed the absence of documentation regarding the client's current medications. A review of Client #2's PEPP dated 11/20/2025 showed the absence of documentation regarding the client's current medications. A review of Client #3's PEPP dated 07/09/2026 showed the absence of documentation regarding the client's current medications. During an interview on 08/26/2026 at 4:20 PM, the Qualified Intellectual Disabilities Professional acknowledged that the PEPPs for Clients #1, #2, and #3 did not include their current medications and confirmed that the facility had not incorporated			E0007			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
E0007	Continued from page 2 medication information into the individualized emergency plans.	E0007			
W0137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is NOT MET as evidenced by: Based on observations and interview, the facility failed to ensure that clients personal items are labeled in an inconspicuous manner for two of the three clients in the sample (Client #1 and #2). Findings included: On 08/24/2026 at 3:45 PM, Client #2 arrived home from day program. The shoes he was wearing had his initials written on the back in permanent marker. On 08/28/2026 at 2:40 PM, during the environmental inspection, three pairs of tennis shoes belonging to Client #2 were observed with his initials written on the back in permanent marker. Further observations showed that Client #1 had two pairs of tennis shoes with his initials written on the back in black permanent marker. During an interview with the Qualified Intellectual Disabilities Professional stated that staff "should not have done that," and added, "I will speak to the staff and find out who wrote their initials on their shoes.	W0137			
W0192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is NOT MET as evidenced by: Based on observations, interview and record reviews the facility failed to implement its infection control policy.	W0192			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0192	Continued from page 3 Findings included: 1. On 08/4/2026 at 3:10 PM, Client #1 arrived home from day program and was transferred to his recliner chair. He was observed hand mouthing. At 3:18 PM, Direct Support Professional (DSP) #6 provided the client with a cup of juice and yogurt for his afternoon snack and assisted him back to the recliner chair in the living room. At 3:25 PM, the client was again, observed hand-mouthing for several minutes. DSP #6 then began a ball toss activity with the client, during which the client continued to hand-mouth. At no time did DSP #6 wash or sanitize the client's hands before his snack, after his snack, or during the period in which he repeatedly hands mouthed. During an interview with the Qualified Intellectual Disabilities Professional (QIDP) on 08/26/2026, she stated that staff should encourage Client #1 to wash their hands after hand-mouthing and then assist him to participate in activities involving hand use. The further also stated that staff received training infection control. Review of the training records on 08/26/2026 at 11:00 AM showed that DSPs #5 and #6 had received training on infection control on 11/25/2025. 2. On 08/25/2026 at 5:00 PM. a diaper soiled with urine and feces was observed lying on the bathroom floor. During an interview on 08/26/2026 at 1:00 PM, the Registered Nurse Supervisor stated that DSP #5 and #6 should discard soiled diapers immediately after a client has been changed. She reported she had spoken that she would speak with the DSP's on duty to determine who left the soiled diaper in the bathroom. A review of the training records on 08/26/2026 at 1:30 PM, showed that DSP's #5 and #6 received	W0192			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0192	Continued from page 4 training on infection control on 11/25/2025.	W0192			
W0194	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and record reviews the facility failed to ensure Direct Support Professionals (DSP) demonstrated competency in the implementation of each clients Individual Program Plan (IPP) for two of the three clients in the sample (Clients #1 and #2). Findings included: 1. On 08/24/2026 at 1:00 PM, a review of Client #1's IPP dated 09/04/2025, showed an objective that stating: "Given verbal cues, will ambulate up and down the stairs from the basement to the first floor three out of three trials, three day per week for six consecutive months. " Observations from 08/24/2026 through 08/26/2026 showed no evidence that Client #1 ambulated up or down the stairs. On 03/25/2025 at 11:00 AM, a review of Client #1's IPP data documentation book revealed no data sheets documenting stair-ambulation participation. On 08/25/2026 at 11:10 AM, a review of Client #1's Physical Therapy assessment 01/05/2026 and quarterly reviews dated 03/04/2026 and 05/08/2026 showed recommendations for a program in which Client #2 should ambulate up and down the stairs three times per week to her increase endurance. During an interview on 08/25/2026 at 1:30 PM, the Qualified Intellectual Disability Professional (QIDP) stated that Client #1 does not participate in the stair ambulation program due to his unsteady gait but confirmed that the client does walk throughout the facility and in the community.	W0194			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0194	Continued from page 5 2. On 08/24/2026 at 1:00 PM, a review of Client #1's IPP dated 09/04/2025, revealed an additional objective that stated "Given verbal cues, will ambulate in the community for 10 minutes, three days per week for six consecutive months. On 08/24/2026 at 3:18 PM, DSP #6 assisted Client #1 to the dining room table for a snack. At 6:00 PM, DSP #3 assisted the client to the dining table for dinner. On 08/27/2026 at 11:40 AM, DSP #6 was observed walking Client #1 around the facility for approximately 12 minutes. During an interview at 3:30 PM, DSP #6 stated that Client #1 participates in a walking program and is doing much better since he arrived at the facility. When asked whether the client walk in the community, DSP #6 stated, "No not generally because he uses a wheelchair when in the community." There was no evidence that the staff allowed the client to participate in his community walks, as required by his IPP. 3. On 08/24/2026 at 1:30 PM, the review of Client #2's IPP dated 11/20/2025 showed an objective stating "Given physical assistance, will walk 10 consecutive minutes, three days per week for 12 consecutive months." On 08/24/2026 at 3:00 PM, Client #2 arrived home from day program in a wheelchair. At 3:28 PM, DSP #6 propelled the client to the bathroom for a haircut and returned him to the living room shortly afterward. At 6:00 PM, DSP #3 assisted the client to the dining table for dinner. During an interview on 08/25/2026 at 3:30 PM, DSP #6 indicated that Client #2 refuses on most occasions or requires physical assistance. There was no evidence that Client #2 participated in the required walking program as outlined in his IPP. On 08/26/2026 at 11:30 AM, a review of the training records showed that DSPs #5 and #6 received	W0194			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0194	Continued from page 6 training on clients IPPs on 11/24/2025 and 04/09/2026.	W0194			
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement each client's Individual Program Plan (IPP) for two of the three clients in the sample (Clients #1 and #2). Findings included: 1. On 08/24/2026 at 1:00 PM, a review of Client #1's IPP dated 09/04/2025, showed an objective that stated: "Given verbal cues, will ambulate up and down the stairs from the basement to the first floor three out of three trials, three day per week for six consecutive months. " Observations from 08/24/2026 through 08/26/2026 showed no evidence that Client #1 ambulated up or down the stairs. On 03/25/2025 at 11:00 AM, a review of Client #1's IPP data documentation book revealed no data sheets documenting stair-ambulation participation. On 08/25/2026 at 11:10 AM, a review of Client #1's Physical Therapy assessment 01/05/2026 and quarterly reviews dated 03/04/2026 and 05/08/2026 showed recommendations for a program in which Client #2 should ambulate up and down the stairs three times per week to her increase endurance. During an interview on 08/25/2026 at 1:30 PM, the Qualified Intellectual Disability Professional (QIDP) stated that Client #1 does not participate in the stair ambulation program due to his unsteady gait but confirmed that the client does walk throughout the facility and in the community. 2. On 08/24/2026 at 1:00 PM, a review of Client #1's	W0249			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0249	Continued from page 7 IPP dated 09/04/2025, revealed an additional objective that stating "Given verbal cues, will ambulate in the community for 10 minutes, three days per week for six consecutive months. On 08/24/2026 at 3:18 PM, DSP #6 assisted Client #1 to the dining room table for a snack. At 6:00 PM, DSP #3 assisted the client to the dining table for dinner. On 08/27/2026 at 11:40 AM, DSP #6 was observed walking Client #1 around the facility for approximately 12 minutes. During an interview at 3:30 PM, DSP #6 stated that Client #1 participates in a walking program and is doing much better since he arrived at the facility. When asked whether the client walk in the community, DSP #6 stated, "No not generally because he uses a wheelchair when in the community." There was no evidence that the staff allowed the client to participate in his community walks, as required by his IPP. 3. On 08/24/2026 at 1:30 PM, the review of Client #2's IPP dated 11/20/2025 showed an objective stating "Given physical assistance, will walk 10 consecutive minutes, three days per week for 12 consecutive months." On 08/24/2026 at 3:00 PM, Client #2 arrived home from day program in a wheelchair. At 3:28 PM, DSP #6 propelled the client to the bathroom for a haircut and returned him to the living room shortly afterward. At 6:00 PM, DSP #3 assisted the client to the dining table for dinner. During an interview on 08/25/2026 at 3:30 PM, DSP #6 indicated that Client #2 refuses on most occasions or requires physical assistance. There was no evidence that Client #2 participated in the required walking program as outlined in his IPP.	W0249			
W0252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is NOT MET as evidenced by: Findings included:	W0252			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0252	Continued from page 8 On 08/24/2026 at 1:00 PM, a review of Client #1's IPP dated 09/04/2025 revealed an objective that stating: "Given verbal cues, will ambulate in the community for 10 minutes, three days per week for six consecutive months. The IPP required staff to document the client's performance using 15, 30 or 60 minutes increments on the IPP data sheet. On 08/26/2026 at 11:30 AM, the review of Client #1's IPP data sheets from 01/2026 through 05/2026 showed that staff documented using terms such as hand-over-hand, physical assistance, model demonstration rather than the required time-increment data codes. On 08/26/2026 at 12:30 PM, during an interview, the Qualified Intellectual Disabilities Professional confirmed that direct support professionals did not document using the required IPP data codes and added that additional staff would be needed.	W0252			
W0365	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(4) An individual medication administration record must be maintained for each client. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and record review, the facility failed to maintain an accurate individual Medication Administration Record (MAR) for one of the three sampled clients (Client #3). Findings included: A review of the facility's policy titled "Medication Administration" stated that all as-needed (PRN) medications administered must be signed on the Medication Administration Record (MAR) immediately after administration, and an explanation documented on the back of the MAR indicated the reason the medication was administered. The policy further stated that failure to complete this documentation constitutes a medication error.	W0365			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0365	Continued from page 9 A review of Client #3's Physician's Orders Sheet (POS) dated July 2026 showed an order for Acetaminophen 500 milligram (mg)/15 milliliter (mL) and Ibuprofen 600 mg to be administered as needed for pain. On 08/24/2026 at 7:46 PM, Licensed Practical Nurse (LPN) #2 stated that she would administer PRN pain medication to Client #3 because he was experiencing pain due to kidney stones. At that time, LPN #2 displayed both PRN pain medications – Acetaminophen 500 mg/15 mL and Ibuprofen 600 mg – and Client #3's POS to the surveyor prior to administration. On 08/25/2026 at 1:20 PM, during a reconciliation of the MAR, it was noted that LPN #2 had not signed the MAR to indicate which PRN pain medication was administered to Client #3, the time of administration, or the reason for administering the PRN medication. During an interview on 08/25/2026 at 1:25 PM, LPN #2 stated that she administered both Acetaminophen 500 mg/15 mL and Ibuprofen 600 mg to Client #3 and reported that she forgot to sign the MAR. LPN #2 then signed the MAR; however, she did not document the reason for administering the PRN medications as required by facility policy.	W0365			
W0381	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(1) The facility must store drugs under proper conditions of security. This STANDARD is NOT MET as evidenced by: Findings included: The review of a facility policy titled, "Medication Administration" dated 05/01/2026 listed that all medications and other drugs, including treatment items, shall be stored in a locked cabinet or room, inaccessible to persons we support and visitors. 1. On 08/24/2026 at 4:20 PM, Licensed Practical Nurse (LPN) #2 entered the nurse office/medication room opened two unlocked cabinets; one cabinet	W0381			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0381	Continued from page 10 stored Client #3's medications and the second cabinet contained Scheduled II medications. The LPN #2 retrieved a set of keys from an unlocked box on the counter and then locked cabinets. During evening medication administration on 08/24/2026 at 4:31 PM, Trained Medication Employee (TME) #1 retrieved a key from the same unlocked box on the counter, which contained keys to cabinets that stored Client #1, #2, #3, #4, #5, #6's medications, including controlled substance medications. At 4:40 PM, TME #1 stated in an interview that "the locked box has been broken since last week." At 5:30 PM, the LPN Coordinator confirmed the medication key box has been broken for approximately two weeks and stated that he informed the Registered Nurse Supervisor. 2. On 08/26/2026 at 2:40 PM, during the environmental inspection, a vial of Ipratropium bromide plus albuterol sulfate 3 ml was found inside Client #2's personal hygiene kit located in the client's bathroom. During an interview with the Qualified Intellectual Disabilities Professional (QIDP) stated that Client #2 is not prescribed Ipratropium Bromide plus albuterol sulfate and does not receive nebulizer treatment. A review of Client #2's physician orders (POS) dated 08/01/2026, confirmed this. The QIDP further stated that Clients #4 and #6 receive nebulizer treatment. A review of Client #6's POS dated 08/01/2026 showed an order for Ipratropium-Albuterol Outer UD 3 mg, one vial via nebulizer every four hours as needed for shortness of breath/cough. The medication found in Client #2's personal hygiene kits was unsecured and accessible, posing a risk for all clients.	W0381			
W0383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area.	W0383			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0383	Continued from page 11 This STANDARD is NOT MET as evidenced by: Based on observation, interview, and record reviews the facility failed to ensure only authorized persons may have access to the keys to the drug storage area for three of the 17 personnel in the facility (Qualified Intellectual Disabilities Professional, Direct Support Professionals #1 and #2). Findings included: The review of a facility policy titled, "Medication Administration" dated 05/01/2026 listed that "all medications and other drugs, including treatment items, shall be stored in a locked cabinet or room, inaccessible to persons we support and visitors." 1. On 08/24/2026 at 4:20 PM, Licensed Practical Nurse (LPN) #2 entered the nurse office/medication room opened two unlocked cabinets; one cabinet stored Client #3's medications and the second cabinet contained Scheduled II medications. The LPN #2 retrieved a set of keys from an unlocked box on the counter and then locked cabinets. During evening medication administration on 08/24/2026 at 4:31 PM, Trained Medication Employee (TME) #1 retrieved a key from the same unlocked box on the counter, which contained keys to cabinets that stored Client #1, #2, #3, #4, #5, #6's medications, including controlled substance medications. At 4:40 PM, TME #1 stated in an interview that "the locked box has been broken since last week." At 5:30 PM, the LPN Coordinator confirmed the medication key box has been broken for approximately two weeks and stated that he informed the Registered Nurse Supervisor. 2. On 08/26/2026 at 2:40 PM, during the environmental inspection, a vial of Ipratropium bromide plus albuterol sulfate 3 ml was found inside Client #2's personal hygiene kit located in the client's bathroom. During an interview with the Qualified Intellectual Disabilities Professional (QIDP) stated that Client #2 is not prescribed Ipratropium Bromide plus albuterol sulfate and does not receive nebulizer treatment. A	W0383			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0383	Continued from page 12 review of Client #2's physician orders (POS) dated 08/01/2026, confirmed this. The QIDP further stated that Clients #4 and #6 receive nebulizer treatment. A review of Client #6's POS dated 08/01/2026 showed an order for Ipratropium-Albuterol Outer UD 3 mg, one vial via nebulizer every four hours as needed for shortness of breath/cough. The medication found in Client #2's personal hygiene kits was unsecured and accessible, posing a risk for all clients. On 08/26/2026 at 12:10 PM, a review of the personnel records showed that QIDP, DSP #1, and DSP #2 are not trained medication employees.	W0383			
W0418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. This STANDARD is NOT MET as evidenced by: Based on observations, interview, and record reviews, the facility failed to provide a comfortable mattress for one of the six clients in the facility (Client #5). Findings included: On 08/26/2026 at 3:10 PM, during an environmental inspection accompanied by the Qualified Intellectual Disabilities Professional (QIDP), Client #5's mattress was observed to be worn and sunken in the middle, indicating that it no longer provided adequate support. At that time, the QIDP acknowledged that Client #5's mattress was worn and no longer supportive.	W0418			
W0425	CLIENT BATHROOMS CFR(s): 483.470(d)(2) The facility must provide for individual privacy in toilets, bathtubs, and showers.	W0425			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0425	Continued from page 13 This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to provide individual privacy in a bathroom used by clients for four of the six clients in the facility (Clients #1, #2, #3 and #5). Findings included: On 08/26/2026 at 3:15 PM, during an environmental inspection, the bathroom used by the clients was observed with a window blind that was improperly installed and in disrepair. Slats were bent and missing, preventing the blind from fully closing. As a result, gaps were present between the slats, allowing a clear line of sight into the restroom from outside the window. During an interview at the time of the observation, the Qualified Intellectual Disabilities Professional acknowledged that the blind was improperly installed and confirmed that the slats were in disrepair, preventing the blind from providing full coverage of the window.	W0425			
W0454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to prevent the spread of infection for two of the two clients in the sample (Clients #1 and 2). Findings included: 1. On 08/24/2026 at 3:10 PM, Client #1 arrived home from day program and was transferred to his recliner chair. He was observed hand mouthing. At 3:18 PM, Direct Support Professional (DSP) #6 provided the client with a cup of juice and yogurt for his afternoon snack and assisted him back to the recliner chair in the living room. At 3:25 PM, the client was again, observed hand-mouthing for several minutes. DSP #6 then began a ball toss activity with the	W0454			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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	
W0454	Continued from page 14 client, during which the client continued to hand-mouth. At no time did DSP #6 wash or sanitize the client's hands before his snack, after his snack, or during the period in which he repeatedly hand mouthed. During an interview with the Qualified Intellectual Disabilities Professional (QIDP) on 08/26/2026, she stated that staff should encourage Client #1 to wash their hands after hand-mouthing and then assist him to participate in activities involving hand use. The further also stated that staff received training infection control. Review of the training records on 08/26/2026 at 11:00 AM showed that DSPs #5 and #6 had received training on infection control on 11/25/2025. 2. On 08/25/2026 at 5:00 PM. a diaper soiled with urine and feces was observed lying on the bathroom floor. During an interview on 08/26/2026 at 1:00 PM, the Registered Nurse Supervisor stated that DSP #5 and #6 should discard soiled diapers immediately after a client has been changed. She reported she had spoken that she would speak with the DSP's on duty to determine who left the soiled diaper in the bathroom. A review of the training records on 08/26/2026 at 1:30 PM, showed that DSP's #5 and #6 received training on infection control on 11/25/2025. 3. On 08/26/2026 at 3:25 PM, during an environmental inspection of the shared bedroom occupied by Clients #1 and #2, both clients' electric toothbrushes were observed standing upright in charging docks on their bedside nightstands. The toothbrushes were uncovered, leaving the brush heads fully exposed to dust, airborne particles, and potential contamination from the surrounding environment. During an interview at the time of the observation, the Qualified Intellectual Disabilities Professional acknowledged that the toothbrushes were not stored in a sanitary manner.	W0454			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G216		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE, WASHINGTON, District of Columbia, 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
W0460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially prescribed diets. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that each client's received a modified diet in accordance with the assessed needs and physician orders, for one of the three clients residing in the facility (Client #2). Findings included: A review of Client #2's physician order sheet (POS) dated 08/01/2026 documented the following diet order: 1800 calories, high fiber, low fat, low cholesterol, no concentrated sweets, no added salt, high iron diet, pureed, ten cups of water or sugar free beverages at meals and between meals daily. On 08/24/2026 at 3:11 PM, during snack observations, Client #2 received a cup of light cranberry juice. At 6:00 PM, during dinner observations, Client #2 again received a cup of light cranberry juice mixed and on 08/25/2026 during lunch observation, the client received another cup of light cranberry juice. During an interview on 08/25/2026 at 3:00 PM, DSP #4 reported that she provided Client #2 light cranberry juice mix with water no sugar free cranberry juice or apple juice was available. She confirmed that the facility did not have any sugar-free juice in the facility.			W0460			