

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

PRINTED: 05/25/2010
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 05/06/2010
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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 929 55TH STREET, NE WASHINGTON, DC 20019
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(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
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from May 5, 2010 through May 6, 2010. A sample of three clients was selected from a population of five men and women with varying degrees of intellectual disabilities. One of the three sampled clients was admitted to the facility on April 23, 2010 (less than 2 weeks prior to the survey). In addition, a focused review was conducted of the medical care and follow-up received by another (fourth) client who was being treated for a breast anomaly. This survey was initiated utilizing the fundamental process.</p> <p>The findings of the survey were based on observations, interviews with staff and clients in the home and at three day programs, as well as a review of client and administrative records, including incident reports.</p>	W 000	<p><i>Received 4/21/10</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services met the needs of one of the three sampled clients. [Client #2]</p> <p>The findings include:</p> <p>Day Program staff did not notify the home when Client #2 did not consume most of his meal, as previously agreed upon, as follows:</p> <p>On May 5, 2010, at 5:08 p.m., the Residential</p>	W 120	<p>W 120</p> <p>In the future the QMRP will ensure that the day program will regularly communicate food related concerns at least on a weekly basis. The QMRP visited the Day Program and in serviced the staff on the diet, mealtime protocol and Weekly dietary record. Weekly dietary Record will now be sent to the home every Friday.</p>	5/27/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Swan T. Swan</i>	TITLE <i>VP Operations</i>	(X6) DATE <i>6/1/10</i>
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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.

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W 120 Continued From page 1
Coordinator (RC) stated that in the past, Client #2's day program had notified the home if/when he refused to eat his lunch. He and the QMRP visited the day program routinely and it was agreed that the day program would inform them if there were any concerns with Client #2's food intake. The RC further indicted that there had been no recent reports of poor food intake.

W 120

The QMRP was interviewed the next morning, at 10:27 a.m. She shared the same information as the RC the night before, stating that the day program "will call or send something home." The LPN, who was in the same room at the time, corroborated the QMRP's information. This was verified moments later, at approximately 10:40 a.m., through review of the client's day program correspondence. On March 2, 2010, and on March 12, 2010, the day program nurse had sent notes home reporting Client #2's poor food and liquid intake. Attached were "Weekly Dietary Record" forms for the periods February 22 - 26, 2010 and March 3 - 12, 2010 that provided supportive data. There was no evidence of any correspondence received by the home from the day program since March 2010. Both the QMRP and the LPN stated that the facility had not received any communications recently of food-related concerns. Neither was aware that the client had been refusing to eat his lunches that week.

[Note: Review of Client #2's weight chart confirmed that he had gained weight beginning in late 2009 and as of April 2010, he remained within his "desirable weight range."]

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

W 249

As soon as the interdisciplinary team has

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W 249	<p>Continued From page 2</p> <p>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, interview, and record review, the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for three of five clients in the sample. (Client #2, #4 and #5)</p> <p>The finding includes:</p> <p>The facility failed to implement Client #2, #4 and #5's self medication programs as evidenced below:</p> <p>1. Observation of medication administration on May 5, 2010, at 7:25 a.m., revealed TME #1 (Trained Medication Employee) placed all medications in a cup of chocolate pudding and spoon-fed the medications to Client #2. Further observation revealed TME #1 held a cup of water to Client #2's mouth in order for the client to consume the water with one (1) physical prompt.</p> <p>Face-to-face interview with the Supervisory LPN #1 on May 5, 2010, at approximately 8:25 a.m., revealed Client #2 had a self-medication program which was to be implemented daily. Further interview revealed data was to be the documented on the self-medication program</p>	W 249	<p>W249 1. 2. & 3. All TME staff have been retrained in Medication Policy and Procedures, Documentation, individuals' self medication programs. In the future the RN Supervisor will ensure she completes the TME observation record after monitoring the TME at least on a monthly basis. The RN Supervisor will conduct in services on Medication P/P, documentation and changes made on the IPP at least annually or when needed.</p>	5/29/10
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W 249	<p>Continued From page 3</p> <p>three times a week (Monday, Wednesday and Friday).</p> <p>Review of Client #2's self-medication program dated May, 2010, on May 5, 2010, at approximately 8:55 a.m., indicated Client #2's self-medication program was as follows:</p> <ul style="list-style-type: none"> a. Take medications from TME (Trained Medication Employee)/Nurse; b. Takes his water and c. Put cup in trash. <p>There was no evidence that the client was given the opportunity to fully participate in the self-medication program.</p> <p>2. Observation of medication administration on May 5, 2010, at 7:15 a.m., revealed TME #1 placed all medications in a cup of applesauce and spoon-fed the medications to Client #4. Further observation revealed TME #1 held a cup of water to Client #4's mouth in order for the client to consume the water with one (1) physical prompt.</p> <p>Face-to-face interview with the Supervisory LPN #1 on May 5, 2010, at approximately 8:30 a.m., revealed Client #4 had a self-medication program which was to be implemented daily. Further interview revealed data was to be the documented on the self-medication program three times a week (Monday, Wednesday and Friday).</p> <p>Review of Client #4's self-medication program dated May, 2010, on May 5, 2010,, at</p>	W 249		
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W 249	<p>Continued From page 4</p> <p>approximately 9:00 a.m., indicated Client #4's self- medication program was as follows:</p> <p>a. Identify Medication- Lactulose;</p> <p>b. Identify Purpose - Constipation</p> <p>There was no evidence that the client was given the opportunity to fully participate in the self-medication program.</p> <p>3. Observation of medication administration on May 5, 2010, at 7:00 a.m., revealed TME #1 placed all medications in a cup of applesauce and spoon-fed the medications to Client #5. Further observation revealed TME #1 held a cup of water to Client #5's mouth in order for the client to consume the water with one (1) physical prompt.</p> <p>Face-to-face interview with the Supervisory LPN #1 on May 5, 2010, at approximately 8:35 a.m., revealed Client #5 had a self-medication program which was to be implemented daily. Further interview revealed data was to be the documented on the self-medication program three times a week (Monday, Wednesday and Friday).</p> <p>Review of Client #5's self-medication program dated May, 2010, on May 5, 2010,, at approximately 9:15 a.m., indicated Client #5's self- medication program was as follows:</p> <p>a. Identify Medication- Docusate;</p> <p>b. Identify Purpose - Constipation</p> <p>There was no evidence that the client was given</p>	W 249		
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W 249	Continued From page 5 the opportunity to fully participate in the self-medication program.	W 249		
W 381	<p>483.460(I)(1) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must store drugs under proper conditions of security.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security for five of five clients residing in the facility. (Clients # 1, #2, #3, # 4 and # 5)</p> <p>The finding includes:</p> <p>On May 5, 2010, at approximately 7:33 a.m., TME #1 (Trained Medication Employee) was observed to leave the door to the medication room open when she administered medications in the kitchen to Client #2. Further observation revealed the key was left in the lock of the opened medication cabinet door. Further observation revealed Clients #1, #3, #4, #5 and direct care staff were sitting in the living room next to the opened medication room.</p> <p>In an interview with TME #1 on May 5, 2010, at approximately 8:00 a.m., it was acknowledged the door to the medication room was left open when she administered medications in the kitchen to Client #2.</p> <p>There was no evidence drugs that all drugs were stored under proper conditions of security at all times.</p>	W 381	<p>W381</p> <p>All TME staff have been retrained in Medication Policy and Procedures, documentation and the safe storage of medications</p> <p>In the future the RN Supervisor will ensure she completes the TME observation record after monitoring the TME at least on a monthly basis. The RN Supervisor will conduct in services on Medication P/P, documentation and safety principles in medication administration.</p>	5/29/10
W 455	483.470(I)(1) INFECTION CONTROL	W 455		

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W 455	<p>Continued From page 6</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 observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for five of five clients residing in the facility. (Clients #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>On May 5, 2010, at approximately 6:55 a.m., the TME #1 (Trained Medication Employee) was observed to use sanitizer to cleanse her hands prior to administering medications to Client #1. However, TME #1 touched the MAR's, blister packs and then touched each of Client #1's medications with her bare hands when she placed the medications in a small clear plastic envelope before placing the envelope into the pill crusher.</p> <p>During a face to face interview with TME #1 on May 5, 2010, at approximately 7:05 a.m., it was acknowledged that after using hand sanitizer to cleanse her hands the TME #1 touched the MAR's, blister packs and then touched each medication with her bare hands.</p> <p>There was no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p>	W 455	<p>I 455</p> <p>All TME staff have been retrained in Infection control especially related to Medication Policy and Procedures. In the future the RN Supervisor will ensure she completes the TME observation record after monitoring the TME at least on a monthly basis. The RN Supervisor will conduct in services on Medication P/P, safety precautions and infection control procedures at least on an annual basis or when needed.</p>	5/29/10
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Health Regulation 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 05/06/2010
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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 5, 2010 through May 6, 2010. A sample of three residents was selected from a population of five men and women with varying degrees of intellectual disabilities. One of the three sampled residents was admitted to the facility on April 23, 2010 (less than 2 weeks prior to the survey). In addition, a focused review was conducted of the medical care and follow-up received by another (fourth) resident who was being treated for a breast anomaly.</p> <p>The findings of the survey were based on observations, interviews with staff and residents in the home and at three day programs, as well as a review of resident and administrative records, including incident reports.</p>	I 000		
I 226	<p>3510.5(c) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(c) Infection control for staff and residents;</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for five of five residents residing at the home. (Residents #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>On May 5, 20010, at approximately 6:55 a.m., the TME #1 (Trained Medication Employee) was observed to use sanitizer to cleanse her hands prior to administering medications to Resident #1.</p>	I 226	<p>I 226 All TME staff have been retrained in Infection control especially related to Medication Policy and Procedures. In the future the RN Supervisor will ensure she completes the TME observation record after monitoring the TME at least on a monthly basis. The RN Supervisor will conduct in services on Medication P/P, safety precautions and infection control procedures at least annually or when needed.</p>	5/29/10

Health Regulation Administration

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

TITLE

 (X6) DATE
 6/1/10

Health Regulation Administration

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I 226	Continued From page 1 However, TME #1 touched the MAR's, blister packs and then touched each of Resident #1's medications with her bare hands when she placed the medications in a small clear plastic envelope before placing the envelope into the pill crusher. During a face to face interview with TME #1 on May 5, 2010, at approximately 7:05 a.m., it was acknowledged after using hand sanitizer to cleanse her hands, TME #1 touched each of Resident #1's medications with her bare hands. There was no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.	I 226		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute 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 resident participated in a self-medication training program, for three of the three residents in the facility on a self-medication program. (Resident # 2, #4 and #5) The findings include:	I 436	I436 All TME staff have been retrained in Medication Policy and Procedures, documentation, individuals' IPPs and the safe storage of medications In the future the RN Supervisor will ensure she completes the TME observation record after monitoring the TME at least on a monthly basis. The RN Supervisor will conduct in services on Medication P/P, documentation, infection control, IPP changes and safety principles in medication administration.	5/29/10

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I 436	Continued From page 2 1. Observation of medication administration on May 5, 2010, at 7:25 a.m., revealed TME #1 (Trained Medication Employee) placed all medications in a cup of chocolate pudding and spoon-fed the medications to Resident #2. Further observation revealed TME #1 held a cup of water to Resident #2's mouth in order for the client to consume the water with one (1) physical prompt. Face-to-face interview with the Supervisory LPN #1 on May 5, 2010, at approximately 8:25 a.m., revealed Resident #2 had a self-medication program which was to be implemented daily. Further interview revealed data was to be the documented on the self-medication program three times a week (Monday, Wednesday and Friday). Review of Resident #2's self-medication program dated May, 2010, on May 5, 2010,, at approximately 8:55 a.m., indicated Resident #2's self- medication program was as follows: a. Take medications from TME /Nurse; b. Takes his water and c. Put cup in trash. There was no evidence that the resident was given the opportunity to fully participate in the self- medication program. 2. Observation of medication administration on May 5, 2010, at 7:15 a.m., revealed TME #1 placed all medications in a cup of applesauce and spoon-fed the medications to Resident #4. Further observation revealed the TME #1 held a	I 436		

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I 436	<p>Continued From page 3</p> <p>cup of water to Resident #4's mouth in order for the client to consume the water with one (1) physical prompt.</p> <p>Face-to-face interview with the Supervisory LPN #1 on May 5, 2010, at approximately 8:30 a.m., revealed Resident #4 had a self-medication program which was to be implemented daily. Further interview revealed data was to be the documented on the self-medication program three times a week (Monday, Wednesday and Friday).</p> <p>Review of Resident #4's self-medication program dated May, 2010, on May 5, 2010,, at approximately 9:00 a.m., indicated Resident #4's self- medication program was as follows:</p> <ul style="list-style-type: none"> a. Identify Medication- Lactulose; b. Identify Purpose - Constipation <p>There was no evidence that the resident was given the opportunity to fully participate in the self- medication program.</p> <p>3. Observation of medication administration on May 5, 2010, at 7:00 a.m., revealed TME #1 placed all medications in a cup of applesauce and spoon-fed the medications to Resident #5. Further observation revealed TME #1 held a cup of water to Resident #5's mouth in order for the client to consume the water with one (1) physical prompt.</p> <p>Face-to-face interview with the Supervisory LPN #1 on May 5, 2010, at approximately 8:35 a.m., revealed Resident #5 had a self-medication program which was to be implemented daily.</p>	I 436		
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Health Regulation 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 05/06/2010
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 436	Continued From page 4 Further interview revealed data was to be the documented on the self-medication program three times a week (Monday, Wednesday and Friday). Review of Resident #5's self-medication program dated May, 2010, on May 5, 2010,, at approximately 9:15 a.m., indicated Resident #5's self- medication program was as follows: a. Identify Medication- Docusate; b. Identify Purpose - Constipation There was no evidence that the resident was given the opportunity to fully participate in the self- medication program.	I 436			