

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 14TH STREET, NW WASHINGTON, DC 20011
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from April 11, 2012 through April 13, 2012. A sample of three clients was selected from a population of three men and three women with various degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.

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

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

W 111 483.410(c)(1) CLIENT RECORDS

W 111

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that client records reflected accurate information, for one of the three clients in the sample. (Client #1)

The findings include:

On April 12, 2012, beginning at approximately 9:05 p.m., review of Client #1's physician orders (POs) revealed the following incomplete or inaccurate orders:

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

W111

All nursing staff was trained in Medication Administration Policy and Procedure – documentation. In the future the RN Supervisor will ensure that all POS/MAR records are reviewed for accuracy and audits of the medical records are completed at least monthly.

5/10/12

See attached – Corrected POS and MAR, in service record and medical record audit

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

Smaw J. Sloan

TITLE

VP Operations

(X6) DATE

5/17/12

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

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W 111 Continued From page 1

W 111

1. During the entrance conference on April 11, 2012, at approximately 10:00 a.m., the qualified intellectual disabilities professional (QIDP) and licensed practical nurse coordinator (LPNC) revealed that Client #1 was admitted to the facility on May 18, 2011, with a left Ischial wound and a left heel wound. Further interview revealed the client sustained another wound on the left foot after she was hospitalized on September 15, 2011.

On April 13, 2012, beginning at 3:00 p.m., review of Client #1's medical chart revealed a nursing assessment dated December 15, 2011. Continued review revealed the wounds were identified as wound #1 and wound #2.

The facility failed to identify wound #1 and #2 as the left Ischial wound, Left heel wound or left foot wound.

2. May 18, 2011 - "Sodium cl 0.9% for Irrigation as directed."

Interview with the qualified intellectual disabilities professional (QIDP) and licensed practical nurse coordinator (LPNC) on April 11, 2012, at approximately 10:00 a.m., revealed the client had a left Ischial wound and a wound on the left heel. However; the order failed to indicate which wound was to be irrigated.

3. August 23, 2011 - "Bactrim DS tab by mouth every twelve hours at 7 a.m., and 7 p.m., for 28 doses."

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W 111 Continued From page 2 W 111

The order failed to show why the client was prescribed the Bactrim DS.

4. November 1, 2011 - first order "Left Ischium ulcer - apply Iodosorb packing every other day." The second order documented "wound #1 left Ischial, cleanse wound gently with sterile normal saline, pack wound every other day with Iodoform packing, cover with abdominal pad every other day and secure.

The order failed to prescribe one order to pack the left Ischial.

5. December 28, 2011 - "Change dressing on back three or four times a day until healed.

The order failed to indicate a specific frequency for the dressing change.

6. January 11, 2012 - Change sterile gauze strip to Iodoform strip twice a day.

Review of the wound clinic assessment dated January 11, 2012 on April 12, 2012, beginning at 11:00 a.m., revealed the client was provided treatment to the left Ischial wound and the left heel wound.

The order failed to indicate which wound required the Iodoform strip twice a day.

7. March 14, 2012 - Change Iodoform packing strips to plain packing strips to left Ischial wound everyday. May also use Iodoform strips.

The order failed to prescribe a specific packing strip for the left Ischial wound.

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W 114 483.410(c)(4) CLIENT RECORDS

W 114

Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.

This STANDARD is not met as evidenced by:
Based on interview and record review the facility failed to ensure all persons making entries into the medical record dated and signed his/her entry for one of the three clients in the sample. (Client #1)

The finding includes:

During the entrance conference on April 11, 2012, at approximately 10:00 a.m., the qualified intellectual disabilities professional (QIDP) and licensed practical nurse coordinator (LPNC) revealed that Client #1 was admitted to the facility on May 18, 2011 with a left Ischial wound and a left heel wound. Further interview revealed the client sustained another wound on the left foot after she was hospitalized on September 15, 2011.

Review of Client #1's medical record on April 12, 2012, revealed that the Primary Care Physician (PCP) and the licensed practical nurse coordinator (LPNC) failed to date and sign physician orders as evidenced below:

1. Tylenol 325 mg tabs by mouth every six hours for pain prn.

The facility failed to indicate the date and time of the aforementioned order.

2. Apply vitamin A and D ointment to buttocks

W114

All nursing staff was trained in Medication Administration Policy and Procedure – documentation. In the future the RN Supervisor will ensure that all POS/MAR records are reviewed for accuracy and audits of the medical records are completed at least monthly.

See attached – Corrected POS and MAR, in service record and medical record audit

5/10/12

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W 114 Continued From page 4
after each diaper change.

The facility failed to indicate the date and time of the aforementioned order.

3. June 18, 2011 order - "Vascular evaluation to rule out deep vein thrombosis and use of ted hose, physical therapy evaluation, cardiology evaluation, neurology evaluation, (baclofen use) plastic surgery evaluation to rule out abscess vs. decubitus, psychology evaluation, bilateral MRI of pelvic without contrast."

The PCP and the LPNC failed to date and state the time of the order.

4. July 26, 2011 order - " DuoDerm four times a week (every other day) Boot prafo for lateral calcaneous."

The PCP and the LPNC failed to date and state the time of the order.

5. July 29, 2011 order - keep legs elevated while in bed and in wheelchair."

The PCP failed to date the order. The time of the order was not indicated.

6. August 31, 2011 order - "Cleanse left Ischial with sterile normal saline and pack wound with one inch Idoform strip. Cover with abdominal pad everyday. discontinue wet to dry dressing."
"Apply topical Isosorb and cover with abdominal pad everyday. discontinue wet to dry dressing"

The medical staff failed to indicate a time on the order.

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W 114

7. October 25, 2011 order - Discontinue hydrogel to left Ischial and left heel wound, start Iodosord.

The LPNC failed to sign and date the order. The time of the order was not indicated.

8. October 20, 2011 order - Augmentin 500mg/125mg tablet. One tablet by mouth three times a day for seven days to complete fourteen days original order.

The medical staff failed to indicate a time on the order.

9. October 21, 2011 order - Discontinue Baclofen 10mg by mouth twice a day. Start Baclofen 5mg by mouth twice a day for contractures.

The medical failed to indicate a time on the order.

10. December 15, 2011 order - MRI without contrast to rule out osteomyelitis to left Ischial, left heel and left foot.

The medical staff failed to indicate a time on the order.

11. December 27, 2011 order - Cleanse back blisters with sterile normal saline and apply neosporin until healed.

The LPNC failed to date the order. The time of the order was not indicated.

12. February 15, 2012 order - "Discontinue left Ischial dressing twice a day. Cleanse with sterile normal saline. Pack Iodoform one inch strip in

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W 114 Continued From page 6
wound. Cover with abdominal pad and secure with tape everyday." "Discontinue dressing every other day to the left heel. Start cleansing with sterile normal saline. Apply Isosorb paste and cover with abdominal pad and wrap with keflex. Secure with tape everyday.

W 114

The medical staff failed to indicate the time of the order.

13. February 16, 2012 order - Discontinue Iodosorb, start Keflex AMD after cleansing with sterile normal saline. Apply dressing and secure with tape everyday.

The facility failed to indicate the time of the order.

14. March 14, 2012 order - Change Iodoform packing strips to plain packing strips everyday. May also use Iodoform strips.

The PCP and the LPNC failed to date and state the time of the order.

W 322 483.460(a)(3) PHYSICIAN SERVICES

W 322

The facility must provide or obtain preventive and general medical care.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure preventive services were provided, for one of the three clients in the sample. (Client #1)

The findings include:

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W 322 Continued From page 7
1. Observation on April 11, 2012, at approximately 9:30 a.m., revealed the licensed practical nurse coordinator (LPNC) was providing wound care to Client #1's left Ischial wound.

W 322

On April 12, 2012, at 11:00 a.m., review of the physician's orders dated June 18, 2011, revealed an order to obtain a wound care evaluation for Client #1. Continued review of the medical records revealed the client had an appointment at the wound care specialty clinic on June 28, 2011; however, the client arrived too late. Therefore the appointment was rescheduled for July 26, 2011. Interview with the LPNC on April 13, 2012, at 4:25 p.m., confirmed Client #1 arrived late to the first appointment because the driver was unable to find a parking space. Further record review revealed the client's July 2011 appointment was cancelled. According to interview with the LPNC on April 13, 2012, at 4:26 p.m., the clinic canceled the July 2011 appointment. Additional review of Client #1's medical record revealed a wound clinic consult dated August 17, 2011. The consult revealed that the client had a stage three left Ischial wound and a stage three left heel wound. Continued review revealed a recommendation for the client to follow up in one week.

W322

In the future the nursing staff will ensure that all referral reports, radiology results, lab reports and specialty recommendations are received and the PCP is notified in a timely manner. All nurses were in serviced to record the date and time of notification to the PCP

4/12/12

See attached in service record on documentation

Further review of the medical records on April 12, 2012 at 11:40 a.m., revealed an MRI of the pelvic area dated July 21, 2011, that Client #1 was diagnosed with osteomyelitis (bone infection). Interview with the LPNC on April 12, 2012, at approximately 11:55 a.m., revealed the left Ischial is difficult to heal with osteomyelitis.

The facility's nursing services failed to obtain

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W 322 Continued From page 8 W 322

Client #1's wound care evaluation timely as ordered by the primary care physician.

2. The facility's nursing personnel failed to provide evidence that Client #1's PCP was made aware of a change in her wound condition.

Record review on April 12, 2012, beginning at 10:00 a.m., revealed a nursing note dated October 20, 2011, that indicated Client #1's "left heel wound appears necrotic around the surrounding tissues and in the center."

Review of the medical records on April 12, 2012, beginning at approximately 10:30 a.m., failed to reveal that the primary care physician (PCP) was made aware of the aforementioned change in condition.

W 331 483.460(c) NURSING SERVICES W 331

The facility must provide clients with nursing services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on observation, staff interviews and record review, the facility's nursing staff failed to provide each client with nursing services in accordance with their needs, for one of the three clients in the sample. (Client #1)

The findings include:

1. The facility's nursing personnel failed to assess for and/or provide pain management treatment for Client #1.

On April 11, 2012, at approximately 9:30 a.m., the

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W 331 Continued From page 9

surveyor heard a loud cry. Upon inspection, the surveyor observed the licensed practical nurse coordinator (LPNC) providing wound care to Client #1's left Ischial decubitus.

On April 12, 2012, at approximately 9:30 a.m., the LPNC informed the surveyor that she was about to provide wound care to Client #1's left Ischial ulcer. At 9:35 a.m., the LPNC began to provide the wound care treatment. At 9:40 a.m. the client cried out loud when the LPNC used a long Q-tip with saline water to clean inside the left Ischial wound then packed it with packing strips. The surveyor asked the client if she was in pain. The client responded "Yes". The LPNC overheard the client and responded that the client was "showing off because the surveyor was in the facility." During this time, the LPNC failed to assess the client for pain.

Review of the client's physician's order dated April 1, 2012, revealed an order to administer Tylenol "two tabs (650mg) by mouth every six hours as needed for hip/foot pain."

2. The facility's nursing personnel failed to ensure Client #1's wound dressing was maintained.

On April 12, 2012, beginning at 11:00 a.m., review of the wound clinic assessments revealed the following:

a. On August 31, 2011, Client #1 arrived at the clinic without her wound dressing to the left Ischial. The assessment document that the "Aid stated the patient's nurse was on vacation ." Interview with the qualified intellectual disabilities professional (QIDP) on April 13, 2012, at 4:15

W 331

W331

All the nursing staff have been in serviced on the wound dressing procedure and pain management procedure.

This individual now receives her pain medication routinely an hour prior to her dressing change if she experiences pain. Pain is also monitored during the day and pain meds given when needed.

The RN Supervisor has a nurse accompany the individual to her wound clinic appointments and the size of the DU has decreased considerably although the tunneling is the same. All nurses were in serviced on infection control and pain management procedures.

See attached – in service record on infection control, dressing and pain management procedures.

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p.m., revealed the direct support staff reported that they took the dressing out of the wound during Client #1's shower "because it was wet and messy." Further interview revealed there were other nurse's available to assist the client, but the staff failed to inform anyone of the need for a new dressing.

b. On September 7, 2011, Client #1's abdominal (ABD) pad was secured to the hip area instead of the left Ischial. Interview with the Director of nursing (DON) on April 13, 2012, at 4:16 p.m., revealed that "perhaps the dressing was shifted".

c. On December 1, 2011, Client #1 arrived at the clinic without a packing strip in the wound bed of the left Ischial. Interview with the DON and the QIDP on April 13, 2012, at 4:17 p.m., revealed they were not aware that Client #1 arrived without a packing strip to the left Ischial.

W 331

W 365 483.460(j)(4) DRUG REGIMEN REVIEW

W 365

An individual medication administration record must be maintained for each client.

This STANDARD is not met as evidenced by:
Based on observation and record review, the facility failed to ensure medication records were accurately maintained for one of three clients in the sample. (Client #1)

The finding includes:

Observation of the medication administration on April 11, 2012, beginning at 7:33 p.m., revealed Client #1 was observed to receive Baclofen, Calcium, Kepra, Citrucel, Beneprotein, Juven

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W 365 Continued From page 11 and mineral oil by mouth from the evening trained medication employee (TME).

Review of Client #1's medication administration records (MAR) on April 12, 2012, beginning at 9:20 a.m., revealed the following:

- March 2012 MAR revealed there were no initials documented that indicated the client was administered the aforementioned medications;

- March 2012 MAR revealed there were no initials documented that indicated the client was administered mineral oil on March 19, 23, 26 and 28, 2012; and

- January 2012, MAR revealed there were no initials documented that indicated the client was administered mineral oil on January 1, 6, 9, 13, 16, 20, 23, 27, and 30, 2012.

Continued review of the MARs for January 2012 and March 2012 on April 12, 2012, revealed that there was no information documented on the back of the MARs to explain why the initials were missing.

W 368 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure that all prescribed medications were administered in accordance with each client's physician orders,

W 365

W365
The TME is no longer responsible to administer the routine medications to the individuals in this home. The LPN medication nurse will administer medications permanently.
The TME was in serviced on Medication Administration Policy and Procedure

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See attached TME in service record

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for three of the six clients residing in the facility.
(Clients #1, #3, and #4)

The findings include:

1. Observation of the medication administration on April 11, 2012, at 6:33 p.m., revealed Client #4 received Keppra. Interview with the trained medication employee (TME) at the same time revealed Keppra was prescribed for the client's seizures. At 7:49 p.m., the client received Miralax. When asked, the TME stated that the Miralax was prescribed for constipation. On April 12, 2012, at 9:15 a.m., review of the client's April 2012 medication administration record (MAR) and current physician orders dated April 2012, revealed an order to administer Keppra two hours before Miralax.

Interview with the licensed practical nurse coordinator (LPNC) on April, 12, 2012, at approximately 1:00 p.m., revealed Keppra has to absorb in the client's system before Miralax is administered.

At the time of the survey, the facility's TME failed to administer Client #4's Keppra as prescribed by the primary care physician.

2. On April 12, 2012, at approximately 9:00 a.m., review of Client #1's physician's order dated January 7, 2012, revealed an order to apply "polysporin powder to affected area on back bid [twice a day] until healed."

On April 12, 2012, at approximately 10:00 a.m., review of Client #1's corresponding January 2012 MAR revealed "apply polysporin powder to left

W 368

W368

The TME is no longer responsible to administer the routine medications to the individuals in this home. The LPN medication nurse will administer medications permanently.
The TME was in serviced on Medication Administration Policy and Procedure

See attached TME in service record

5/12/12

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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 14TH STREET, NW WASHINGTON, DC 20011
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W 368 Continued From page 13 W 368

upper back affected area prn [as needed] up to four times a day until healed." Continued review of the January 2012 MAR revealed that there were no initials to indicate the client continuously received the polysporin powder twice a day as ordered.

The facility failed to assure that the aforementioned drug was administered in accordance with the physician order.

3. Observation of the medication administration on April 11, 2012, at 6:51 p.m., revealed Client #3 was administered Metoprolol Tartrate. On April 12, 2012, at 9:00 a.m., review of the client's April 2012 MAR and April 2012 physician orders, revealed an order to hold the aforementioned medication if the client's blood pressure was less than 90/60. During the medication administration, the TME failed to check the client's blood pressure before administering the medication. Interview with the director of nursing (DON) on April 12, 2012 at approximately 4:30 p.m., confirmed that the TME was required to check the client's blood pressure before administering the Metoprolol Tartrate.

At the time of the survey, the facility failed to ensure Client #3 received her medication in accordance with the physician's orders.

4. Observation of the medication administration on April 11, 2012, at 7:06 p.m., revealed Client #3 was administered Ferrous Sulfate. On April 12, 2012, at 9:10 a.m., review of the client's April 2012 MAR and physician orders dated April 1, 2012, revealed the aforementioned medication was to be administered with the morning

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W 368 Continued From page 14
medications. Interview with the registered nurse (RN) on April 13, 2012, at approximately 5:45 p.m., confirmed that the Ferrous Sulfate was ordered for the morning medication administration.

W 368

At the time of the survey, the facility failed to ensure Client #3 received her medication in accordance with the physician's orders.

5. On April 12, 2012, beginning at 11:00 a.m., review of Client #1's physician order dated November 18, 2011, revealed an order to administer Bactrim DS 800 mg/160 mg by mouth twice a day for a wound infection for fourteen days. According to the corresponding MAR (November 2011), administration of the Bactrim began on November 19, 2011 and concluded on November 30, 2011 (12 days). Continued review of Client #1's record, including the MAR for November and December 2011, failed to provide evidence the client received the aforementioned medication for fourteen days as prescribed. At the time of the survey, the facility failed to ensure Client #1 received her medication in accordance with the physician's orders.

W 369 483.460(k)(2) DRUG ADMINISTRATION

W 369

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that medications were administered without error, for three of the six clients residing in the facility.

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(Clients #3, #5 and #6)

W 369

The findings include:

1. Observation of the medication administration on April 11, 2012, at 5:45 p.m., revealed the trained medication employee (TME) poured 25 ml of Senna for Client #6. Review of the medication label on the bottle revealed the client was prescribed Senna 15 ml. Prior to the TME attempting the administer the Senna 25 ml, the surveyor informed the TME of the 15 ml prescribed dosage thereby preventing the administration of the Senna 25 ml. When asked, the licensed practical nurse coordinator (LPNC) and the registered nurse (RN) confirmed the TME poured 25 ml of senna instead of 15 ml. The TME then administered 15 ml of Senna to Client #6.

2. Observation of the medication administration on April 11, 2012, at 6:06 p.m., revealed Client #5 was administered Buspirone, Phenytoin, Olanzapine, Generlac, Debrox, and Patanol. On April 12, 2012, at 8:50 a.m., review of the client's medication administration record (MAR) and physician orders dated April 1, 2012, revealed mineral oil light (ear drops) was ordered. However, it was not administered during the evening medication pass. Interview with the registered nurse (RN) on April 13, 2012, confirmed that the mineral oil light was ordered for the evening medication. At the time of the survey, the facility failed to ensure Client #5 was administered his mineral oil.

3. Observation of the medication administration on April 11, 2012, at 7:09 p.m., revealed the TME poured 25 ml of Ferrous Sulfate in a medication

W369

The TME is no longer responsible to administer the routine medications to the individuals in this home. The LPN medication nurse will administer medications permanently. The TME was in serviced on Medication Administration Policy and Procedure

See attached TME in service record

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cup for Client #3. Review of the Ferrous Sulfate label at the same time, revealed the client was prescribed 7.5 ml. The LPNC then stated to the TME, "7.5 ml is just below the 10 ml." The TME then re-measured the medication. Just before the TME administered the Ferrous Sulfate, the surveyor asked to see the medication cup. The Ferrous Sulfate measured 10 ml upon the surveyors inspection. When asked, the TME and the RN stated the medication was measured at 7.5 ml. The surveyor then asked the LPNC to look at the measuring cup. The LPNC confirmed the medication was measured at 10 ml instead of the prescribed 7.5 ml. After several attempts by the TME, the director of nursing (DON) measured 7.5 ml of Ferrous Sulfate for Client #3.

4. Observation of the medication administration on April 11, 2012, at 7:42 p.m., revealed the TME applied Refresh to Client #3's right and left eye lid. On April 12, 2012, at 9:10 a.m., review of the client's medication administration record (MAR) and current physician orders dated April 2012, revealed an order to apply the aforementioned medication to the left eye lid only. Interview with the DON on April 13, 2012, at approximately 5:30 p.m., revealed she was unsure regarding the application of the Refresh, but indicated it should be applied to both eye lids.

W 436 483.470(g)(2) SPACE AND EQUIPMENT W 436

The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

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W 436

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure necessary adaptive equipment was maintained in good repair, for one of two clients included in the sample. (Client #3)

The finding includes:

On April 11, 2012, at approximately 4:35 p.m., observations of Client #3's wheelchair revealed the left armrest was missing. The left armrest was not attached to the wheelchair during the survey process, which ended on April 13, 2012. Continued observations revealed duck tape was used to cover the worn areas of the client's foot box.

On April 12, 2012, at approximately 4:30 p.m., interview with Staff #1 (assigned to Client #3) confirmed that the client's armrest was missing. Staff #1 stated that frequent repairs had been made to Client #3's armrest. When asked, Staff #3 further stated that he could not recall how long the client's wheelchair armrest had been damaged.

Review of Client #3's individual support plan (ISP) on April 13, 2012, at approximately 12:52 p.m., revealed the last repairs made to the client's wheelchair (foot box) was documented on February 10, 2010. Further review revealed there was no documented evidence that Client #3's wheelchair armrest had been repaired.

Interview with the qualified intellectual disabilities

W436

Metro Homes, Inc. has an Adaptive Equipment policy and procedure. On a daily basis all adaptive equipment is checked by the staff and notification to the QDDP is made for needed repairs. There were no repairs needed for this individual since Feb 2010 as he had been hospitalized for more than a year. His custom molded wheelchair initial try out fitting will be completed in the next 10 days.

See attached letter from the ~~PAE~~ vendor, adaptive equipment policy and forms

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professional (QIDP) on April 13, 2012, at approximately 3:20 p.m., confirmed that Client #3's wheelchair was without his left arm rest. When queried about the status of the client's current wheelchair, the QIDP stated that Client #3 was fitted for a new custom molded wheelchair on April 10, 2012.

At the time of the survey, the facility failed to ensure Client #3's adaptive equipment was maintained in good repair.

W 436

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I 000 INITIAL COMMENTS

I 000

A licensure survey was conducted from April 11, 2012 through April 13, 2012. A sample of three residents was selected from a population of three men and three women with various degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and at one day program, interviews with direct support staff, administrative staff and one resident, as well as a review of resident and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

I 082 3503.10 BEDROOMS AND BATHROOMS

I 082

Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.

This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to equip the bathroom located on the main hallway with a toilet paper and tissue holder, for six of six residents who used the bathroom. (Residents #1, #2, #3, #4, #5 and #6)

The finding includes:

On April 12, 2012, at approximately 3:30 p.m., revealed there was no tissue located in the bathroom.

I082

Staff did have toilet tissue but it was placed above the tank of the toilet as there was no room to have a wall toilet paper holder placed due to space restrictions. A floor toilet paper holder has been provided

5/17/12

See receipt for floor toilet paper dispenser

Health Regulation & Licensing Administration

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

Gusman D. Gboam

VP TITLE Operations

(X6) DATE

5/17/12

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I 082	Continued From page 1 Interview with the qualified intellectual disabilities professional (QIDP) on April 13, 2012, at approximately 4:10 p.m., revealed that the bathroom was just remodeled to accommodate the residents in wheelchairs. Further interview with the QIDP confirmed that there was no tissue holder or toilet tissue located in the bathroom.	I 082		
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 intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for two of the eleven consultants. (Consultants #9 and #10) The finding includes: On April 13, 2012, beginning 2:38 p.m., review of the personnel records failed to show evidence of a current physician's health inventory/ certificate for consultants #9 and #10. At approximately 4:20 p.m., on the same day, interview with the qualified intellectual disabilities professional confirmed that there was no evidence of health inventories performed by a physician for the aforementioned personnel.	I 206	I206 In the future the QDDP will ensure that monthly QA of personnel files is completed. HR Department has a new computer system – 'Imanage' to monitor/audit personnel files to prevent future personnel record deficiencies. See attached health records	5/17/12

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I 291	<p>3514.2 RESIDENT RECORDS</p> <p>Each record shall be kept current, dated, and signed by each individual who makes an entry.</p> <p>This Statute is not met as evidenced by: Based on interview and record review the facility failed to ensure all persons making entries into the medical record dated and signed his/her entry for one of the three residents in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>During the entrance conference on April 11, 2012, at approximately 10:00 a.m., the qualified intellectual disabilities professional (QIDP) and licensed practical nurse coordinator (LPNC) revealed that Resident #1 was admitted to the facility on May 18, 2011 with a left Ischial wound and a left heel wound. Further interview revealed the resident sustained another wound on the left foot after she was hospitalized on September 15, 2011.</p> <p>Review of Resident #1's medical record on April 12, 2012, revealed that the Primary Care Physician (PCP) and the licensed practical nurse coordinator (LPNC) failed to date and sign physician orders as evidenced below:</p> <ol style="list-style-type: none"> 1. Tylenol 325 mg tabs by mouth every six hours for pain prn. <p>The facility failed to indicate the date and time of the aforementioned order.</p> <ol style="list-style-type: none"> 2. Apply vitamin A and D ointment to buttocks after each diaper change. 	I 291	<p>I291</p> <p>5/17/12</p> <p>All nursing staff was trained in Medication Administration Policy and Procedure – documentation. In the future the RN Supervisor will ensure that all POS/MAR records are reviewed for accuracy and audits of the medical records are completed at least monthly.</p> <p>See attached – Corrected POS and MAR, in service record and medical record audit</p>

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I 291	Continued From page 3 The facility failed to indicate the date and time of the aforementioned order. 3. June 18, 2011 order - "Vascular evaluation to rule out deep vein thrombosis and use of ted hose, physical therapy evaluation, cardiology evaluation, neurology evaluation, (baclofen use) plastic surgery evaluation to rule out abscess vs. decubitus, psychology evaluation, bilateral MRI of pelvic without contrast." The PCP and the LPNC failed to date and state the time of the order. 4. July 26, 2011 order - " DuoDerm four times a week (every other day) Boot prafo for lateral calcaneous." The PCP and the LPNC failed to date and state the time of the order. 5. July 29, 2011 order - keep legs elevated while in bed and in wheelchair." The PCP failed to date the order. The time of the order was not indicated. 6. August 31, 2011 order - "Cleanse left Ischial with sterile normal saline and pack wound with one inch Idoform strip. Cover with abdominal pad everyday. discontinue wet to dry dressing." "Apply topical Isosorb and cover with abdominal pad everyday. discontinue wet to dry dressing" The medical staff failed to indicate a time on the order. 7. October 25, 2011 order - Discontinue hydrogel to left Ischial and left heel wound, start Iodosord.	I 291		

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1 291	Continued From page 4 The LPNC failed to sign and date the order. The time of the order was not indicated. 8. October 20, 2011 order - Augmentin 500mg/125mg tablet. One tablet by mouth three times a day for seven days to complete fourteen days original order. The medical staff failed to indicate a time on the order. 9. October 21, 2011 order - Discontinue Baclofen 10mg by mouth twice a day. Start Baclofen 5mg by mouth twice a day for contractures. The medical failed to indicate a time on the order. 10. December 15, 2011 order - MRI without contrast to rule out osteomyelitis to left Ischial, left heel and left foot. The medical staff failed to indicate a time on the order. 11. December 27, 2011 order - Cleanse back blisters with sterile normal saline and apply neosporin until healed. The LPNC failed to date the order. The time of the order was not indicated. 12. February 15, 2012 order - "Discontinue left Ischial dressing twice a day. Cleanse with sterile normal saline. Pack Iodoform one inch strip in wound. Cover with abdominal pad and secure with tape everyday." "Discontinue dressing every other day to the left heel. Start cleansing with sterile normal saline. Apply Isosorb paste and cover with abdominal pad and wrap with keflex. Secure with tape everyday.	1 291	

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I 291	Continued From page 5	I 291		
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The medical staff failed to indicate the time of the order.

13. February 16, 2012 order - Discontinue Iodosorb, start Keflex AMD after cleansing with sterile normal saline. Apply dressing and secure with tape everyday.

The facility failed to indicate the time of the order.

14. March 14, 2012 order - Change Iodoform packing strips to plain packing strips everyday. May also use Iodoform strips.

The PCP and the LPNC failed to date and state the time of the order.

I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		
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Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.

This Statute is not met as evidenced by:
Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included treatment services, and services designed to prevent deterioration or further loss of functioning by the resident for one of three residents in the sample. (Resident #1)

The finding includes:

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NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 14TH STREET, NW WASHINGTON, DC 20011
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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) COMPLETE DATE
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I 401	Continued From page 6 Observation on April 11, 2012, at approximately 9:30 a.m., revealed the licensed practical nurse coordinator (LPNC) was providing wound care to Resident #1's left ischial wound. On April 12, 2012, at 11:00 a.m., review of the physician's orders dated June 18, 2011, revealed an order to obtain a wound care evaluation for Resident #1. Continued review of the medical records revealed the client had an appointment at the wound care specialty clinic on June 28, 2011; however, the client arrived too late. Therefore the appointment was rescheduled for July 26, 2011. Interview with the LPNC on April 13, 2012, at 4:25 p.m., confirmed Resident #1 arrived late to the first appointment because the driver was unable to find a parking space. Further record review revealed the resident's July 2011 appointment was cancelled. According to interview with the LPNC on April 13, 2012, at 4:26 p.m., the clinic canceled the July 2011 appointment. Additional review of Resident #1's medical record revealed a wound clinic consult dated August 17, 2011. The consult revealed that the resident had a stage three left Ischial wound and a stage three left heel wound. Continued review revealed a recommendation for the resident to follow up in one week. Further review of the medical records on April 12, 2012 at 11:40 a.m., revealed an MRI of the pelvic area dated July 21, 2011, that Resident #1 was diagnosed with osteomyelitis (bone infection). Interview with the LPNC on April 12, 2012, at approximately 11:55 a.m., revealed the left Ischial is difficult to heal with osteomyelitis. The facility's nursing services failed to obtain Resident #1's wound care evaluation timely as ordered by the primary care physician.	I 401	I401 All the nursing staff have been in serviced on the wound dressing procedure and pain management procedure. This individual now receives her pain medication routinely an hour prior to her dressing change. Pain is also monitored during the day and pain meds given when needed. The RN Supervisor has a nurse accompany the individual to her wound clinic appointments and the size of the DU has decreased considerably although the tunneling is the same. A sinus forceps has been purchased to ensure the packing gauze is filled snugly into the tunnel. All nurses were in serviced on infection control and sterilization procedures. See attached – in service record on infection control, sterilization technique, dressing and pain management procedures.	5/17/12
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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
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I 473 3522.4 MEDICATIONS

I 473

The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician.

This Statute is not met as evidenced by:
Based on observation, interview and record verification, the Group Home for Persons with Intellectual Disability (GHPID) failed to report any irregularities to the Primary Care Physician (PCP) for three of six residents residing in the facility. (Residents #3, #5, and #6)

The findings include:

1. Observation of the medication administration on April 11, 2012, at 5:45 p.m., revealed the trained medication employee (TME) poured 25 ml of Senna for Resident #6. Review of the medication label on the bottle revealed the resident was prescribed Senna 15 ml. Prior to the TME attempting the administer the Senna 25 ml, the surveyor informed the TME of the 15 ml prescribed dosage thereby preventing the administration of the Senna 25 ml. When asked, the licensed practical nurse coordinator (LPNC) and the registered nurse (RN) confirmed the TME poured 25 ml of senna instead of 15 ml. The TME then administered 15 ml of Senna to Resident #6.

2. Observation of the medication administration on April 11, 2012, at 6:06 p.m., revealed Resident #5 was administered Buspirone, Phenytoin, Olanzapine, Generlac, Debrox, and Patanol. On April 12, 2012, at 8:50 a.m., review of the resident's medication administration record (MAR) and physician orders dated April 1, 2012, revealed mineral oil light (ear drops) was ordered. However, it was not administered during the evening medication pass. Interview with the

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I 473 Continued From page 8

I 473

registered nurse (RN) on April 13, 2012, confirmed that the mineral oil light was ordered for the evening medication. At the time of the survey, the facility failed to ensure Resident #5 was administered his mineral oil.

3. Observation of the medication administration on April 11, 2012, at 7:09 p.m., revealed the TME poured 25 ml of Ferrous Sulfate in a medication cup for Resident #3. Review of the Ferrous Sulfate label at the same time, revealed the resident was prescribed 7.5 ml. The LPNC then stated to the TME, "7.5 ml is just below the 10 ml." The TME then re-measured the medication. Just before the TME administered the Ferrous Sulfate, the surveyor asked to see the medication cup. The Ferrous Sulfate measured 10 ml upon the surveyors inspection. When asked, the TME and the RN stated the medication was measured at 7.5 ml. The surveyor then asked the LPNC to look at the measuring cup. The LPNC confirmed the medication was measured at 10 ml instead of the prescribed 7.5 ml. After several attempts by the TME, the director of nursing (DON) measured 7.5 ml of Ferrous Sulfate for resident #3.

4. Observation of the medication administration on April 11, 2012, at 7:42 p.m., revealed the TME applied Refresh to Resident #3's right and left eye lid. On April 12, 2012, at 9:10 a.m., review of the resident's medication administration record (MAR) and current physician orders dated April 2012, revealed an order to apply the aforementioned medication to the left eye lid only. Interview with the DON on April 13, 2012, at approximately 5:30 p.m., revealed she was unsure regarding the application of the Refresh, but indicated it should be applied to both eye lids.

I473

The TME is no longer responsible to administer the routine medications to the individuals in this home. The LPN medication nurse will administer medications permanently. The TME was in serviced on Medication Administration Policy and Procedure

See attached TME in service record

5/12/12

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I 483 Continued From page 9
I 483 3522.10 MEDICATIONS

I 483
I 483

Each medication shall be stored under proper conditions of light and temperature as indicated on its label.

This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for Mentally Retarded Persons (GHMRP), failed to store and administer all drugs under proper conditions of light for six of the six residents residing in the facility. (Resident #1, #2, #3, #4 #5 and #6)

The finding includes:

On April 11, 2012, beginning at 5:39 p.m., the trained medication employee (TME) was observed administering the evening medications under a dim light. Further observation revealed a lamp on the table next to the TME. However, the TME did not turn the lamp on. At 5:45 p.m., the TME poured 25 ml of senna for Resident #6. Review of the blister pack at the same time revealed the resident was prescribed senna 15 ml. The surveyor stopped the TME from administering the 25 ml of senna. When asked, the LPN and the Registered Nurse (RN) confirmed the TME poured 25ml of senna instead of 15ml. The TME then administered 15ml of senna to Resident #6. At 7:06 p.m., the TME began to administer Resident #3's medication. At 7:09 p.m., the Licensed Practical Nurse turned on the lamp. At the same time the TME poured 25ml of Forrous Sulfate. Review of the Forrous sulfate label, revealed the resident was prescribed 7.5ml. The LPN then stated "7.5ml is just below the 10ml. The TME then re-measured the medication. Just before the TME administered the Forrous sulfate, the surveyor asked to the see

I483
A new lamp has been provided to ensure there is adequate lighting during medication administration. All nursing staff was trained in Medication Administration Policy and Procedure – documentation. In the future the RN Supervisor will ensure that all POS/MAR records are reviewed for accuracy and audits of the medical records are completed at least monthly.

5/10/12

See attached – Corrected POS and MAR, in service record and medical record audit

Health Regulation & Licensing Administration

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I 483	<p>Continued From page 10</p> <p>the measured medication. 10ml of Forrous sulfate was observed in the medication cup. When asked, the TME and the RN stated the medication was measured at 7.5ml. The surveyor then asked the LPN to look at the measuring cup. The LPN then confirmed the medication was measured at 10ml. After several attempts by the TME, The Director of nursing measured 7.5ml of Forrous Sulfate for Resident #3. At 7:33 p.m., the TME took the lamp shade off the lamp prior to measuring Resident #1's mineral oil.</p> <p>Interview with the LPN on April 13, 2012, at 4:36 p.m., revealed she turned the lamp on to "help" the TME. At the same time, the DON revealed that she retrained the TME after he completed his medication administration. Further interview indicated that the TME was required to turn the lamp on when conducting medication administration.</p>	I 483		
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