

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

PRINTED: 07/22/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/12/2013
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NAME OF PROVIDER OR SUPPLIER  METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from July 10, 2013 through July 12, 2013. A sample of three clients was selected from a population of six females with profound 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 two day programs, interviews with one guardian, direct support staff, nursing and administrative staff, 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 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, interview and record review, the trained medication employee (TME) failed to ensure that each client received medications as prescribed, for one of six clients in the facility. (Client #4)

The finding includes:

On July 10, 2013, beginning at 6:30 p.m., TME #1 began to prepare Client #4's medication. At 6:43 p.m., TME #1 administered Cogentin, Calcium, Ferrous Sulfate, Risperdal, Depakote, Mineral oil

*DOH Received  
7/25/13*

W 368 W 368

The delegating RN will re-train TME #1 and all TME's on ensuring that Individual #4 and all individuals residing at 1433 Northgate Road NW receives all medications in accordance with physicians orders.

7/29/13

SYSTEM: The delegating RN will at least quarterly observe and document observations for medication administration for all TME's working at 1433 Northgate Road NW.

Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Emily J. Horner</i>	TITLE Exec. Director of Operations	(X6) DATE 7/25/13
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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 368	Continued From page 1 and Enulose to Client #4. TME #1 then placed the aforementioned medications in the closet. TME #1 indicated that the medication administration was completed for Client #4.  On July 10, 2013, at 7:32 p.m., review of the client's physician's order sheets (POS) and medication administration record (MAR) dated July 1, 2013, revealed an order to administer Bisacodyl and Metoprolol in the evening. Continued review revealed that the MAR was signed, indicating that Bisacodyl and Metoprolol was administered with her evening medications.  During an interview on July 10, 2013, at approximately 8:00 p.m., TME #1 reopened the medication closet and proceeded to look at Client #4's medications. TME #1 then stated that the Metoprolol was administered in the morning and there was no more Bisacodyl to administer to the client. Further interview confirmed that she signed the MAR, indicating that Metoprolol and Bisacodyl were administered with Client #4's evening medications. On July 12, 2013, at approximately 3:00 p.m., observation and interview with Licensed Practical Nurse (LPN) #1 revealed the Bisacodyl was available in the refrigerator. Continued interview indicated that TME #1 failed to retrieve the medication from the refrigerator to administer to Client #4.  At the time of survey, the facility failed to ensure clients received their medications in accordance with their physician orders.	W 368			
W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369			
	The system for drug administration must assure that all drugs, including those that are				

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W 369 Continued From page 2  
self-administered, are administered without error.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the trained medication employee (TME) failed to ensure that each client medications were administered as prescribed, for one of six clients in the facility. (Client #4)

The finding includes:

On July 10, 2013, beginning at 6:30 p.m., TME #1 began to prepare Client #4's medication. At 6:43 p.m., TME #1 administered Cogentin, Calcium, Ferrous Sulfate, Risperdal, Depakote, Mineral oil and Enulose to Client #4. TME #1 then placed the aforementioned medications in the closet. TME #1 indicated that the medication administration was completed for Client #4.

On July 10, 2013, at 7:32 p.m., review of the client's physician's order sheets (POS) and medication administration review (MAR) dated July 1, 2013, revealed an order to administer Bisacodyl and Metoprolol in the evening. Continued review revealed that the MAR was signed, indicating that Bisacodyl and Metoprolol was administered with her evening medications.

During an interview on July 10, 2013, at approximately 8:00 p.m., TME #1 reopened the medication closet and proceeded to look at Client #4's medications. TME #1 then stated that the Metoprolol was administered in the morning and there was no more Bisacodyl to administer to the client. Further interview confirmed that she signed the MAR, indicating that Metoprolol and Bisacodyl

W 369 W 369  
The delegating RN will re-train TME #1 and all TME's on the proper administration of individual #4's medication (i.e. Metoprolol, and Bisacodyl) and all individuals receiving medications at 1433 Northgate Road NW. 7/29/13  
SYSTEM: The delegating RN will at least quarterly observe and document observations for administration of medication for individual #4 and all individuals residing at 1433 Northgate Road NW. ongoing

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W 369 Continued From page 3  
were administered with Client #4's evening medications. On July 12, 2013, at approximately 3:00 p.m., observation and interview with Licensed Practical Nurse (LPN) #1 revealed the Bisacodyl was available in the refrigerator. Continued interview indicated that TME #1 failed to retrieve the medication from the refrigerator to administer to Client #4.

W 369

At the time of survey, the facility failed to administer Client #4's Metoprolol and Bisacodyl as prescribed.

W 381 483.460(I)(1) DRUG STORAGE AND RECORDKEEPING

W 381 W 381

The facility must store drugs under proper conditions of security.

The delegating RN will re-train TME #1 and all TME's on maintaining medication under proper conditions of security for individual #6, and #1, and all individuals residing at 1433 Northgate Road NW. 7/29/13  
SYSTEM: The delegating RN will quarterly observe and record medication administration for TME #1 and all TME's that administer medication at 1433 Northgate Road NW. Ongoing

This STANDARD is not met as evidenced by:  
Based on observation and interview, the trained medication employee (TME) failed to ensure medications were maintained under proper conditions of security, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)

The finding includes:

On July 10, 2013, at 5:56 p.m., TME #1 was observed to leave the medication closet door open as she went into Client #6's bedroom to administer medications. At 6:14 p.m., TME #1 left the closet door open as she walked into Client #3's bedroom to administer her medications. At 6:57 p.m., TME #1 left the closet door open again while she administered Client #1's medications. During this time, all the clients and facility staff

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W 381 Continued From page 4  
were in close proximity to the unsecured medications.

When interviewed on July 10, 2013, at approximately 8:00 p.m., TME #1 stated that the medication door was not locked each time she walked away.

W 381

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

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.

W 436

W 436  
The head rest for individual #1 has been ordered from Advanced Medical Concepts. Replacement will occur upon receiving part. 8/9/13  
SYSTEM: The QIDP will review adaptive equipment checklist and monitor for disrepair on a monthly basis. Ongoing

This STANDARD is not met as evidenced by:  
Based on observation, staff interview and record review, the facility failed to establish a system to ensure each client's wheelchair was maintained in good repair, for one of three clients in the sample. (Client #1)

The findings include:

On July 10, 2013, at 8:50 a.m., Client #1 was observed in her wheelchair as she was wheeled to the facility's van. The material along the front edge of the headrest on her wheelchair had numerous tears.

According to the review of Client #1's habilitation records on July 11, 2013, beginning at 10:38 a.m., the physical therapist (PT) assessment dated February 19, 2013, recommended that the client's "head rest needs to be replaced and

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W 436 Continued From page 5  
adjusted". At 11:43 a.m., review of the 719A form dated June 18, 2013, revealed a request to replace Client #1's head rest.

W 436

Interview with qualified intellectual disabilities professional (QIDP) #1 on July 12, 2013 at approximately 3:30 p.m., revealed Client #1's head rest was adjusted but was not replaced as recommended.

At the time of survey, the facility failed to ensure Client #1 received a new head rest as recommended by the physical therapist.

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS  A licensure survey was conducted from July 10, 2013 through July 12, 2013. A sample of three residents was selected from a resident population of six females with profound intellectual disabilities. This survey was initiated utilizing the fundamental survey process  The findings of the survey were based on observations in the home and two day programs, interviews with one guardian, direct support staff, nursing and administrative staff, 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 000		
I 090	3504.1 HOUSEKEEPING  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for six of the six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6)  The findings include:	I 090		

Health Regulation & Licensing Administration

*Emily A. Hammer*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Exec. Director of Operations*  
TITLE

7/25/13  
(X6) DATE

STATE FORM

6899

BMCF11

If continuation sheet 1 of 3

Health Regulation & Licensing Administration

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I 090	Continued From page 1  Observation during the inspection of the environment on July 12, 2013, beginning at 2:48 p.m., revealed the following:  1. Resident #5 and #6's dresser drawers were off track, creating a potential safety hazard.  2. The paint on the ceiling in the dining room was peeling.  3. The wood on Resident #4 and #6's bedroom door was striped on the bottom.  The house manager (HM #1) who was present during the environmental inspection, stated she would make maintenance aware of the aforementioned concerns.	I 090	1090 Resident #5 and #6's dresser drawers have been repaired. 7/29/13 The ceiling in the dining room has been painted. 7/29/13 The wood on resident #4 and #6's room will be repaired. 7/29/13  SYSTEM: The residential Coordinator will do monthly inspections and document accordingly in the IMANAGE system. Maintenance will repair upon reporting into IMANAGE. Ongoing	
I 473	3522.4 MEDICATIONS  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 review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each resident received medications as prescribed, for one of six residents in the facility. (Resident #4)  The finding includes:  On July 10, 2013, beginning at 6:30 p.m., trained medication employee (TME) #1 began to prepare Resident #4's medication. At 6:43 p.m., TME #1 administered Cogentin, Calcium, Ferrous Sulfate, Risperdal, Depakote, Mineral oil and Enulose to Resident #4. TME #1 then placed the	I 473	1473 Cross Reference with W 369	

Health Regulation & Licensing Administration

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I 473	<p>Continued From page 2</p> <p>forementioned medications in the closet. TME #1 indicated that the medication administration was completed for Resident #4.</p> <p>On July 10, 2013, at 7:32 p.m., review of the Resident's physician's order sheets (POS) and medication administration record (MAR) dated July 1, 2013, revealed an order to administer Bisacodyl and Metoprolol in the evening. Continued review revealed that the MAR was signed, indicating that Bisacodyl and Metoprolol was administered with her evening medications.</p> <p>During an interview on July 10, 2013, at approximately 8:00 p.m., TME #1 reopened the medication closet and proceeded to look at Resident #4's medications. TME #1 then stated that the Metoprolol was administered in the morning and there was no more Bisacodyl to administer to the Resident. Further interview confirmed that she signed the MAR, indicating that Metoprolol and Bisacodyl were administered with Resident #4's evening medications. On July 12, 2013, at approximately 3:00 p.m., observation and interview with Licensed Practical Nurse (LPN) #1 revealed the Bisacodyl was available in the refrigerator. Continued interview revealed that the primary care physician was not made aware of the aforementioned findings.</p> <p>At the time of the survey, there was no documented evidence these irregularities were reported to the PCP.</p>	I 473		
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