

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

PRINTED: 04/26/2013
FORM APPROVED
OMB NO. 0938-0391

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 04/12/2013
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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 A recertification survey was conducted from April 9, 2013 through April 12, 2013. A sample of three clients was selected from a population of three males and three females with varying 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 one day program, interviews with one client, 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 000		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the qualified intellectual disabilities professional (QIDP) failed to coordinate services and referrals timely (specifically, notify the speech language pathologist of a recommended Modified Barium Swallow study) when indicated, for one of three clients in the sample. (Client #2) The finding includes:	W 159	On 5/3/13, client #2 had a bedside swallow study completed on 4/20/13. The recommendation was to schedule a modified barium swallow study (MBS). The MBS has been scheduled for June 6, 2013 at 11:08am @ The QIDP was re-inserviced on coordination of services and recommendations made from consultants. SYSTEM: During quarterly quality assurance reviews conducted by a team of nurses, the team will review all recommendations by the medical and therapeutic team to ensure all recommendations are being carried out in a timely manner.	06/06/13 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Emily J. Thomas TITLE
Executive Dir Operations (X6) DATE
5/16/13

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 159	<p>Continued From page 1</p> <p>On April 9, 2013, beginning at 7:19 a.m., Client #2 was observed eating pureed foods and drinking from a specialized cup at breakfast. A short time later, at approximately 9:15 a.m., the qualified intellectual disabilities professional (QIDP, Staff #1) referred to the client's specialized cup as a "dysphasia cup" and stated that his foods were pureed and liquids were thickened to a nectar consistency due to his risk of aspiration. On April 9, 2013 at 6:35 p.m., Client #2 was observed vomiting while seated at the dinner table; he had already eaten most of his meal. The director of nursing (DON, Staff #3) and the QIDP (Staff #1) stated that he had a long history of vomiting during meals and was seen regularly by a gastro-intestinal (GI) specialist. Staff #1, Staff #3 and a direct support staff (Staff #12) all stated that he had not vomited during a meal in "over a year."</p> <p>Client #2's medical and habilitation records were reviewed on April 11, 2013, beginning at 1:39 p.m. His Individual Support Plan (ISP), dated September 7, 2012 reflected the observed adaptive equipment, pureed diet and liquids thickened to nectar consistency. His records also reflected a history of vomiting and GI consultations.</p> <p>On April 11, 2013, beginning at approximately 4:55 p.m., review of Client #2's gastro-intestinal (GI) consultations revealed that on August 31, 2012, the GI specialist recommended that the facility contact the speech language pathologist to schedule a Modified Barium Swallow (MBS) study. According to a nurse progress note also dated August 31, 2012, the client's primary care physician "agreed" with the recommendation for a</p>	W 159		
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W 159	Continued From page 2 MBS study. Further review of the record, however, failed to show evidence that the speech-language pathologist had been contacted or that Client #2 was referred for a MBS study. On April 12, 2013, at 12:32 p.m., the QIDP (Staff #1) was queried about the status of the recommended MBS study. She stated that Client #2's next Speech-Language Evaluation was due in May 2013. She then acknowledged that the speech-language pathologist had not been contacted regarding the need for an updated MBS study. The facility's licensed practical nurse coordinator (Staff #5) and the DON (Staff #3) were both present at the time. They examined the record and confirmed there was no evidence of any follow-up to the August 31, 2012 recommendation that Client #2 receive a MBS study.	W 159		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the provision of one-to-one (1:1) staffing support had been reviewed and/or approved by the specially constituted committee (i.e. Human Rights Committee), for one of three clients in the sample. (Client #2)	W 262	On 5/9/13 at approximately 1:17pm, the QIDP received emergency HRC approval for individual #2 residing at 5701 14th Street NW Washington, DC 20011. The approval was received for Metro Homes, Inc. to provided 1:1 supports to individual #2 for the purpose of health and safety, due to the risk of aspiration and skin breakdown. The Program Director re-inserviced the QIDP on the Human Rights Committee policy and procedures in obtaining emergency HRC approval for anything related to the restrictions of rights for individual #2 and all individuals residing at 5701 14th Street NW Washington, DC 20011. 05/10/13	

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W 262	<p>Continued From page 3 The finding includes:</p> <p>On April 9, 2013, beginning at 7:19 a.m., Client #2 was observed seated in his wheelchair. A direct support staff (Staff #8) remained by his side throughout the next 50 minutes. At 8:07 a.m., Staff #8 discussed Client #2 with another direct support staff (Staff #10) who arrived on duty. Staff #8 stated that she provided 1:1 support during the overnight shift and Staff #10 would provide 1:1 support through the day shift. She further stated that Client #2 received 1:1 staffing 24 hours a day, 7 days a week. She explained the staffing was prescribed for health and safety reasons (not behavioral). When interviewed on April 9, 2013, at 9:38 a.m., the qualified intellectual disabilities professional (QIDP, Staff #1) clarified that Client #2 received 1:1 staffing "officially" for 16 hours a day but that facility staff provided 1:1 coverage throughout the night to ensure his health and safety.</p> <p>On April 11, 2013, beginning at 1:39 p.m., review of Client #2's Individual Support plan (ISP) dated February 7, 2013, confirmed the 1:1 staffing support was for 16 hours/day due to a high risk of aspiration and skin breakdown.</p> <p>On April 12, 2013, beginning at 9:48 a.m., review of the facility's Human Rights Committee (HRC) minutes from the past year revealed that committee had reviewed his adaptive equipment needs and a recent visit to the emergency room. There was no evidence, however, that the committee had reviewed and approved his 1:1 staffing.</p> <p>In a follow-up interview with the QIDP (Staff #1)</p>	W 262	<p>SYSTEM: A new procedure was developed to receive emergency approval for any restrictions of rights issues. This system was developed to ensure that restrictions of rights were being approved immediately, from HRC members, and then represented at the quarterly HRC meeting for follow up with all HRC members.</p>	Ongoing

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W 262	Continued From page 4 on April 12, 2013, at 11:32 am, she stated she believed the HRC had reviewed Client #2's 1:1 staffing supports at some point in the past. She confirmed that the HRC had not reviewed his 1:1 supports within the past year. She thought she might locate evidence of past HRC approval; however, no additional information was made available for review before the survey ended at 3:30 p.m.	W 262		
W 368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and review of client records, the facility failed to ensure that clients' medications were administered in accordance with physician's orders, for four of six clients residing in the facility. (Clients #1, #3, #5 and #6)</p> <p>The findings include:</p> <p>The evening medication administration was observed on April 9, 2013, beginning at 5:08 p.m.</p> <p>I. Nursing staff failed to ensure that Client #3's prescribed eye and ear drops were administered as ordered, as follows:</p> <p>A. During the process of the evening medication administration, a licensed practical nurse (Staff #7) was observed administering Travatan Z Benzalkonium Free 0.004% eye drops. Client #3 was to receive one drop in each eye. The first</p>	W 368	<p>Staff #7, the nurse will be re-trained on appropriate procedure/technique for administering eye drops for individual # 3. Furthermore, the Director of Nursing will re-inservice staff #7, the nurse, and all nurses on ensuring that all individuals medications are administered in accordance with physicians orders for individual #3 and all individuals residing at 5701 14th Street, NW Washington, DC20011.</p> <p>SYSTEM: Supervising Registered Nurse (RN) will conduct quarterly medication administration observations for all individuals residing at 5701 14th Street, NW Washington, DC 20011, and document accordingly.</p>	<p>05/06/13</p> <p>05/06/13</p> <p>Ongoing</p>

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W 368	<p>Continued From page 5</p> <p>drop missed his right eye and rolled down his cheek. The medication did not enter his eye. Staff #7 subsequently administered a drop of Travatan to his left eye and then one drop of Artificial Tears eye drops into each eye before the client's medication administration ended.</p> <p>On April 10, 2013, at 9:33 a.m., review of Client #3's physician's order sheets (POS) and medication administration records (MARs) for April 2013 confirmed that he was prescribed Travatan Z Benzalkonium Free 0.004% eye drops "one drop in each eye every evening for glaucoma."</p> <p>B. On April 10, 2013, at 9:35 a.m., continued review of Client #3's POS and MARs for April 2013 revealed an order for "Ear Drops (Generic Debrox) 6.5% Drops Instill 2 drops in each ear every evening to prevent wax build up." Client #3 was not, however, observed to receive the ear drops on the evening of April 9, 2013.</p> <p>II. Nursing staff failed to seek clarification of orders when indicated, as follows:</p> <p>A. On April 9, 2013, at 5:15 p.m., Staff #7 was observed preparing Client #6's medications. The client received Risperidone 0.5 mg and Senekot 15 milliliters (ml), followed by water. On April 10, 2013, at 9:23 a.m., review of Client #6's POS and MARs for April 2013 revealed that the order for Risperidone 0.5 mg was to take one tablet by mouth "at bedtime." The designated time, however, on the MAR was 5:00 p.m.</p> <p>B. On April 9, 2013, at 5:21 p.m., Staff #7 was observed administering Client #5's medications,</p>	W 368		

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W 368	<p>Continued From page 6</p> <p>including Polyethylene Glycol (Miralax) 17 grams (1 scoop) powder mixed with water. She administered the aforementioned medications at 5:32 p.m. On April 10, 2013, at 9:56 a.m., review of Client #5's POS for April 2013 revealed that the order read "Polyethylene Glycol (Miralax) 17 gram dissolved in 4 ounce liquid by mouth twice daily." The same order was on the MAR, with 7:00 p.m. as the designated administration time. It was noted that all of Client #5's other evening medications had a 5:00 p.m. designated administration time.</p> <p>C. On April 9, 2013, at 6:56 p.m., Staff #7 was observed administering Client #1's medications, including Protonix 40 mg. On April 10, 2013, at 10:30 a.m., review of Client #1's POS and MARs for April 2013 revealed that the order for Pantoprazole Sodium (Protonix) 40 mg said to take "one tablet by mouth at bedtime for reflux." The designated time, however, on the MAR was 5:00 p.m.</p> <p>On April 12, 2013, at 12:13 p.m., the licensed practical nurse coordinator (Staff #5) was interviewed to ascertain the reasoning for administering clients' evening medications at one time, rather than at the designated times (i.e. 5:00 p.m., 7:00 p.m. and bedtime). Upon review of Clients #1, #5 and #6's POS and MARs, Staff #5 stated that she would seek clarification on the aforementioned orders.</p> <p>This is a repeat deficiency. See Federal Deficiency Report dated April 13, 2012.</p>	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure	W 369		

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W 369	<p>Continued From page 7</p> <p>that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure that each client's prescribed drugs were administered without error, for one of six clients residing in the facility. (Client #3)</p> <p>The findings include:</p> <p>I. The evening medication administration was observed on April 9, 2013. At 6:05 p.m., a licensed practical nurse (Staff #7) was observed administering Client #3's medications, including Travatan Z Benzalkonium Free 0.004% eye drops. She stated he was to receive one drop in each eye. The first drop missed his right eye and rolled down his cheek. The medication did not enter his eye. Staff #7 subsequently administered a drop of Travatan to his left eye and then one drop of Artificial Tears eye drops into each eye before the client's medication administration ended.</p> <p>On April 10, 2013, at 9:33 a.m., review of Client #3's physician's order sheets (POS) and medication administration records (MARs) for April 2013 confirmed that he was prescribed Travatan Z Benzalkonium Free 0.004% eye drops "one drop in each eye every evening for glaucoma."</p> <p>II. On April 10, 2013, at 9:35 a.m., continued review of Client #3's POS and MARs for April 2013 revealed an order for "Ear Drops (Generic</p>	W 369	<p>The Director of Nursing re-inserviced staff #7, the nurse, for appropriate techniques/procedure for administering individual #3's eye drops. Furthermore, The Director of Nursing re-inserviced all nurses on medication administration for ear drops, eye drops, and nose drops.</p> <p>SYSTEM: The supervising Registered Nurse will conduct quarterly medication administration observations, and document accordingly.</p>	<p>05/06/13</p> <p>Ongoing</p>

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W 369	Continued From page 8 Debrox) 6.5% Drops Instill 2 drops in each ear every evening to prevent wax build up." Client #3 was not, however, observed to receive the ear drops on the evening of April 9, 2013.	W 369		
W 382	This is a repeat deficiency. See Federal Deficiency Report dated April 13, 2012. 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep each client's prescribed eye ointments locked securely when not being prepared for administration, for one of six clients residing in the facility. (Client #3) The finding includes: On April 9, 2013, at approximately at 3:50 p.m., a prescription bottle of Refresh P.M. 3% eye ointment was observed in the top drawer of Client #2's nightstand in his bedroom. The label showed that it was filled for Client #2 on October 16, 2012 and was to be applied to his left eye lid three times a day. The qualified intellectual disabilities professional (Staff #1) and the residential coordinator (Staff #2) who were both present at the time, were unable to explain why the ointment had been placed in an unsecured location.	W 382	Director of Nursing re-inserviced staff #7, the nurse and all nurses on medication administration policies and procedures to include proper storage (secure locking) for individual #3's eye ointment as well all drugs and biologicals. SYSTEM: The supervising Registered Nurse will conduct monthly observation of medications and document accordingly. Furthermore, a nursing team will be conducting quarterly quality assurance reviews, which includes the proper storage of medications.	05/06/13 Ongoing
W 385	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING	W 385		

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W 385	Continued From page 10 and sent to the facility on February 6, 2013. Seven (7) of the 2-mg tablets were missing; 23 remained in the pack. The director of nursing (DON, Staff #3) and Staff #5 were unable to locate a Controlled Medication Utilization Record form for the 30-tablet blister pack of lorazepam. After examining Client #3's medical chart, including MARs from February, March and April 2013, Staff #3 and #5 confirmed the client had been administered 2 tablets of 2 mg each on two occasions only. At 11:07 a.m., Staff #3 stated "the count is not adding up" and at 11:27 a.m., she indicated they were unable to account for 3 tablets that were missing from the blister pack. She had initiated an investigation and was trying to reach a former nurse (Staff #6) who was responsible for receiving and managing medications in February and March 2013. There was no evidence that the facility utilized an effective system to record the receipt, disposition and monitoring of controlled drugs.	W 385	
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. 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 that each client received timely wheelchair seating systems and dentures, and that facility	W 436	The QIDP was re-inserviced on proper policies and procedures for furnishing maintaining in good repair, and teaching individuals about making informed choices about the use of adaptive equipment. 05/09/13 The follow up for seating system for individual #1 has been scheduled for a return follow up visit to Nascott for final fitting. Seating system should be ready for final fitting on June 6, 2013. 06/06/13

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W 436	<p>Continued From page 11</p> <p>staff implemented adaptive/safety protocols in accordance with prescribed needs, for two of three clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>I. The facility failed to secure a new custom-molded seating system timely for Client #1's wheelchair, as follows:</p> <p>On April 9, 2013, at 8:37 a.m., interview with Client #1 revealed that she had a pressure wound on her buttocks that was healing. The client's daytime 1:1 direct support staff (Staff #9) who was present at the time, confirmed the wound had improved. The client was to spend not more than 30 minutes in the wheelchair. Later on April 9, 2013, at 4:18 p.m., Staff #9 was observed wheeling Client #1 out from her bedroom to the dining room. The wheelchair did not appear to accommodate the client's body size (large) comfortably.</p> <p>On April 10, 2013, beginning at 2:20 p.m., review of a wound care clinic report, dated November 14, 2012, revealed a recommendation that Client #1 spend less time in the wheelchair. It also included: "patient is to have seating and mapping performed for optimal offloading cushion to be made. Patient is to call <local hospital> Seating Mapping." Three weeks later, on December 3, 2012, the facility obtained a telephone order for "Referral for Seating/mapping evaluation." The record indicated she was evaluated on February 5, 2013.</p> <p>On April 10, 2013, at 4:33 p.m., the qualified intellectual disabilities professional (QIDP, Staff</p>	W 436	<p>The QIDP is exploring other options for the purchase of dentures for individual #1. In the meantime, Metro Homes Inc. will schedule a dental appointment and obtain a set of dentures for individual #1.</p> <p>The QIDP re-inserviced staff #8 and all staff working at 5701 14th St. NW, Washington, DC 20011 on the current bunny boots protocol.</p> <p>QIDP has requested a review of the current protocol by the Physical Therapist. QIDP to immediately implement any recommendations made from the consultation.</p> <p>SYSTEM: The QIDP will update via email every 2 weeks any adaptive equipment issues, and report to Executive Director immediately.</p>	<p>06/30/13</p> <p>05/01/13</p> <p>05/20/13</p> <p>04/12/13</p>

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

PRINTED: 04/26/2013
FORM APPROVED
OMB NO. 0938-0391

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 04/12/2013
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 436	<p>Continued From page 12</p> <p>#1) stated that she was unsure of the current status of the seating system. At 4:55 p.m., the registered nurse (Staff #4) reported having telephoned the wheelchair clinic a few minutes earlier. The molding process reportedly was underway at an outside vendor and Client #1 would need a return appointment for a "second fitting" (on a date to be determined). Staff #1 and #4 acknowledged that Client #1 remained without a new wheelchair seating system 5 months after the need was first identified.</p> <p>II. The facility failed to obtain dentures timely for Client #1, as follows:</p> <p>On April 11, 2013, beginning at 10:30 a.m., review of Client #1's dental records revealed that "full upper and lower dentures impressions" had been taken on May 25, 2012. When the client returned to the dentist on July 27, 2012, however, she was informed "Medicaid will not pay, already received upper and lower set." At 10:35 a.m., interview with Client #1 revealed that she was without dentures. The client's 1:1 direct support staff (Staff #13) who was present at the time, confirmed that Medicaid had denied payment. Staff #13 further indicated the client had been admitted to this facility without dentures in May 2011.</p> <p>On April 11, 2013, at 11:06 a.m., review of Client #1's nursing assessment, dated September 15, 2012, revealed a history of owning dentures and "Medicaid will not pay for the dentures." Monthly Progress Notes prepared by the QIDP (Staff #1) also reflected a history of dentures and the dentures were "missing since admitted to" the facility. The monthly notes did not, however,</p>	W 436		

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W 436	<p>Continued From page 13</p> <p>reflect actions taken to obtain replacement dentures.</p> <p>On April 9, 2013, at 11:28 a.m., the facility's registered nurse (RN, Staff #4) stated there had been discussions regarding the dentures. She then acknowledged that there was no documentation of said discussions available for review in Client #1's record. At 12:22 p.m., Staff #1 stated the dentures "were a big issue at <her> second quarterly meeting." A decision had been made to contact Client #1's former residential provider to ask whether the client's dentures could be located and returned. Staff #1 confirmed the client was admitted in May 2011, almost 2 years before this survey.</p> <p>III. Facility staff failed to consistently implement the protocol designed for Client #2's specialized foot coverings, as follows:</p> <p>On April 9, 2013, at approximately 7:45 a.m., Client #2 was observed wearing slippers that had extra padding. Interview with a direct support staff (Staff #8) revealed the special slippers were prescribed after the client developed pressure sores on his feet while in hospital. Staff #8 further indicated the sores had healed but he was to continue wearing the slippers at all times. The client was observed wearing the slippers, which staff referred to as "bunny boots" while at the day program (beginning at 12:21 p.m.) and again upon arrival home that afternoon.</p> <p>Continued observations, however, on April 9, 2013, at 4:42 p.m., revealed Client #2's 1:1 direct support staff (Staff #11) removed the bunny boots while the client was repositioned in a recliner. He</p>	W 436		

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W 436	<p>Continued From page 14</p> <p>replaced the bunny boots when he was transferred back into the wheelchair at some time after 5:08 p.m. The client's records reflected a protocol for the bunny boots, dated December 16, 2012. The protocol said he should wear them at all times unless he was being bathed.</p> <p>On April 12, 2013, at 11:55 a.m., when asked whether Client #2's bunny boots protocol from December 2012 remained current, the QIDP (Staff #1) replied yes. moments later, she presented documentation of an in-service training provided by the RN (Staff #4) on January 29, 2013, that addressed the boots. Staff #11's signature was observed on the attendance sheet.</p>	W 436		

Health Regulation & Licensing Administration

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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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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from April 9, 2013 through April 12, 2013. A sample of three residents was selected from a population of three males and three females with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and one day program, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1 000		
1 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinate services and referrals timely (specifically, notify the speech language pathologist of a recommended Modified Barium Swallow study). for one of three residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On April 9, 2013, beginning at 7:19 a.m., Resident #2 was observed eating pureed foods</p>	1 180	<p>The Program Director has re-inserviced the QIDP on the roles and responsibilities of coordinating services for all individuals to include, but not limited to medical needs, speech, physical therapy, occupational therapy, etc. at 5701 14th St. NW, Washington, DC 20011.</p> <p>SYSTEM: A nursing team will conduct a quarterly quality assurance review to ensure that all medical/ therapeutic recommendations are followed through on in a timely manner.</p>	<p>05/08/13</p> <p>Ongoing</p>

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Emily J. Hamed* TITLE: *Exec. Director of Operations* (X6) DATE: *5/10/13*

STATE FORM 6899 WBU611 If continuation sheet 1 of 11

Health Regulation & Licensing Administration

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I 180	<p>Continued From page 1</p> <p>and drinking from a specialized cup at breakfast. A short time later, at approximately 9:15 a.m., the qualified intellectual disabilities professional (QIDP, Staff #1) referred to the resident's specialized cup as a "dysphasia cup" and stated that his foods were pureed and liquids were thickened to a nectar consistency due to his risk of aspiration. On April 9, 2013 at 6:35 p.m., Resident #2 was observed vomiting while seated at the dinner table; he had already eaten most of his meal. The director of nursing (DON, Staff #3) and the QIDP (Staff #1) stated that he had a long history of vomiting during meals and was seen regularly by a gastro-intestinal (GI) specialist. Staff #1, Staff #3 and a direct support staff (Staff #12) all stated that he had not vomited during a meal in "over a year."</p> <p>Resident #2's medical and habilitation records were reviewed on April 11, 2013, beginning at 1:39 p.m. His Individual Support Plan (ISP), dated September 7, 2012 reflected the observed adaptive equipment, pureed diet and liquids thickened to nectar consistency. His records also reflected a history of vomiting and GI consultations.</p> <p>On April 11, 2013, beginning at approximately 4:55 p.m., review of Resident #2's gastro-intestinal (GI) consultations revealed that on August 31, 2012, the GI specialist recommended that the facility contact the speech language pathologist to schedule a Modified Barium Swallow (MBS) study. According to a nurse progress note also dated August 31, 2012, the resident's primary care physician "agreed" with the recommendation for a MBS study. Further review of the record, however, failed to show evidence that the speech-language pathologist had been contacted or that Resident</p>	I 180		

Health Regulation & Licensing Administration

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I 180	Continued From page 2 #2 was referred for a MBS study. On April 12, 2013, at 12:32 p.m., the QIDP (Staff #1) was queried about the status of the recommended MBS study. She stated that Resident #2's next Speech-Language Evaluation was due in May 2013. She then acknowledged that the speech-language pathologist had not been contacted regarding the need for an updated MBS study. The facility's licensed practical nurse coordinator (Staff #5) and the DON (Staff #3) were both present at the time. They examined the record and confirmed there was no evidence of any follow-up to the August 31, 2012 recommendation that Resident #2 receive a MBS study.	I 180		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to maintain a system that ensured a complete accounting of each resident's personal funds, for two of three residents in the sample. (Residents #1 and #3) The findings include: I. On April 11, 2013, beginning at 1:00 p.m., review of Resident #1's financial records revealed the following: A. \$200 dollars was withdrawn from Resident #1's account on October 12, 2012. There was a receipt dated October 30, 2012 for a purchase of \$163.16. There was no record of what happened	I 189	The QIDP/Residential Coordinator were re-inserviced on the client funds policies and procedures. Metro Homes, Inc. finance department is conducting an audit for individuals #1 and #3 individual financial records. Individuals will be reimbursed money owed, based upon the results of the audit. SYSTEM: On 11/20/12, Metro Homes, Inc. initiated a new individual funds policy and procedure. All Residential Coordinators and QIDP's were inserviced on 11/20/12. The procedure includes reconciling monies on a weekly basis.	05/08/13 5/18/13

Health Regulation & Licensing Administration

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I 189	<p>Continued From page 3 to the balance (\$36.84).</p> <p>B. \$200 dollars was withdrawn from Resident #1's account on December 19, 2012. There was a receipt dated December 24, 2012 for a purchase of \$146.13. There was no record of what happened to the balance (\$53.63).</p> <p>Interview with the qualified intellectual disabilities professional (QIDP, Staff #1) on April 11, 2013, at 2:25 p.m. revealed that some of Resident #1's funds withdrawn on October 12, 2012 were used to make a purchase for Resident #4. She added that Resident #1 "has to be reimbursed" and there was "no special reason" why Resident #1 had not yet been reimbursed. When asked about the December 19, 2012 withdrawal, she examined the records and stated she believed that the sales receipt was for another resident's purchase, and the other resident likely had Resident #1's receipt.</p> <p>II. Resident #3's financial records were reviewed also on April 11, 2013, beginning at 1:13 p.m. Three concerns were identified, as follows:</p> <p>A. There was a receipt dated August 3, 2012 showing that Resident #3 had paid for 3 admission tickets @ \$18.99 each, for an amusement park while vacationing in Ocean City, MD. With tax added, the total cost to Resident #3 was \$56.68. Continued review of his records failed to show evidence that he had been reimbursed for the other 2 admissions.</p> <p>B. Similarly, there was a receipt dated August 2, 2012 for multiple admissions to a museum. The receipt indicated there were 5 adult admissions, yet someone had written a notation "\$20.58" on the receipt (suggesting that there had been 3</p>	I 189		

Health Regulation & Licensing Administration

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I 189	<p>Continued From page 4 admission tickets purchased).</p> <p>C. Continued review of Resident #3's finances revealed a receipt for a purchase made on December 22, 2012, totaling \$78.51. The receipt indicated the purchase of 2 "Boys Athletic Shirts" and a "Boys Large Size Polo" shirt. By comparison, the receipts for other clothing purchases made during the past year consistently showed adult sized clothes were purchased. It should be noted that Resident #3 is not of short stature or otherwise small in size.</p> <p>Further interview with the QIDP (Staff #1) on April 11, 2013, at 2:34 p.m., revealed that both she and the residential coordinator (Staff #2) were to review sales receipts and compare them with requests made for residents' funds. The agency's accountant also was tasked with reviewing residents' financial transactions and signing-off on the information before filing the original documents at the corporate office.</p> <p>The QIDP stated that Resident #3 "should have paid \$18.99 plus tax. He shouldn't have paid for anyone else" to enter the amusement park. The agency reportedly paid for staff admissions. She examined the receipt and stated it should indicate only 3 admissions, since only 3 of the 5 residents who went on the beach vacation were ambulatory and able to enjoy amusement park rides. By contrast, she confirmed that the museum admission would have been for 5 adults because the museum was wheelchair accessible, allowing all 5 individuals to enjoy the displays. She acknowledged there was no evidence that Resident #3 had been reimbursed after paying for everyone else's admissions. As for the boys-sized clothing purchased in December, she stated she would ask Staff #2 about the purchase.</p>	I 189		

Health Regulation & Licensing Administration

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I 189	Continued From page 5 Upon arrival at the facility the next morning (April 12, 2013), Staff #2 indicated that he thought the sales receipt dated December 22, 2012, that showed boys-sized clothing items were purchased belonged to a different individual. He said that was just a guess, because he made numerous purchases for individuals all within the same day or two before Christmas.	I 189		
I 261	<p>3512.2 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure all personnel records were available for inspection by personnel of the Department of Health, Health Regulation and Licensing Administration.</p> <p>The finding includes:</p> <p>On April 9, 2013, at 9:45 a.m., the qualified intellectual disabilities professional (QIDP, Staff #1) agreed to make available for review the records of all personnel, including licensed health professionals. On April 10, 2013, at 5:40 p.m., the QIDP (Staff #1) presented personnel records. They did not include records for their professional consultants. She explained the consultant files were unavailable but would be brought to the facility on the next day. On April 11, 2013, beginning at 9:18 a.m., review of the records that were available revealed the consultant files had</p>	I 261	<p>Human Resources will be inserviced by the Executive Director of Operations on the importance of providing all personnel records to authorized regulatory agencies upon request.</p> <p>SYSTEM: Human resources will provide Executive Director of Operations a copy of all consultants information in an organized book, and provide updated information by email as expiration occurs.</p>	<p>05/13/13</p> <p>Ongoing</p>

Health Regulation & Licensing Administration

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I 500	Continued From page 10 C. On April 9, 2013, at 6:56 p.m., Staff #7 was observed administering Resident #1's medications, including Protonix 40 mg. On April 10, 2013, at 10:30 a.m., review of Resident #1's POS and MARs for April 2013 revealed that the order for Pantoprazole Sodium (Protonix) 40 mg said to take "one tablet by mouth at bedtime for reflux." The designated time, however, on the MAR was 5:00 p.m. On April 12, 2013, at 12:13 p.m., the licensed practical nurse coordinator (Staff #5) was interviewed to ascertain the reasoning for administering residents' evening medications at one time, rather than at the designated times (i.e. 5:00 p.m., 7:00 p.m. and bedtime). Upon review of Residents #1, #5 and #6's POS and MARs, Staff #5 stated that she would seek clarification on the aforementioned orders.	I 500		

Health Regulation & Licensing Administration

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I 500	<p>Continued From page 9</p> <p>April 2013 confirmed that he was prescribed Travatan Z Benzalkonium Free 0.004% eye drops "one drop in each eye every evening for glaucoma."</p> <p>B. On April 10, 2013, at 9:35 a.m., continued review of Resident #3's POS and MARs for April 2013 revealed an order for "Ear Drops (Generic Debrox) 6.5% Drops Instill 2 drops in each ear every evening to prevent wax build up." Resident #3 was not, however, observed to receive the ear drops on the evening of April 9, 2013.</p> <p>II. Nursing staff failed to seek clarification of orders when indicated, as follows:</p> <p>A. On April 9, 2013, at 5:15 p.m., Staff #7 was observed preparing Resident #6's medications. The resident received Risperidone 0.5 mg and Senekot 15 milliliters (ml), followed by water. On April 10, 2013, at 9:23 a.m., review of Resident #6's POS and MARs for April 2013 revealed that the order for Risperidone 0.5 mg was to take one tablet by mouth "at bedtime." The designated time, however, on the MAR was 5:00 p.m.</p> <p>B. On April 9, 2013, at 5:21 p.m., Staff #7 was observed administering Resident #5's medications, including Polyethylene Glycol (Miralax) 17 grams (1 scoop) powder mixed with water. She administered the aforementioned medications at 5:32 p.m. On April 10, 2013, at 9:56 a.m., review of Resident #5's POS for April 2013 revealed that the order read "Polyethylene Glycol (Miralax) 17 gram dissolved in 4 ounce liquid by mouth twice daily." The same order was on the MAR, with 7:00 p.m. as the designated administration time. It was noted that all of Resident #5's other evening medications had a 5:00 p.m. designated administration time.</p>	I 500	

Health Regulation & Licensing Administration

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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 500	<p>Continued From page 8</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for individuals with intellectual disabilities (GHIID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for four of six residents of the facility. (Residents #1, #3, #5 and #6)</p> <p>The findings include:</p> <p>[483.420(a)(7)] The GHIID failed to ensure Residents #1, #3, #5 and #6's right to receive medications in accordance with physician's orders and without error, as follows:</p> <p>I. Nursing staff failed to ensure that Resident #3's prescribed eye and ear drops were administered as ordered, as follows:</p> <p>A. During the process of the evening medication administration, a licensed practical nurse (Staff #7) was observed administering Travatan Z Benzalkonium Free 0.004% eye drops. Resident #3 was to receive one drop in each eye. The first drop missed his right eye and rolled down his cheek. The medication did not enter his eye. Staff #7 subsequently administered a drop of Travatan to his left eye and then one drop of Artificial Tears eye drops into each eye before the resident's medication administration ended.</p> <p>On April 10, 2013, at 9:33 a.m., review of Resident #3's physician's order sheets (POS) and medication administration records (MARs) for</p>	I 500		
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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 04/12/2013
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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I 478	<p>Continued From page 7</p> <p>was administered Ativan 4 mg on March 5, 2013 for ENT and again on March 12, 2013 for audiology.</p> <p>On April 12, 2013, at approximately 10:58 a.m., the licensed practical nurse coordinator (Staff #5) presented a blister pack of lorazepam (Ativan). The label showed Resident #3's name on it and 30 tablets, 2 milligrams (mg) each, had been filled and sent to the facility on February 6, 2013. Seven (7) of the 2-mg tablets were missing; 23 remained in the pack. The director of nursing (DON, Staff #3) and Staff #5 were unable to locate a Controlled Medication Utilization Record form for the 30-tablet blister pack of lorazepam. After examining Resident #3's medical chart, including MARs from February, March and April 2013, Staff #3 and #5 confirmed the resident had been administered 2 tablets of 2 mg each on two occasions only. At 11:07 a.m., Staff #3 stated "the count is not adding up" and at 11:27 a.m., she indicated they were unable to account for 3 tablets that were missing from the blister pack. She had initiated an investigation and was trying to reach a former nurse (Staff #6) who was responsible for receiving and managing medications in February and March 2013.</p> <p>There was no evidence that the facility utilized an effective system to record the receipt, disposition and monitoring of controlled drugs.</p>	I 478	
I 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p>	I 500	Cross Reference with W368

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 04/12/2013	
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I 261	Continued From page 6 not been retrieved. At 10:13 a.m., the residential coordinator (Staff #2) was offered a reminder. No additional information was made available for review before the survey ended on April 12, 2013, at 3:30 p.m.	I 261		
I 478	<p>3522.6(d) MEDICATIONS</p> <p>The record for a resident 's prescribed controlled substances shall include the following:</p> <p>(d) Date dispensed, amount and expiration date; and...</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to maintain records of the receipt and disposition of all controlled drugs, for one of three residents in the sample. (Resident #3)</p> <p>The finding includes;</p> <p>Resident #3's habilitation and medical records were reviewed on April 12, 2013, beginning at 9:02 a.m. According to the resident's Individual Support Plan (ISP) dated February 7, 2013, his sister was his designated substituted health care decision-maker. Review of consent forms revealed that on February 25, 2013, the sister signed consent for Resident #3 to receive Ativan 4 mg prior to audio testing and an ear-nose-throat (ENT) appointment (dates not specified). Prior to that, on February 5, 2013, the psychiatrist wrote a prescription for "Ativan 4 mg, 30 tablets, take one hour prior to medical appointments." On March 6, 2013, the primary care physician (PCP) signed an identical order that was written by the psychiatrist on March 5, 2013. The resident's Medication Administration Record (MAR) showed that he</p>	I 478	<p>The Director of Nursing re-inserviced all nursing staff employed at Metro Homes, Inc. on proper reconciliation of narcotics and narcotic counts. An investigation is still being conducted at the time of the plan of correction.</p> <p>SYSTEM: A new system has been developed to ensure that all narcotics going into the home are signed in, each home will maintain a narcotics log book that will indicate which individuals are currently administered narcotics. During quarterly quality checks, and other reviews, the narcotics book will be reviewed to ensure that all narcotics are present and current policy is being adhered to. Supervising Registered Nurse will monitor monthly to ensure that all narcotics are present and accounted for, and document accordingly.</p>	<p>05/06/13</p> <p>Ongoing</p>