

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

PRINTED: 06/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2009
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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
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W 000	INITIAL COMMENTS A recertification survey was conducted on May 21, 2009 through May 22, 2009. The survey was initiated as a full survey due to facility's history of condition level deficiencies during the previous survey period. A random sampling of two clients from the residential population of four females was selected for the survey. The results of the survey were based on observations in the home and at two day programs, staff interviews, as well as a review of the client and administrative records, including a review of the unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to ensure operating direction over the facility as evidenced below: The findings include: 1. [Cross refer to W393]. The facility failed to ensure it met the requirements for performing glucose monitoring testing, for clients in the facility whose blood glucose was being tested by facility staff, for Client #2. Interview with the Qualified Mental Retardation Professional (QMRP) on May 22, 2009 at approximately 4:00 PM revealed that the Program Director had submitted an application form for obtaining a Clinical Laboratory Improvement Act	W 104	It is the Policy of St. John's Community Services to provide quality services to its residents, exercise general policy, budget and operating direction over the facility. The request for the Clinical Laboratory Improvement Act CLIA Certificate of Waiver was submitted twice to the Department of Health, on 3/16/2009 and 4/14/2009 respectively. A copy of the completed forms which were submitted to DOH along with a copy of the fax confirmation sheet is attached for your review.	4/14/09

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
M. [Signature] TITLE
Program Director (X5) DATE
6/15/09

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 discloseable 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 discloseable 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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W 104	<p>Continued From page 1</p> <p>(CLIA) certificate of waiver. She did not, however, know the status of the application. She further indicated that she faxed an application to the appropriate office but failed to provide evidence. No additional information was made available for review before the survey ended. There was no evidence that the governing body had established a policy regarding CLIA certificates of waiver.</p> <p>2. [Cross refer to W426]. The facility failed to effectively implement its policy to ensure water temperatures did not to exceed 110 degrees Fahrenheit.</p> <p>Measurement of the hot water temperature on May 22, 2009 beginning at 4:17 PM, in each of the three bathrooms in the facility, and also in the kitchen, revealed that the temperature exceeded 110 degrees at all tested faucets. Further observation revealed a gauge installed on the hot water heater that showed that the hot water temperature was set at 110 degrees Fahrenheit. Interview with the QMRP on May 22, 2009 at 5:00 PM revealed staff should test the water temperatures during each shift.</p> <p>The review of the hot water temperature log on May 22, 2009 at 5:00 PM revealed instructions for monitoring water temperatures as evidenced below:</p> <p>*The water temperature log should be completed at the beginning of every shift (6:00 AM -10:00 AM, 7:00 AM - 3:00 PM. If applicable, 8:00 AM - 4:00 PM, 10:00 PM -8:00 AM, 11:00 PM - 7:00 AM, 12:00 AM - 10:00 AM). Weekend staff should follow the same routine in collecting the data for each shift. Prior to AM and PM hygiene,</p>	W 104	<p>It is the policy of St John's Community Services to ensure the safety and protection of all of the Individuals in its care. The Magnolia Company was hired and all repairs pertaining to the temperatures were made. Please see the attached completed work orders. The log for documentation for taking water temperature was revised on 6/10/09 and staff in-serviced on 6/11/09.</p>	6/11/09	

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W 104	<p>Continued From page 2 or whenever hygiene care is deemed necessary, the temperature of the water must always be taken."</p> <p>The review of temperatures on the same water temperature log revealed staff had not collected the required data as evidenced below:</p> <ul style="list-style-type: none"> - May 12, 2009 (6:30 AM and 5:00 PM) - May 13, 2009 (4:30 PM) - May 14, 15, 16, 2009 (no temperatures documented) - May 17, 2009 (6:30 AM and 3:00 PM) - May 18, 2009 (6:30 AM and 5:00 PM) - May 19, 2009 (4:30 PM) - May 20, 2009 (5:30 PM) - May 21, 22, 2009 (no temperatures documented) <p>Additional instructions on the water temperature log revealed that the residential team leader should initial the form on a daily basis and the QMRP should monitor the water temperatures weekly.</p> <p>The review of water temperatures documented on the aforementioned days revealed a range of 99 to 103 degrees Fahrenheit. At the time of the survey, however, there was no evidence that the governing body had established an Internal Quality Assurance system to ensure it policy on monitoring of water temperatures at the beginning of each shift was implemented.</p> <p>3. During observations of the environment on May 22, 2009 at 4:30 PM, Client 4's mattress was observed to be too small for the frame for the bed, with extra space being observed at the side and foot of the bed frame. Interview with the QMRP revealed that the mattress had been</p>	W 104	3. The bed for Sample # 4 was replaced on 6/12/09.	

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W 104	Continued From page 3	W 104		
W 120	<p>purchased too small for the bed. There was no evidence that the facility had provided Client #4 with a properly fitting mattress for her bed.</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that outside services met the needs of each client, for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure that the day program provided Client #1's therapeutic diet as prescribed as evidenced below:</p> <p>On May 21, 2009 at 11:52 AM, Client #1 was observed at her day program eating a chopped hamburger, mix vegetables, rice water, and kool aid. Interview with the day program counselor at approximately 11:55 AM, indicated that Client #1 was eating a 1500 calorie diet.</p> <p>Review of the day program meal time protocol dated October 2008 at approximately 12:00 PM, revealed the client was prescribed a 1500 calorie, mechanical soft, low sodium diet with thin liquids. Review of the group home meal time protocol at 1:10 PM revealed that Client #1 was prescribed a 1200 calorie reducing, chopped diet. Review of the physician's order dated May 5, 2009 at 1:30 PM, confirmed that Client #1 was prescribed a 1200 calorie reducing, chopped diet. Further</p>	W 120	<p>It is the Policy of SJCS to ensure that outside services meet the needs of all the individuals in its care. The Day Program Staff was in-serviced on the mealtime time protocol and diet order for sample # 1 on 6/15/09.</p>	6/15/09

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W 120	Continued From page 4 record review revealed that Client #1 weighed 126 lbs and exceeded her desirable weight range of 86-104 lbs. The meal time protocol noted nutrition concerns that Client #1 was overweight and had the potential for weight gain.	W 120		
W 124	Interview with the Qualified Mental Retardation Professional (QMRP) on May 14, 2009, at approximately 2:30 PM indicated that the group home had informed the day program of Client #1's mealtime protocol and prescribed diet order. At the time of the survey, there was no evidence that Client #1's day program was providing the therapeutic diet as prescribed. 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the four clients included in the sample. (Client #1) The finding includes: The facility failed to ensure that informed consent	W 124		

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W 124	<p>Continued From page 5</p> <p>was obtained from Client #1 and/or her legal guardian prior to the implementation of her Behavior Support Plan (BSP).</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on May 21, 2009 at 9:15 AM, revealed that Client #1 had a Behavior Support Plan (BSP), and did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>The QMRP's statement was verified on May 21, 2009 at 3:50 PM through review of Client #1's psychological assessment dated August 21, 2008. According to the assessment, Client #1 "does not evidence the capacity to make independent decisions in the areas of habilitation, residential placement, medical decisions, finances, and life planning. Continued interview with the QMRP, revealed that Client #1's sister acted as her guardian.</p> <p>At the time of the survey, however, the facility failed to provide evidence that the potential risks involved in use of restrictive interventions, or the client's right to refuse treatment had been explained to the client and/or her legally sanctioned representative. (See W263)</p>	W 124	<p>It is the policy of St. John's Community Services to inform each individual's parent or legal guardian of the medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. The informed consent for Sample #1 has been requested for the use of the BSP.</p>	6/11/09
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record</p>	W 159		

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W 159	<p>Continued From page 6</p> <p>review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for four of the four clients residing in the facility. (Clients #1, #2, #3, and #4)</p> <p>The findings include:</p> <p>1. The QMRP failed to coordinate with the physical therapist to determine how Client #2's objective to "roll right to left for 25 consecutive minutes three days a week" was to be implemented.</p> <p>On May 21, 2009 at 2:40 PM, the review of Client #2's Individual Program Plan revealed a goal to improve the the client's transferring skills. The objectives stated "Given physical assistance, ... will roll right to left for 25 consecutive minutes, 3 days a week for twelve (12) consecutive months. Data reflected that the client accomplished the criteria on 100% of the trials during the month of April 2009.</p> <p>Interview with the QMRP and the Residential Director (RD) indicated that the client was turned to various positions during her personal care while in bed, which may be included within the 25 minute period. Interview with staff revealed that with physical assistance, the client was able to roll from one side to the other. At the time of the survey, however, there was no evidence that it had been determined if the client was to be provided physical assistance to roll from right to left 25 times or for 25 minutes.</p> <p>2. The QMRP failed to coordinate services with Client #1's day program to ensure that she</p>	W 159	<p>It is the policy of St. John's Community Services to ensure that the active treatment program is integrated, coordinated and monitored by the Qualify Mental Retardation Professional (QMRP). The Physical Therapist was contacted and the programs for Sample #2 was revised and staffs in-serviced on 6/11/09</p> <p>It is the Policy of SJCS to ensure that outside services meet the needs of all the individuals in its care. The Day Program Staff was in-serviced on the mealtime time protocol and diet order for sample # 1 on 6/15/09.</p> <p>2. The Day Program staff was in-serviced 6/15/09.</p>	6/11/09	6/15/09

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W 159 Continued From page 7 received her therapeutic diet as prescribed. [See W120]

3. The QMRP failed to coordinate with nursing services to ensure that self medications programs were implemented as written for Clients #1, #2, #3 and #4. [See W249]

4. The QMRP failed to coordinate services to ensure that Client #1's wheelchair was maintained in good repair. [See W436]

5. The QMRP failed to coordinate services to ensure monitoring of the water temperature log for completion as required, at the beginning of each shift. [See W104]

W 159

3. Staffs were in-serviced by the Nurse and QMRP on the Self Medication Program on 6/10/09.

4. The Wheelchair was repair on 5/25/09.

5. The Staffs were in-serviced on the revised water temperature log on 6/10/09

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that as soon as the interdisciplinary team formulated a client's individual program plan (IPP), each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the Individual Program Plan (IPP), for four of the four clients residing in the facility. (Clients #1, #2, #3,

W 249

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W 249	<p>Continued From page 8 and #4)</p> <p>The findings include:</p> <p>1. The facility failed to ensure that the clients participated in their activities of daily living skills program (Self Medication Program) as specified in their IPP.</p> <p>During medication observation on May 21, 2009 at 7:09 PM, the Trained Medication Employee (TME) removed Client #2's medications from her blister pack. The TME spoon fed Client #2 her medications and handed her a cup of water to drink independently.</p> <p>At 7:25 PM the TME was observed removing Client #3's medications from her blister pack. Client #3 was spoon fed her medications by the TME. Further observation revealed Client #3 drinking water as the TME held the cup.</p> <p>At 7:35 PM the TME was observed removing Client #4's medications from her blister pack. Client #4 was spoon fed her medications and drank her water as the TME held the cup.</p> <p>At 7:43 PM TME was observed removing Client #1's medications from her blister pack. The TME spoon fed Client #1 her medications and handed her a cup of water to drink independently.</p> <p>Interview with the TME at approximately 8:00 PM, revealed that the clients participated in a self medication program.</p> <p>Review of the medication administration program data collection for Clients #1, #2, #3 and #4 dated May 1, 2009 on May 22, 2009 at 8:00 PM,</p>	W 249	<p>It is the Policy of St. John's Community Services to ensure that each individual receives continuous active treatment as soon as the Interdisciplinary Team formulates the individual's IPP.</p> <p>1. All staffs were trained on the self Medication program on 6/10/09.</p>		

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W 249	<p>Continued From page 9 revealed the following steps to implement program objectives:</p> <ol style="list-style-type: none"> Identify time of medication Obtain water or juice Obtain medicine cup Remove medicine from blister pack. Throw cup in trash. <p>At the time of the observation, there was no evidence that the TME implemented the clients' medication administration programs.</p> <p>2. The facility failed to ensure that Client #1 received training to improve her sitting balance as recommended by the physical therapist.</p> <p>On May 21, 2009 at 7:25 AM, Client #1 was observed sitting in her wheelchair with her left arm bent upward. Further observation confirmed that Client #1 did not use her left arm.</p> <p>Review of the client's physicians order dated May 2009 on May 21, 2009, at 1:10 PM revealed that Client #1 has a history of a stroke and a diagnosis of hemiplegia. Record review on May 21, 2009 at approximately 5:00 PM, revealed a physical therapy objective for Client #1 which stated, "Given stand by assistance, Client #1 will tolerate sitting on the side of her bed for ten repetitions, three days per week for twelve consecutive months.</p> <p>Interview with the Qualified Mental Retardation Professional on May 22, 2009 at approximately 1:30 PM, confirmed that the physical therapy goal was not included in the into Client #1's Individual Program Plan.</p>	W 249	<p>2. The PT revised the programs to improve the sitting balance for Sample #1 and staffs were in-serviced on 6/11/09.</p>		

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 10	W 249	1. The QMRP had contacted the Physical Therapist. The program was revised and staffs were in-serviced on 6/11/09.	
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for one of the two clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>[Cross refer to W124] Observation of the evening medication administration on May 21, 2009 at 7:43 PM revealed Client #1 was administered Clonazepam 1 mg. Interview with the Licensed Practical Nurse (LPN), revealed the aforementioned medication were used to address the client's aggression.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on May 21, 2009 at 9:15 AM, revealed that Client #1 had a Behavior Support Plan (BSP), and did not have the capacity to give informed consent for the use of medications and habilitation services. Continued interview with the QMRP, revealed that Client #1 sister acted as her</p>	W 263	<p>The Informed Consent for Sample #1 was requested from the Sister of Sample #1 6/11/09 (See W124)</p>	

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
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W 263	Continued From page 11 guardian.	W 263		
	<p>The review of Client #1's record on May 21, 2009, at 3:58 PM confirmed that the client, in addition to taking psychotropic medications, also had a Behavior Support Plan (BSP) dated September 15, 2008 to address her behavior of physical aggression. At the time of the survey however, the facility failed to evidence that written consent was obtained from a legally sanctioned representative for the use of the psychotropic medication and the BSP to reduce Client #1's behaviors.</p>		<p>It is the policy of St. John's Community Services to inform each individual's parent or legal guardian of the medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. The informed consent for Sample #1 has been requested for the use of the Psychotropic Medication.</p>	6/11/09
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide preventive and general care, for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure that Client #1 received an evaluation of her abdominal distention as recommended. [See W331]</p>	W 322		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record</p>	W 331	<p>It is the Policy of St John's Community Services to provide or obtain preventative and general medical care. Sample #1 received an evaluation for abdominal distention on 6/4/09. A copy of the consultation form is attached for your review.</p>	

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2718 13TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 13</p> <p>confirmed that the TME did not wait ten minutes between administering two different eye drops.</p> <p>2. The facility's nursing services failed to ensure that Client #1's salt intake was monitored.</p> <p>On May 21, 2009 at approximately 1:10 PM, review of Client #1's physician's orders (POs) for the period from July 2008 through May 2009 indicated that the client had a history of strokes. Review of the pharmacy review dated May 5, 2009 at 2:20 PM revealed the pharmacist's recommendation to monitor Client #1's salt intake.</p> <p>Interview with the LPN on May 22, 2009 at approximately 3:00 PM revealed that she was unaware of the recommendation by the pharmacist.</p> <p>There was no evidence that the pharmacist's recommendation to monitor Client #1's salt intake had been addressed.</p> <p>3. The facility's nursing services failed to ensure a referral for follow-up on Client #1's abdominal distention as recommended.</p> <p>Review of the primary care physician's medical consultation form dated January 22, 2008 on May 22, 2009 at approximately 4:30 PM revealed Client #1 had nonpainful abdominal distention. The primary care physician recommended a flat and erect abdominal x-ray and thereafter, a follow-up evaluation in one week.</p> <p>Interview with the LPN at approximately 4:45 PM, indicated that she attempted to schedule an</p>	W 331	<p>2. The Diet Order for Sample #1 was changed to include no added salt by the Medical Director. A copy of the PMOF is attached for your review. In the future the diet order will be written as ordered by the Pharmacist.</p> <p>Staffs were in-serviced on the new diet order on 6/10/09</p> <p>3. Sample # 1 completed consultation for abdominal distention on 6/4/09. In the future, all consultation will be completed timely.</p>		

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	Continued From page 14 appointment, but was unsuccessful.	W 331	See W104		
W 393	<p>At the time of the survey, there was no evidence that the follow-up on Client #1's abdominal distention had been completed.</p> <p>483.460(n)(1) LABORATORY SERVICES</p> <p>If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for clients in the facility whose blood glucose was being tested by facility staff, for one of the four clients residing in the facility. (Client #2)</p> <p>The finding includes:</p> <p>On May 21, 2009 at approximately 1:10 PM, review of Client #2's physician's orders (POs) for the period from July 2008 through May 2009 indicated that the client had an order for in-home finger sticks (fasting) "twice daily AM/PM every two days." Interview with the Licensed Practical Nurse (LPN) confirmed that Client #2 receives finger sticks every two days at the group home.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on May 22, 2009 at approximately 4:00 PM revealed that the Program Director had submitted an application to obtain a Clinical Laboratory Improvement Act (CLIA) certificate of waiver. She did not, however, know the status of the application. She further indicated that she faxed an application to the</p>	W 393			

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
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W 393	Continued From page 15 appropriate office, but failed to provide evidence. No additional information was made available prior to the survey exit to provide as evidence that the the CLIA certificate of waiver had been obtained.	W 393		
W 426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure water temperatures did not exceed 110 degrees Fahrenheit.</p> <p>The findings include:</p> <p>[Cross refer to W104.2]. Observation of the master bathroom #3 on May 20, 2009 at 9:50 AM revealed a thermometer was available to monitor the hot water temperatures. Observation of Master bathrooms #1 and #2 on May 22, 2009 at 4:17 PM and 4:19 PM respectively, revealed the same type of thermometers were available to monitor the water temperature in these areas.</p> <p>Assessment of the water temperatures on May 22, 2009, beginning at 4:17 PM revealed that the temperatures in all bathroom and the kitchen exceeded 110 degrees Fahrenheit as evidenced below:</p> <ul style="list-style-type: none"> - Master bathroom #1 (Clients #1 and #2): 120 degrees Fahrenheit 	W 426	<p>It is the policy of St John's Community Services to ensure the safety and protection of all of the Individuals in its care. The Magnolia Company was hired and all repairs pertaining to the temperatures were made. Please see the attached completed work orders. The log for documentation for taking water temperature was revised on 6/10/09 and staff in-serviced on 6/11/09. Also See (W104)</p>	6/10/09

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
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W 428	<p>Continued From page 16</p> <ul style="list-style-type: none"> - Master bathroom #2 (Clients #3 and #4): 126 degrees Fahrenheit - Master bathroom #3(Adjacent to office): 119 degrees Fahrenheit - Kitchen - 118 degrees Fahrenheit <p>Observation of the thermometer installed on the hot water heater to monitor the temperature revealed it registered a water temperature of 110 degrees Fahrenheit.</p> <p>Interview with the QMRP on May 22, 2009 at 4:19 PM revealed that hot water temperatures had been maintained at less than 110 degrees Fahrenheit. The QMRP then summoned the agency's engineer to the facility by telephone to correct the hot water temperature.</p> <p>The review of the hot water temperature log on May 22, 2009 at 5:00 PM revealed it should be completed at the beginning of every shift. According to the log, no water temperatures were recorded after May 20, 2009 at 5:30 PM.</p> <p>At approximately 5:00 PM, the engineer reduced the temperature setting on the hot water heater and, thereafter remained onsite to monitor the water temperatures. The surveyor measured the water temperatures again several times, and finally at 6:10 PM the water temperature in each of the four aforementioned areas was between 95 and 103 degrees Fahrenheit.</p> <p>At the time of the survey, however, there was no evidence the group home had ensured that the water temperature did not exceed 110 degrees</p>	W 428	<p>It is the policy of St John's Community Services to ensure the safety and protection of all of the Individuals in its care. The Magnolia Company was hired and all repairs pertaining to the temperatures were made. Please see the attached completed work orders. The log for documentation for taking water temperature was revised on 6/10/09 and staff in-serviced on 6/11/09.</p>	
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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
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W 426	Continued From page 17 Fahrenheit in areas of the facility used by individuals who had not been trained to regulate water temperature.	W 426			
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 maintain adaptive equipment, for one of the two clients included in the sample. (Client #1) The finding includes: On May 21, 2009 at 8:30 AM, the armrests on Client #1's wheel chair were observed to be very worn, with the fabric visible through the vinyl covering on both sides. Review of the 719 form dated January 4, 2009 at 5:00 PM, confirmed the order to repair the armrest. Further review revealed a 719 form dated March 12, 2009. The 719 form stated "Present wheelchair has parts which continue to need repair. In spite of various repairs, the wheelchair is wobbling and really poses some concerns." Interview with the Qualified Mental Retardation Professional on May 22, 2009 at approximately 3:00 PM indicated that the foot rest was the only	W 436	It is the Policy of St. John's Community Services to maintain the adaptive equipment for all its residents. The Armrest of the wheelchair was repair on 5/25/09.	5/25/09	

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2719 13TH STREET, NE WASHINGTON, DC 20018	
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W 436	Continued From page 18 repair made to Client #1's wheelchair.	W 436		
W 460	At the time of the survey, there was no evidence Client #1's wheelchair had been maintained in good repair. 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet was provided as prescribed to meet the nutritional needs of one of two clients in the sample. (Client #1) The finding includes: Cross refer to W120. The facility failed to ensure that the day program provided Client #1's therapeutic diet as prescribed. a. Interview with the day program counselor on May 21, 2009 at approximately 11:55 AM, indicated that Client #1 was eating a meal prepared in accordance with the 1500 calorie/day meal plan. Review of the day program meal time protocol dated October 2008 at approximately 12:00 PM, revealed the client was prescribed a 1500 calorie, mechanical soft, low sodium diet with thin liquids. Review of the group home meal time protocol and the physician's orders later that afternoon revealed Client #1 was prescribed a 1200 calorie reducing, chopped diet. The weight record reflected that Client #1 weighed 126 lbs	W 460	a. It is the Policy of SJCS to ensure that outside services meet the needs of all the individuals in its care. The Day Program Staff was in-serviced on the mealtime time protocol and diet order for sample # 1 on 6/15/09.	6/15/09

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2716 13TH STREET, NE WASHINGTON, DC 20018		
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W 460	<p>Continued From page 19</p> <p>and exceeded her desirable weight range of 86-104 lbs. The meal time protocol noted nutritional concerns that Client #1 was overweight and had the potential for further weight gain.</p> <p>At the time of the survey, there was no evidence that Client #1's therapeutic diet had been implemented as prescribed to promote weight loss to within her desirable weight range.</p> <p>b. On May 21, 2009, at 7:48 PM, Client #1 was observed eating her dinner meal that consisted of a chopped turkey burger, mashed potatoes, salad and cranberry juice.</p> <p>Interview with the House Manager and the Direct Care Aids at 7:55 PM revealed that Client #1 receives a 1500 calorie diet.</p> <p>Review of Client #1's physician's order dated May 5, 2009 on May 21, 2009 at 1:10 PM, revealed that the client was prescribed a 1200 calorie diet. Review of the nutritional assessment dated July 24, 2008 at 1:30 PM also revealed a 1200 calorie diet. Interview with the Licensed Practical Nurse (LPN) on May 22 2009, at approximately 4:00 PM, indicated that Client #1 should receive a 1200 calorie diet.</p> <p>There was no evidence that the facility ensured that Client #1 received the recommended daily calories in accordance with the written prescribed physician's order.</p>	W 480	<p>b. It is the Policy of SJCS to ensure that outside services meet the needs of all the individuals in its care. The Staffs was in-serviced on the mealtime time protocol and diet order for sample #1 on 5/25/09.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
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1 000	INITIAL COMMENTS A licensure survey was conducted on May 21, 2009 through May 22, 2009. A random sample of two residents was selected from a residential population of four females with mental retardation and other disabilities. The survey findings were based on observations in the group home and day programs. In addition, the findings were based on interviews with direct care, administrative, nursing, and day program staff. A review of the facility's records, including the unusual incident reports was also conducted.	1 000		
1 090	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 GHMRP failed to maintain the interior of the GHMRP in a safe, clean, orderly, and attractive manner. The findings include: 1. The GHMRP failed to maintain the interior environment safe, clean, orderly, and attractive as evidenced below: A. On May 22, 2009 at beginning at 4:17 PM, assessment of the hot water temperatures in the GHMRP revealed that they exceeded the allowable temperature of 110 degrees Fahrenheit as evidenced below: [Cross refer to W104.2] Observation of the	1 090	1. It is the policy of St John's Community Services to ensure the safety and protection of all of the individuals in its care. The Magnolia Company was hired and all repairs pertaining to the water temperatures were made. Please see the attached completed work orders. The log for documentation of water temperature was revised on 6/10/09 and staff in-serviced on 6/11/09.	

Health Regulation Administration

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

TITLE

(X6) DATE

STATE FORM

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37P711

If continuation sheet 1 of 17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
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1090	<p>Continued From page 1</p> <p>master bathroom #3 on May 20, 2009 at 9:50 AM revealed a thermometer was available. Subsequent observations in master bathrooms #1 and #2 on May 22, 2009 at 4:17 PM and 4:19 PM respectively, revealed the same type of thermometers were available to monitor the water temperature in these areas.</p> <p>Assessment of the water temperatures on May 22, 2009, beginning at 4:17 PM revealed that the temperatures in all bathroom and the kitchen exceeded 110 degrees Fahrenheit as evidenced below:</p> <ul style="list-style-type: none"> - Master bathroom #1 (Residents #1 and #2): 120 degrees Fahrenheit - Master bathroom #2 (Residents #3 and #4): 126 degrees Fahrenheit - Master bathroom #3(Adjacent to office): 119 degrees Fahrenheit - Kitchen - 118 degrees Fahrenheit <p>The thermometer installed on the hot water heater to monitor the temperature revealed it registered a water temperature of 110 degrees Fahrenheit.</p> <p>Interview with the QMRP on May 22, 2009 at 4:19 PM revealed that hot water temperatures had been maintained at less than 110 degrees Fahrenheit. The QMRP then summoned the agency's engineer by telephone to the GHMRP to correct the hot water temperature.</p> <p>The review of the hot water temperature log on May 22, 2009 at 5:00 PM revealed it should be completed at the beginning of every shift.</p>	1090	<p>A. It is the policy of St John's Community Services to ensure the safety and protection of all of the Individuals in its care. The Magnolia Company was hired and all repairs pertaining to the temperatures were made. Please see the attached completed work orders. The log for documentation for taking water temperature was revised on 6/10/09 and staff in-serviced on 6/10/09.</p>	6/10/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
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I 090	Continued From page 4 (3) Resident #3's tooth paste was stored without the top. (4) . Resident #4's toiletry items (tooth paste and toothbrush and Deodorant, etc.) were observed to be stored with topical medication in Resident #4's personal kit. H. Master Bathroom #2: (1) The shower chair was uneven, due to end covers missing from the two front legs. (2) The towel rack installed on the back of the door had one end missing and also the towel rod was missing. J. Lighting: (1) On the May 21, 2009 at 9:30 AM, three of four lights in the kitchen ceiling were observed to be inoperable. (2) During the same time, two of three ceiling light in the living/dining area were observed to be inoperable. Interview with the QMRP revealed that lighting in the GHMRP was monitored by the maintenance department. The ceiling lights in the living/dining area were replaced during the afternoon of May 21, 2009. The ceiling lights in the kitchen were replaced on May 22, 2009. (3) On May 22, 2009, the closet on the right side of the bedroom of Resident #3 and #4 was observed to be without an operable light. II. The GHMRP failed to maintain the exterior environment as evidenced below: On May 22, 2009, at approximately 1:30 PM, the bottom of the downspout, leading from the gutter on the right side of the roof, was was observed to	I 090	3. Resident #3's toothpaste has been replaced and the replacement does have top. 4. The Personal Kit for Resident # 4 has been separated. All toiletries are in a separate kit and all topical are in a separate kit. H. Master Bedroom #2 1. The Shower Chair has been replaced 2. The towel rack has been removed and the door repair. J. Lighting: 1. All lights in the kitchen were replaced with new bulbs. 2. The Ceiling light bulbs were replaced and are indeed operable. In the future, all bulbs will be replaced timely. 3. The light bulb in the closet on the right side of the bedroom of Resident #3 and #4 has been replaced. The light is operable. !!1. It is the policy of St. John's Community Services to maintain the exterior environment of the facility. The downspout has been cleaned and repair made to the disconnected pipe.	5/25/09 5/25/09 5/25/09 5/25/09 5/25/09 5/25/09	

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1090	Continued From page 5 be bent and to contain grass and debris. Further observation of the downspout revealed it was disconnected from the pipe installed in the ground to carry from the gutter away from the GHMRP. This condition created a potential for water excess water accumulation at the foundation of the QMRP.	1090		
1208	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 GHMRP failed to ensure that annual health certificates/ inventories were obtained for two (2) of thirteen (13) staff and eight (8) of eight (8) consultants working with the residents of the GHMRP. The findings include: Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on May 21, 2009 at approximately 9:45 AM, revealed that personnel records were maintained at the administrative office and would be provided for review on the next day. At this time, the QMRP was requested to obtain the the health certificates of all for staff and consultants working with the residents.	1208	It is the Policy of St. John's Community Services To 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. All personnel records for S1 and S2 has been updated. Also updated are the health certificates for C1, C2, C3, C4, C5, C6, C7 and C8.	5/25/09 5/25/09

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
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I 206	Continued From page 6 Review of the provided records on May 22, 2009 at approximately 2:45 PM, revealed there was no health certificates were available for S1, and S2. The review of the consultants files revealed no health certificates were provided for C1, C2, C3, C4, C5, C6, C7 and C8.	I 206		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans: This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure two (2) of thirteen (13) staff were trained to implement emergency measures for four of four residents residing in the GHMRP. (Residents #1, #2, #3, and #4) The findings include: Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on May 21, 2009 at approximately 9:45 AM, revealed that personnel records were maintained at the administrative office and would be provided for review on the next day. At this time, the QMRP was requested to obtain the the CPR certification of all staff working working with the residents. a. Review of the provided records on May 22, 2009 at approximately 2:45 PM revealed the GHMRP failed to provide evidence of certification	I 227	The review of the Personnel Record could not determine the identification of the S2 and S3. The certificates for S2 and S3 will be faxed once the staffs have been identified.	

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1 227	Continued From page 7 in Cardiopulmonary Resuscitation (CPR) for S2 and S3. b. Further review of the provided records on May 22, 2009 at approximately 2:45 PM revealed the GHMRP failed to provide evidence of current First Aid certification for S2 and S3.	1 227		
1 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS 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 GHMRP failed to ensure professional services were provided in accordance with the assessed needs of two of the four residents in the sample. (Residents #1 and #2) The findings include: A. The GHMRP failed to ensure nursing services in accordance with residents needs for Resident #1 and #2. 1. The GHMRP's nursing services failed to ensure that residents received all prescribed medications without error. a. Observation of the medication administration on May 21, 2009 at 7:09 PM, revealed the TME administering Metformin 500 mg to Resident #2. Review of the medication label at approximately	1 401	1. It is the Policy of St. John's Community Services to ensure professional services were provided in accordance with the assessed needs of all its residents.	5/25/09



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FACSIMILE TRANSMITTAL SHEET

TO:	<u>Ms. Karen Jeffers</u>	FROM:	<u>Mabel Johnson for Precious Myers-Brown</u>
COMPANY:	<u>DOH</u>	DATE:	<u>6/15/09</u>
FAX NUMBER:	<u>202-442-9430</u>	TOTAL NO. OF PAGES INCLUDING COVER:	
PHONE NUMBER:	<u>202-442-4726</u>	SENDER'S REFERENCE NUMBER:	<u>POC for 2715 13th Street, NE</u>
RE:	<u>POC for 2715 13th Street, NE, DC 20018</u>	YOUR REFERENCE NUMBER:	<u>202-870-1230</u>

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2009
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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
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W 000	INITIAL COMMENTS A recertification survey was conducted on May 21, 2009 through May 22, 2009. The survey was initiated as a full survey due to facility's history of condition level deficiencies during the previous survey period. A random sampling of two clients from the residential population of four females was selected for the survey. The results of the survey were based on observations in the home and at two day programs, staff interviews, as well as a review of the client and administrative records, including a review of the unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to ensure operating direction over the facility as evidenced below: The findings include: 1. [Cross refer to W393]. The facility failed to ensure it met the requirements for performing glucose monitoring testing, for clients in the facility whose blood glucose was being tested by facility staff, for Client #2. Interview with the Qualified Mental Retardation Professional (QMRP) on May 22, 2009 at approximately 4:00 PM revealed that the Program Director had submitted an application form for obtaining a Clinical Laboratory Improvement Act	W 104	It is the Policy of St. John's Community Services to provide quality services to its residents, exercise general policy, budget and operating direction over the facility. The request for the Clinical Laboratory Improvement Act CLIA Certificate of Waiver was submitted twice to the Department of Health, on 3/16/2009 and 4/14/2009 respectively. A copy of the completed forms which were submitted to DOH along with a copy of the fax confirmation sheet is attached for your review.	4/14/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Frances Myers Brown TITLE: Program Director (X5) DATE: 6/15/09

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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1401	<p>Continued From page 8</p> <p>7:20 PM, indicated to take it with meals. At 7:48 PM Resident #2 was observed eating a 1500 calorie chopped dinner.</p> <p>Interview with the Licensed Practical Nurse (LPN) on May 22, 2009 at approximately 2:40 PM, confirmed that Resident #2 did not take her Metformin with a meal.</p> <p>b. Observations of the medication administration on May 21, 2009 at approximately 7:15 PM, revealed the TME administering one drop of Travatan 0.004% in both eyes. Less than a minute later, the TME administered Cosopt oph drops in the Resident #2's right eye.</p> <p>Review of the medication administration instructions on May 22, 2009 at 10:45 AM, revealed the following directions "If you are using more than one eye drop medicine, each medicine should be given at least ten minutes apart."</p> <p>Interview with the LPN at approximately 2:30 PM confirmed that the TME did not wait ten minutes between administering two different eye drops.</p> <p>2. The GHMRP's nursing services failed to ensure that Resident #1's salt intake was monitored.</p> <p>a. On May 21, 2009 at approximately 1:10 PM, review of Resident #1's physician's orders (POs) for the period from July 2008 through May 2009 indicated that the resident had a history of strokes. Review of the pharmacy review dated May 5, 2009 at 2:20 PM revealed the pharmacist's recommendation to monitor Resident #1's salt intake.</p> <p>Interview with the LPN on May 22, 2009 at</p>	1401	<p>a. Medication with labels gives with food means do not give on an empty stomach. The Metformin 500 mg was administered to Sample #2 after she had consumed her PM snack. The review of the administration of the Metformin 500mg was made with the TME and that it should be given after breakfast and after dinner. In the future, the Metformin 500mg will be administered after breakfast and after the dinner. A check with the Consulting Pharmacist confirmed that Metformin can be given 1 to 2 hours after a meal.</p> <p>b. The TMEs were in-serviced on the proper administration of the eye drops for Sample #2. In the future all eye drops will be spaced accordingly.</p> <p>The TME's were in-serviced on 6/10/09 for the proper duration of time between two eye drops when administering more than one eye drop. In the future, staffs will wait for the specified period of time before administering more than one eye drop.</p> <p>2. The Diet Order for Sample #1 was changed to include no added salt by the Medical Director. A copy of the PMOF is attached for your review. In the future the diet order will be written as ordered by the Pharmacist.</p>	<p>6/15/09</p> <p>6/15/09</p> <p>6/10/09</p>

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1401	<p>Continued From page 9</p> <p>approximately 3:00 PM revealed that she was unaware of the recommendation by the pharmacist.</p> <p>There was no evidence that the pharmacist's recommendation to monitor Resident #1's salt intake had been addressed.</p> <p>3. The GHMRP's nursing services failed to ensure a referral for follow-up on Resident #1's abdominal distention as recommended.</p> <p>Review of the primary care physician's medical consultation form dated January 22, 2009 on May 22, 2009 at approximately 4:30 PM revealed Resident #1 had nonpainful abdominal distention. The primary care physician recommended a flat and erect abdominal x-ray and thereafter, a follow-up evaluation in one week.</p> <p>Interview with the LPN at approximately 4:45 PM, indicated that she attempted to schedule an appointment, but was unsuccessful.</p> <p>At the time of the survey, there was no evidence that the follow-up on Resident #1's abdominal distention had been completed.</p> <p>B. The GHMRP failed to ensure coordination of professional services to ensure that Resident #1 received her therapeutic diet as prescribed.</p> <p>1. On May 21, 2009 at 11:52 AM, Resident #1 was observed at her day program eating a chopped hamburger, mix vegetables, rice water, and kool aid. Interview with the day program counselor at approximately 11:55 AM, indicated that Resident #1 was eating a 1500 calorie diet.</p>	1401	<p>3. Sample # 1 completed consultation for abdominal distention on 6/4/09. In the future, all consultation will be completed timely.</p> <p>1. It is the Policy of SJCS to ensure that outside services meet the needs of all the individuals in its care. The Day Program Staff was in-serviced on the mealtime time protocol and diet order for sample # 1 on 6/15/09.</p>		

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1401	<p>Continued From page 10</p> <p>Review of the day program meal time protocol dated October 2008 at approximately 12:00 PM, revealed the resident was prescribed a 1500 calorie, mechanical soft, low sodium diet with thin liquids. Review of the group home meal time protocol at 1:10 PM revealed that Resident #1 was prescribed a 1200 calorie reducing, chopped diet. Review of the physician's order dated May 5, 2009 at 1:30 PM, confirmed that Resident #1 was prescribed a 1200 calorie reducing, chopped diet. Further record review revealed that Resident #1 weighed 126 lbs and exceeded her desirable weight range of 86-104 lbs. The meal time protocol noted nutrition concerns that Resident #1 was overweight and had the potential for weight gain.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on May 14, 2009, at approximately 2:30 PM indicated that the group home had informed the day program of Resident #1's mealtime protocol.</p> <p>At the time of the survey, there was no evidence that Resident #1's mealtime protocol was implemented while at the day program.</p> <p>2. On May 21, 2009, at 7:48 PM, Resident #1 was observed eating her dinner meal that consisted of a chopped turkey burger, mashed potatoes, salad and cranberry juice.</p> <p>Interview with the House Manager and the Direct Care Aids at 7:55 PM revealed that Resident #1 receives a 1500 calorie diet.</p> <p>Review of Resident #1's physician's order dated May 5, 2009 on May 21, 2009 at 1:10 PM, revealed that the resident's dietary order consisted of a 1200 calorie diet. Review of the</p>	1401	<p>2. It is the Policy of SJCS to ensure that outside services meet the needs of all the individuals in its care. The Staffs was in-serviced on the mealtime time protocol and diet order for sample #1 on 5/25/09.</p>	

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
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1401	<p>Continued From page 11</p> <p>nutritional assessment dated July 24, 2008 at 1:30 PM also revealed a 1200 calorie diet. Interview with the License Practical Nurse (LPN) on May 22 2009, at approximately 4:00 PM, indicated that Resident #1 should receive a 1200 calorie diet.</p> <p>There was no evidence that the GHMRP ensured that Resident #1 received her modified diet in accordance with the written prescribed physician order.</p> <p>C. The GHMRP failed to ensure professional services to maintain Resident #1's wheelchair in good repair.</p> <p>On May 21, 2009 at 8:30 AM, the armrests on Resident #1's wheel chair were observed to be very worn, with the fabric visible through the vinyl covering on both sides.</p> <p>Review of the 719 form dated January 4, 2009 at 5:00 PM, confirmed the order to repair the armrest. Further review revealed a 719 form dated March 12, 2009. The 719 form stated "Present wheelchair has parts which continue to need repair. In spite of various repairs, the wheelchair is wobbling and really poses some concerns."</p> <p>Interview with the Qualified Mental Retardation Professional on May 22, 2009 at approximately 3:00 PM indicated that the foot rest was the only repair made to Resident #1's wheelchair.</p> <p>At the time of the survey, there was no evidence Resident #1's wheelchair had been maintained in good repair.</p>	1401	<p>C. It is the Policy of St. John's Community Services to maintain the adaptive equipment for all its residents. The Armrest of the wheelchair was repair on 5/25/09.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2009
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1422	Continued From page 12	1422			
1422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide self medication training in accordance with the Individual Habilitation Plans (IHP) for four of the four residents residing in the GHMRP. (Residents #1, #2, #3, and #4)</p> <p>The findings include:</p> <p>1. The GHMRP failed to ensure that the residents participated in their activities of daily living skills program as specified in their IPP as evidenced below:</p> <p>During medication observation on May 21, 2009 at 7:09 PM, the Trained Medication Employee (TME) removed Resident #2's medications from her blister pack. The TME spoon fed Resident #2 her medications and handed her a cup of water to drink independently.</p> <p>At 7:25 PM the TME was observed removing Resident #3's medications from her blister pack. Resident #3 was spoon fed her medications by the TME. Further observation revealed Resident#3 drinking water as the TME held the cup.</p> <p>At 7:35 PM the TME was observed removing Resident#4's medications from her blister pack. Resident #4 was spoon fed her medications and drank her water as the TME held the cup.</p>	1422 1422	<p>1. It is the Policy of St. John's Community Services to ensure that each individual receives continuous active treatment as soon as the Interdisciplinary Team formulates the individual's IPP.</p> <p>1. All staffs were trained on the self Medication program on 6/10/09.</p> <p>2. Staffs were in-serviced by the Nurse and QMRP on the Self Medication Program on 6/10/09.</p> <p>1. It is the policy of St. John's Community Services to inform each individual's parent or legal guardian of the medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. The informed consent for Sample #1 has been requested for the use of the BSP.</p>	6/15/09	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 8 7:20 PM, indicated to take it with meals. At 7:48 PM Resident #2 was observed eating a 1500 calorie chopped dinner. Interview with the Licensed Practical Nurse (LPN) on May 22, 2009 at approximately 2:40 PM, confirmed that Resident #2 did not take her Metformin with a meal. b. Observations of the medication administration on May 21, 2009 at approximately 7:15 PM, revealed the TME administering one drop of Travatan 0.004% in both eyes. Less than a minute later, the TME administered Cosopt oph drops in the Resident #2's right eye. Review of the medication administration instructions on May 22, 2009 at 10:45 AM, revealed the following directions "If you are using more than one eye drop medicine, each medicine should be given at least ten minutes apart." Interview with the LPN at approximately 2:30 PM confirmed that the TME did not wait ten minutes between administering two different eye drops. 2. The GHMRP's nursing services failed to ensure that Resident #1's salt intake was monitored. a. On May 21, 2009 at approximately 1:10 PM, review of Resident #1's physician's orders (POs) for the period from July 2008 through May 2009 indicated that the resident had a history of strokes. Review of the pharmacy review dated May 5, 2009 at 2:20 PM revealed the pharmacist's recommendation to monitor Resident #1's salt intake. Interview with the LPN on May 22, 2009 at	I 401	a. Medication with labels gives with food means do not give on an empty stomach. The Metformin 500 mg was administered to Sample #2 after she had consumed her PM snack. The review of the administration of the Metformin 500mg was made with the TME and that it should be given after breakfast and after dinner. In the future, the Metformin 500mg will be administered after breakfast and after the dinner. A check with the Consulting Pharmacist confirmed that Metformin can be given 1 to 2 hours after a meal. b. The TMEs were in-serviced on the proper administration of the eye drops for Sample #2. In the future all eye drops will be spaced accordingly. The TME's were in-serviced on 6/10/09 for the proper duration of time between two eye drops when administering more than one eye drop. In the future, staffs will wait for the specified period of time before administering more than one eye drop. 2. The Diet Order for Sample #1 was changed to include no added salt by the Medical Director. A copy of the PMOF is attached for your review. In the future the diet order will be written as ordered by the Pharmacist.	6/15/09 6/15/09 6/10/09

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1401	<p>Continued From page 9</p> <p>approximately 3:00 PM revealed that she was unaware of the recommendation by the pharmacist.</p> <p>There was no evidence that the pharmacist's recommendation to monitor Resident #1's salt intake had been addressed.</p> <p>3. The GHMRP's nursing services failed to ensure a referral for follow-up on Resident #1's abdominal distention as recommended.</p> <p>Review of the primary care physician's medical consultation form dated January 22, 2009 on May 22, 2009 at approximately 4:30 PM revealed Resident #1 had nonpainful abdominal distention. The primary care physician recommended a flat and erect abdominal x-ray and thereafter, a follow-up evaluation in one week.</p> <p>Interview with the LPN at approximately 4:45 PM, indicated that she attempted to schedule an appointment, but was unsuccessful.</p> <p>At the time of the survey, there was no evidence that the follow-up on Resident #1's abdominal distention had been completed.</p> <p>B. The GHMRP failed to ensure coordination of professional services to ensure that Resident #1 received her therapeutic diet as prescribed.</p> <p>1. On May 21, 2009 at 11:52 AM, Resident #1 was observed at her day program eating a chopped hamburger, mix vegetables, rice water, and kool aid. Interview with the day program counselor at approximately 11:55 AM, indicated that Resident #1 was eating a 1500 calorie diet.</p>	1401	<p>3. Sample # 1 completed consultation for abdominal distention on 6/4/09. In the future, all consultation will be completed timely.</p> <p>1. It is the Policy of SJCS to ensure that outside services meet the needs of all the individuals in its care. The Day Program Staff was in-serviced on the mealtime time protocol and diet order for sample # 1 on 6/15/09.</p>	

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1401	<p>Continued From page 10</p> <p>Review of the day program meal time protocol dated October 2008 at approximately 12:00 PM, revealed the resident was prescribed a 1500 calorie, mechanical soft, low sodium diet with thin liquids. Review of the group home meal time protocol at 1:10 PM revealed that Resident #1 was prescribed a 1200 calorie reducing, chopped diet. Review of the physician's order dated May 5, 2009 at 1:30 PM, confirmed that Resident #1 was prescribed a 1200 calorie reducing, chopped diet. Further record review revealed that Resident #1 weighed 126 lbs and exceeded her desirable weight range of 86-104 lbs. The meal time protocol noted nutrition concerns that Resident #1 was overweight and had the potential for weight gain.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on May 14, 2009, at approximately 2:30 PM indicated that the group home had informed the day program of Resident #1's mealtime protocol.</p> <p>At the time of the survey, there was no evidence that Resident #1's mealtime protocol was implemented while at the day program.</p> <p>2. On May 21, 2009, at 7:48 PM, Resident #1 was observed eating her dinner meal that consisted of a chopped turkey burger, mashed potatoes, salad and cranberry juice.</p> <p>Interview with the House Manager and the Direct Care Aids at 7:55 PM revealed that Resident #1 receives a 1500 calorie diet.</p> <p>Review of Resident #1's physician's order dated May 5, 2009 on May 21, 2009 at 1:10 PM, revealed that the resident's dietary order consisted of a 1200 calorie diet. Review of the</p>	1401	<p>2. It is the Policy of SJCS to ensure that outside services meet the needs of all the individuals in its care. The Staffs was in-serviced on the mealtime time protocol and diet order for sample #1 on 5/25/09.</p>		

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I 401	<p>Continued From page 11</p> <p>nutritional assessment dated July 24, 2008 at 1:30 PM also revealed a 1200 calorie diet. Interview with the License Practical Nurse (LPN) on May 22 2009, at approximately 4:00 PM, indicated that Resident #1 should receive a 1200 calorie diet.</p> <p>There was no evidence that the GHMRP ensured that Resident #1 received her modified diet in accordance with the written prescribed physician order.</p> <p>C. The GHMRP failed to ensure professional services to maintain Resident #1's wheelchair in good repair.</p> <p>On May 21, 2009 at 8:30 AM, the armrests on Resident #1's wheel chair were observed to be very worn, with the fabric visible through the vinyl covering on both sides.</p> <p>Review of the 719 form dated January 4, 2009 at 5:00 PM, confirmed the order to repair the armrest. Further review revealed a 719 form dated March 12, 2009. The 719 form stated "Present wheelchair has parts which continue to need repair. In spite of various repairs, the wheelchair is wobbling and really poses some concerns."</p> <p>Interview with the Qualified Mental Retardation Professional on May 22, 2009 at approximately 3:00 PM indicated that the foot rest was the only repair made to Resident #1's wheelchair.</p> <p>At the time of the survey, there was no evidence Resident #1's wheelchair had been maintained in good repair.</p>	I 401	<p>C. It is the Policy of St. John's Community Services to maintain the adaptive equipment for all its residents. The Armrest of the wheelchair was repair on 5/25/09.</p>	

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1422	Continued From page 12	1422		
1422	3521.3 HABILITATION AND TRAINING	1422		
	<p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide self medication training in accordance with the Individual Habilitation Plans (IHP) for four of the four residents residing in the GHMRP. (Residents #1, #2, #3, and #4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The GHMRP failed to ensure that the residents participated in their activities of daily living skills program as specified in their IPP as evidenced below: <p>During medication observation on May 21, 2009 at 7:09 PM, the Trained Medication Employee (TME) removed Resident #2's medications from her blister pack. The TME spoon fed Resident #2 her medications and handed her a cup of water to drink independently.</p> <p>At 7:25 PM the TME was observed removing Resident #3's medications from her blister pack. Resident #3 was spoon fed her medications by the TME. Further observation revealed Resident #3 drinking water as the TME held the cup.</p> <p>At 7:35 PM the TME was observed removing Resident #4's medications from her blister pack. Resident #4 was spoon fed her medications and drank her water as the TME held the cup.</p>		<ol style="list-style-type: none"> It is the Policy of St. John's Community Services to ensure that each individual receives continuous active treatment as soon as the Interdisciplinary Team formulates the individual's IPP. All staffs were trained on the self Medication program on 6/10/09. Staffs were in-serviced by the Nurse and QMRP on the Self Medication Program on 6/10/09. It is the policy of St. John's Community Services to inform each individual's parent or legal guardian of the medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. The informed consent for Sample #1 has been requested for the use of the BSP. 	6/15/09

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1422	<p>Continued From page 13</p> <p>At 7:43 PM TME was observed removing Resident #1's medications from her blister pack. The TME spoon fed Resident #1 her medications and handed her a cup of water to drink independently.</p> <p>Interview with the TME at approximately 8:00 PM, revealed that the residents participated in a self medication program.</p> <p>Review of the medication administration program data collection sheets for Resident #1, #2, #3 and #4 dated May 1, 2009 on May 22, 2009 at 8:00 PM, revealed the following steps to implement program objectives:</p> <ol style="list-style-type: none"> Identify time of medication Obtain water or juice Obtain medicine cup Remove medicine from blister pack. Throw cup in trash. <p>At the time of the observation, there was no evidence that the TME implemented the residents' self medication administration program objectives.</p> <p>2. The GHMRP failed to ensure that Resident #1 received training to improve her sitting balance as recommended by the physical therapist.</p> <p>On May 21, 2009 at 7:25 AM Resident #1 was observed sitting in her wheelchair watching television. Review of the physical therapy objective for Resident #1 on May 21, 2009 at approximately 5:00 PM, revealed it stated, "Given stand by assistance, Resident #1 will tolerate sitting on the side of her bed for ten repetitions, three days per week for twelve consecutive months.</p>	1422	<p>a. It is the Policy of St. John's Community Services to ensure that each individual receives continuous active treatment as soon as the Interdisciplinary Team formulates the individual's IPP.</p> <p>1. All staffs were trained on the self Medication program on 6/10/09.</p>	6/10/09

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I 422	Continued From page 14 Interview with the Qualified Mental Retardation Professional on May 22, 2009 at approximately 1:30 PM, confirmed that the physical therapist goal was not included in the into Resident #1's Individual Program Plan. The review of program data later that day also revealed no evidence that the aforementioned objective was implemented.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS 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. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP 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) that governs the care and rights of persons with mental retardation. The finding includes: 1. The GHMRP failed to ensure that restrictive programs were used only after written consents had been obtained for Resident#1. Observation of the evening medication administration on May 21, 2009 at 7:43 PM revealed Resident #1 was administered Clonazepam 1 mg. Interview with the Licensed Practical Nurse (LPN), revealed the	I 500		

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I 500	<p>Continued From page 15</p> <p>forementioned medication were used to address the resident's aggression.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on May 21, 2009 at 9:15 AM, revealed that Resident #1 had a Behavior Support Plan (BSP), and did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on May 21, 2009 at 3:50 PM through review of Resident #1's psychological assessment dated August 21, 2008. According to the assessment, Resident #1 "does not evidence the capacity to make independent decisions in the areas of habilitation, residential placement, medical decisions, finances, and life planning. Continued interview with the QMRP, revealed that Resident #1 sister acted as her guardian.</p> <p>The review of Resident #1's record on May 21, 2009, at 3:58 PM confirmed that the resident, in addition to taking psychotropic medications, also had a Behavior Support Plan (BSP) dated September 15, 2008 to address her behavior of physical aggression. At the time of the survey however, the facility failed to evidence that consent was obtained from a legally sanctioned representative for the use of the</p> <p>2. The facility failed to demonstrate protection of residents' rights to receive training and habilitation to enable residents to acquire and maintain life skills and achieve their optimum functioning, for Residents #1, #2, #3, and #4 residing in the GHMRP as follows:</p> <p>a. [Cross-refer to I422.1]. On May 21, 2009 observation of the medication administration</p>	I 500		

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1500	Continued From page 16 beginning at 7:09 PM, revealed that Residents #1, #2, #3, and #4 did not receive recommended habilitation and support to maximize their potential to acquire skills in self medication administration. b. [Cross-refer to 1422.2]. Record review on May 21, 2009 and interview with the Qualified Mental Retardation Professional on May 22, 2009 revealed that the facility failed to ensure that Resident #1 received training to improve her sitting balance as recommended by the physical therapist.	1500	b. The PT revised the programs to improve the sitting balance for Sample #1 and staffs were in-serviced on 6/11/09.	

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R 000	INITIAL COMMENTS A licensure survey was conducted on May 21, 2009 through May 22, 2009. A random sample of two residents was selected from a residential population of four females with mental retardation and other disabilities. The survey findings were based on observations in the group home and day programs. In addition, the findings were based on interviews with direct care, administrative, nursing, and day program staff. A review of the facility's records, including the unusual incident reports was also conducted.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check for three (3) of the thirteen (13) employees. The findings include: On May 21, 2009 at 9:45 AM, an entrance conference was conducted with the Qualified Mental Retardation Professional (QMRP) to request documents needed during the survey	R 125	It is the Policy of St John's Community Services to provide criminal background check of all employees. The criminal background check for S1, S3 and S4 has been requested.	6/11/09

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

TITLE

(X6) DATE

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R 125	Continued From page 1 process. During this time, evidence of criminal background checks for staff who worked at the group home was requested. Interview with the QMRP revealed that the requested documents would be provided on May 22, 2009. On May 22, 2009, beginning at 2:45 PM, the review of the provided personnel records revealed that the GHMRP failed to provide evidence that an employee criminal background check was provided for each jurisdiction where the employees had lived and/or had worked during the last seven years for three staff (S1, S3 and S4).	R 125			