FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0071	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/17/2008
NAME OF PROVIDER OR SUPPLIER: ST JOHNS COMMUNITY SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE: 4836 RESERVOIR ROAD NW WASHINGTON, DC 20016		

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I 000	INITIAL COMMENTS A licensure survey was conducted on July 16 and 17, 2008. The client population residing in this facility included four males resident's with varying degrees of mental retardation and other disabilities. The findings of the survey were based on observations at the group home, interviews with the management and direct support staff in the residence and the review of the administrative and habilitation records to include the unusual incident management system.	I 000	Received 8/11/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 010	3501.1 ENVIRONMENTAL REQ / USE OF SPACE: Each GHMRP shall provide a home-like atmosphere in a setting that is the least restrictive of the resident's rights, but yet will allow the resident to function safely and effectively. This Statute is not met as evidenced by: Based on observation and staff interview the GHMRP failed to ensure an atmosphere which allow the residents to be free form restrictive measure. (Resident #1) The finding includes: During an on-site environmental inspection on July 16, 2008 at approximately 1:30 PM revealed that the facility has alarms on the exit doors. According to interview with the house manager, Resident #1 has a history of unauthorized departures from the group home. Review of Resident #1's psychological assessment 10/29/07 and his Behavior Support	I 010	It is the Policy of St. John's Community Services to provide a home-like atmosphere in a setting that is the lest restrictive of the resident's rights which functions safely and effective. A request has been made from the Human Rights Committee for approval of the alarm installed at the entrances in the home.	7/25/08

Health Regulation Administration

Mabel Johnson for Precious Myers-Brown, Director-CLS/QC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 010	Continued From page 1	I 010		
	Plan (BSP) dated 11/14/07 confirm that Resident #1 has a target behavior addressing his leaving the house unauthorized. However, neither the psychological assessment nor the BSP make mentioned the need for the use of the door alarms. Review of the Human Rights committee minutes did not include discussion or approval by the committee the use of the alarms in the facility. Note: It should be noted that Resident #1 has 1:1 assigned to him for the purpose of implementing his BSP to address him leaving the group home.		A request has been made for revision of the BSP to include the resident leaving the residence.	7/25/08
I 082	3503.1 BEDROOMS AND BATHROOMS	I 082		
	Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observations and interview at the GHMFP failed properly equip each bathroom with the appropriate items to meet each residents need. The findings include: During the environmental walk-through on July 30, 2008 revealed the following: 1. Bathroom #1 did not have soap for hand washing, paper towels, and cups for the cup dispenser. 2. Bathroom #2 did not have soap for hand washing, paper towels, cups for the cup dispenser.		1. A Cabinet has been installed in the bathroom for the storage of soap, paper towels, tissue and cups. 2. A cabinet has been installed in the bathroom for the storage of soap, paper towels, tissue and cups.	7/22/08 7/22/08

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I 082	Continued From page 2	I 082		
	Interview with the house manager revealed that when the clients use the bathroom the direct support staff go to the basement and brings toilet paper, soap and paper towels to the bathroom for the client's use. Further interview with the house manager suggest that the Client's behavior of Pica was the reason for not having these bathroom supplies available.		The practice of storing the supplies from all due to concern for the pica behavior of the resident, which deprives other residents of the easy access to these supplies, has been submitted to the Human Rights Committee for approval.	7/22/08
I 090	3504.1 HOUSEKEEPING	I 090		
	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, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.			
	The findings include:			
	Internal			
	1. The leather couch and arm chair in the living room were torn and ripped.		1. The leather couch in the living room which was torn has been replaced.	7/15/08
	2. The area rug in the living room was soiled.		2. The area rug in the living which show some soiled areas has been discarded.	7/25/08
	3. Resident #4's Chester drawer two bottom drawers were off track and therefor the drawere was broken.		3. The Chest of drawers has been replaced.	7/25/08
	4. There were several bulbs not working in the			

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I 090	Continued From page 3 dining room chandelier. External 1. The stairwell leading from the basement rear door has leaves and debris that blocked the outside drain. 2. A black wire was observed hanging from roof on the left side of the group home near the upstairs bathroom window.	I 090	1. All Debris that blocked the outside drain has been removed and the area cleaned. 2. A request was made and an appointment set for 8/15/08 in order to have the wire removed from the home near the upstairs bathroom window.	7/21/08 7/21/08
I 135	3506.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The findings include: On 7/17/08 interview with the House Manager revealed that the staff, according to the agency policy and procedures, were required to conduct a fire drill once per month on each shift. Review of the fire drill log book revealed that the facility failed to hold simulated fire drills at least four times a year for each shift during the periods of August 2007 through December 2007.	I 135	All fire drill for the home has been completed to include all shifts. An In-service training was completed on 7/21/08. In the future all fire drills will be conducted to cover all shifts in a timely manner.	
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed.	I 189		

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I 189	Continued From page 4 This Statute is not met as evidenced by: Based on interview and record review the GHMRF failed to maintained each resident's funds received and disbursed. (Resident #1 and #2) The finding includes: On 7/17/08 at approximately 9:45 AM, interview with the GHMRP's Qualified Mental Retardation Professional(QMRP) and the review of the resident's financial records revealed the Resident #1 and #2 financial record were not updated to reflect the current balances. Although the QMRP indicated monthly bank statements were recieved, the latest bank statement or entry was for April 2008.	I 189	A request has been made from the Chevy Chase Bank for a copy of bank statement for the purpose of updating the financial books up to the month of July, 2008.	7/25/08
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. (Resident #1) The finding includes: The GHMRP failed to ensure that accurate and consistent data was being documented as required by each resident's IPP plan as evidenced below: a. Observation of the medication pass on July 18, 2008 at approximately 8:38 PM and on July 17, 2008, interview with the nurse and the QMRP	I 222	All staffs have been in-serviced on IPP documentation on 7/21/08	7/21/08

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I 224	Continued From page 6	I 224		
	(a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills;		(a) All staffs have been trained on MR Overview.	8/5/08
	This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that staff received training on the health and well-being requirements of caring for the mentally retarded.			
	The finding includes:			
	Interview with the QMRP on July 17, 2008 at approximately 10:20 AM and review of the in-service training records revealed that none of the direct support staff received training specific to the overview of mental retardation and its corresponding service needs to ensure the health and well-being of its residents.			
I 225	3510.5(b) STAFF TRAINING	I 225		
	Each training program shall include, but not be limited to, the following:			
	(b) Human development through the life cycle (birth to death);		(b) All Staffs have been trained on Human Development.	
	This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that direct support staff received training.			
	The finding includes:			

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I 225	Continued From page 7 On July 17, 2008 at approximately 10:00 AM, interview with the QMRP and the review of the in-service training records failed to reflect that the GHMRP failed to provide training in the area of Human Development.	I 225	All staffs have been trained in Human Development on 7/21/08.	7/21/08
I 227	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in the agencies infection control practices for employees. The finding includes: On 7/17/08, interview with the QMRP and the review of in-service training records revealed that the GHMRP did not evidence training in infection control to meet the residents needs.	I 227	(c) All staffs have been trained on Infection Control for staffs and residents.	8/5/08
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and review of training	I 229	(f) All Staffs have been trained on Nutrition, Recreation and Communication	8/5/08

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I 229	Continued From page 8 documents, the GHMRP failed to provide evidence to validate staff training as indicated by residents' need. The findings include: Interview with the QMRP and the review of the in service training records on 7/17/08, the GHMRP failed to provide training on nutrition,sexuality, and communication.	I 229	(e) All Staffs have been trained on Human Sexuality	8/5/08
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that entries into each resident's records were signed and dated for one of two residents included in the sample. (Resident #1) The finding includes: On 7/17/08 at approximately 9:45 AM, interview with the GHMRP's Qualified Mental Retardation Professional(QMRP) and the review of the resident's financial records revealed the Resident #1 and #2 financial record were not updated to reflect the current balances. Although the QMRP indicated monthly bank statments were recieved, the latest bank statement or entry was for April 2008.	I 260	A request has been made from City Bank for the Bank Statements for the period up to July, 2008 in an effort to up-date the financial records.	8/5/08
I 291	3514.2 RESIDENT RECORDS	I 291		

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I 291	Continued From page 9 Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview, and record review the GHMRP failed to ensure each clients records were kept current, dated and signed. The findings include: 1. On July 16, 2008 at approximately 11:00 AM, interview with the Nurse and review of Resident #1 pharmacy review records from July 2008 to current revealed that the date and initials/signatures were missing. According to the nurse the pharmacist had been in the facility in on May 8, 2008, however, did not sign and date the entry made into Resident #1's record at the time of his visit. 2. The GHMRP failed to ensure that Resident #1 and #2's IPP data records were documented as required to ensure current and accurate information was being recorded. [See Deficiency 3512.1]	I 291	The Pharmacist was requested and he signed the Review of Sample #1 pharmacy review sheet.	8/5/08
I 371	3519.2 EMERGENCIES Each GHMRP shall maintain written documentation that each employee has been trained in carrying out the policies and procedures set forth in § 3519.1 of this section. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to train the staff on the agency's emergency policies and procedures. The finding includes:	I 371	All Staffs have been trained on the Agency Policies and Procedures.	8/5/08

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I 371	Continued From page 10 On July 17, 2008 at approximately 10:30 AM, interview with the QMRP and the review of the available training records revealed that the GHMRP failed to have evidence that direct care staff had not been trained on the agencies emergency policies and procedures.	I 371	All staffs have been trained on the Agency Emergency policies and procedures on 7/21/08.	7/21/08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to report to governmental officials within 24 hours in accordance with this regulatory requirement. The findings include: The review of the facility's unusual incident management system and interview with the Qualified Mental Retardation Professional (QMRP) on July 16, 2008 at 10:30 AM, revealed the facility failed to timely notify the to the governmental agency of the following incident(s). 1. Review of an unusual incident report dated November 6, 2007 revealed that Resident #2 was	I 379	All Staffs have been trained on Incident Reporting on 8/5/08. In the future, all incidents will be reported to governmental Agency in a timely manner.	8/5/08

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I 379	Continued From page 11 observed by staff to start sweating and point to his stomach. He was sent to the hospital and was admitted for evaluation. 2. Review of an unusual incident report dated March 13, 2008 revealed that Resident #3 was observed with a swollen hand and was sent to the emergency room for further evaluation and treatment. 3. Review of an unusual incident report dated March 14, 2008 revealed that Resident #2 was observed pointing to his stomach and appearing to be in pain. He was sent to the ER for evaluation. 4. Review of an unusual incident report dated May 29, 2008revealed that Resident #1 was observed limping by the staff and was transferred to the ER for evaluation and treatment	I 379	All Staffs have been trained on Incident Reporting on 8/5/08. In the future, all incidents will be reported to governmental Agency in a timely manner.	8/5/07
I 401	3620.3 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 interview and record review the GHMRF failed to provided diagnosis, evaluation, treatment services and necessary follow up service to prevent deterioration or further loss of functioning for each resident in the facility. The finding includes:	I 401		

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I 401	Continued From page 12 On July 7/16/08 at approximately 12:00 noon interview with nurse revealed that the Pharmacy services is contracted to review of each resident's medication usage on a quarterly basis. Review of Resident #2's medical record revealed that the pharmacy representative had not reviewed the resident's medication regimen for any irregularities for the month of May 2008. According to the nurse, the pharmacist was in the facility 7/8/08.	I 401	A request was made and the Pharmacist revisited the home. He review and signed the records for Sample #2 for a period which covers May, 2008	8/5/08
I 484	3522.1 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to destroy medication which had expired. The finding includes: On July 16, 2008 during the environmental inspection of Resident's #1's bedroom, Sunblock Lotion #5 was discovered on the top of the Chester drawer in a basket. Further look at the bottle revealed that the Sunblock had expired on 6/6/08, however, it had not been removed or destroyed. Interview with the nurse on duty revealed that the agency has a system which monitors the availability of topical treatment medications. According to the nurse the monitoring system included the following: 1. The house manager was to weekly monitor	I 484	It is the Policy of St. John's Communication Services to discard all expired medication according to its policy on discarding Medication by the nurse. In the future all expired medication will be discarded in a timely manner	7/18/08

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I 484	Continued From page 13 the available supply of topical medication for each resident. 2. When the medication is observed low, the nurse was to be notified. 3. The nurse documents the medication on the medication reorder form. 4. The nurse then contacts and forwards the request to the pharmacy to reorder the medication(s) needed. 5. When the topical medication was delivered, the nurse was responsible for replacing the new medication and destroy the empty container. 6. The nurse records the start date in the MAR. There was no evidence that this protocol was implemented	I 484	The expired Sun Block Lotion has been discarded using the proper method put in placed by St. John's Community Services as of July 18, 2008. In the future, All expired medication will be discarded in a timely manner.	7/18/08