

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

COPY

PRINTED: 05/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/11/2007
NAME OF PROVIDER OR SUPPLIER  ST JOHN		STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016	

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W 000	INITIAL COMMENTS  A recertification survey was conducted from May 10, 2007 through May 11, 2007. A random sample of two clients was selected from a residential population of three females with mental retardation and other disabilities. The survey was initiated using the full survey process, however, deficient practices noted during observations and interviews resulted in an extended survey in the Conditions of Participation in Client Protection and Active Treatment. The facility's House Manager was informed that the survey was extended on May 11, 2007 at 12:45 PM.	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 and interview, the facility's Governing Body failed to monitor and/or revised its operation direct ons to ensure needed adaptive equipment was secured, for one of the two clients (Client #2) included in the sample.  The finding includes:  Interview with the facility's House Manager on	W 104	The Governing Body seeks to ensure that the appropriate equipment is available for all individuals served. The governing body through it's operations, policies, and procedures seeks to ensure that the needs of all individuals served are met.	2007 JUN 18 P 4:13  RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Rebecca M. Brown* DIRECTOR CLS-DC TITLE: \_\_\_\_\_ (X6) DATE: 6/15/07

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	<p>Continued From page 1</p> <p>May 10, 2007, at 8:32 AM, revealed Clients #1, #2, and #3 receive in home day programming services. Observations conducted at 9:25 AM revealed Client #2 was seated in her wheelchair at the dining room table with her two housemates. Client #1 was looking at a magazine, Client #2 was stringing beads, and Client #3 was seated in her wheelchair in the dining room (away from the table).</p> <p>At 10:04 AM, while still at the table, Client #2 revealed she had to use the bathroom. Staff was overheard asking Client #2 if she needed to urinate or have a bowel movement. Client #2 revealed she had to have a bowel movement. After their dialogue, staff revealed that Client #2 could not use the toilet in the bathroom. Further discussion with the staff revealed that the facility's practice was to allow the client to urinate and defecate on herself, then clean her up. The staff was interviewed to ascertain how long the facility had been participating with the aforementioned practice. It was revealed that the client began attending in-home day program in December 2006 and that was the practice at that time (over 5 months).</p> <p>Interview with the House Manager (HM) on May 11, 2007, at 12:45 PM revealed that staff used a manual Hoyer lift when transferring Client #2. The HM revealed that Client #2 had a stroke in March or April 2006 that caused the client to lose her ability to stand and therefore, was not able to be transferred using a two person transfer. The HM further revealed that staff had been either injured or complained of back pain related to transferring the client without the use a Hoyer lift due to her weight.</p>	W 104	<p>Client #2 requires the use of a hooyer lift to assist in her activities of daily living. The facility requested the use of the hydrolic lift however, Medicaid denied the request of the hydrolic lift because she was not above a certain weight criteria. Medicaid approved the purchase of the manual lift instead. The manual lift is in the home and used by the staff for Client #2 on a regular and consistent basis.</p> <p>As discussed in the survey, the lift and her body structure poses some barriers for Client #2 to use the commode in the bathroom. Important to note that the Client #2 is incontinent which worsened post stroke. When she reports that she has to go to the bathroom, it is too late. Training with the staff provided the necessary corrections to how to assist Client #2.</p> <p>A new toileting protocol was put in place to assist Client #2 which includes the private use of the commode. The Physical Therapist assisted in the ordering of a new sling for the hooyer lift to assist in giving better positioning for Client #2.</p>	

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W 104	Continued From page 2 Additional discussion with the HM on May 11, 2007 revealed that Client #2's manual Hoyer was not an appropriate lift to transfer the client to the commode or toilet. The HM revealed that the Hoyer lift placed Client #2 in a cradled position when elevated and did not allow for the client to be transferred to a seated position safely. According to the HM, the Hoyer lift's carry bar prohibited the client from transferring to the toilet (seated) without potential injury. Furthermore, the HM revealed that the client leans and had a problem with maintaining a seated position.  Continued interview with the HM revealed that the facility's Physical Therapist (PT) was made aware of the restriction the manual Hoyer lift placed on Client #2. The HM revealed that the PT recommended an electric Hoyer lift that would allow for Client #2 to safely transfer to the toilet or commode. However, according to the HM, the facility attempted to secure the recommended electric Hoyer lift but the client's insurance would not pay for it.  At the time of the survey, the facility failed to provide evidence that the governing body had monitored and/or made revisions to their operating directions to ensure Client #2's rights were maintained and made certain that recommended/alternative adaptive equipment was secured.	W 104		
W 122	483.420 CLIENT PROTECTIONS  The facility must ensure that specific client protections requirements are met.  This CONDITION is not met as evidenced by:	W 122		

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W 122	Continued From page 3 Based on observation, interviews and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed the client's rights to refuse behavioral intervention [See W124]; failed to maintain client's rights and/or ensure each client was encouraged to exercise their rights [See W125]; failed to ensure client's rights to privacy [See W130]; and failed to ensure clients were provided with opportunities for choice and self-management [W247]	W 122	St. John's Community Services seeks to ensure that the rights of all individuals as expressed in established policies and procedures.	6/1/07
W 124	The effects of these systemic practices results in the failure of the facility to protect its clients rights and to ensure individual freedom of choice. 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 the client's rights to refuse behavioral intervention for one of two clients in the sample.  The findings include:  Interview with the facility's House Manager (HM) on May 10, 2007 at 8:32 AM revealed Client #1 was not able to give informed consent for the use	W 124	St. John's Community Services expects that all individuals freedom of choice and individualized rights are protected.	

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W 124	<p>Continued From page 4</p> <p>of her medication, finances or treatment plans. According to the HM, Client #2 had did not have any family or a guardian to assist her with those decisions. Continued with the HM on May 10, 2007 revealed Client #1 had been released from the hospital on May 9, 2007. According to the HM, the client was diagnosed with having seizures and was prescribed an anticonvulsant. The aforementioned information was verified through the review of incident reports.</p> <p>Further interview with the HM on May 10, 2007 at 12:00 PM revealed that none of the clients in the home received one to one staffing supports, but Client #1 was in the process of getting approval for a one to one staff. According to the HM, the attending physician at the hospital recommended that Client #1 receive one to one. The HM revealed that staff were trained on checking on the client every 15 minutes until the one to one staff was approved. Continued discussion with the HM revealed that at the practice had not been reviewed by the facility's Human Rights Committee.</p> <p>Interview with the facility's Director on May 11, 2007 at 2:09 AM revealed that staff were trained to provide line of site supervision and 15 minute checks whenever the client was in her bedroom. Observation of staff and Client #1 in the client's bedroom and interview with staff on May 11, 2007 at 4:34 PM however, revealed that the staff person was Client #1's one to one. The staff member indicated that he/she was Client #1's one to one for that shift (2:00 PM - 12:00 AM) and was relieved by the overnight staff. The staff member revealed that he/she remained by Client #1's side because the client may get up and fall. At the time of the survey the facility failed to provide</p>	W 124	<p>At the time of the survey Client #1 had only been home for less than 48 hours after being released from the hospital. The staff received training to provide line of site supervision and 15 minute checks whenever the client was in her bedroom. The protections were put in place for the protections and preservation of Client #1.</p> <p>Interview with the staff indicated that they were spending more time with Client #1 to observe her new diagnoses since these would be new to the staff. Especially post hospitalization, the staff wanted to be able to know when "differences" occurred.</p> <p>The request for guardianship was sent to DDS Case manager for Client #1.</p>	5/20/07

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W 124	Continued From page 5 evidence that Client #1's rights were protected by ensuring the aforementioned practice was approved by the client and/or a legally sanctioned representative.	W 124		
W 125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain client's rights and/or ensure each client was encouraged to exercise their rights, for two of the two clients (Clients #1 and #2) included in the sample.</p> <p>The finding includes:</p> <p>1. Interview with the facility's House Manager (HM) on May 10, 2007 at 8:32 AM revealed Client #1 was not able to give informed consent for the use of her medication, finances or treatment plans. According to the HM, Client #2 had did not have any family or a guardian to assist her with those decisions. Continued with the HM on May 10, 2007 revealed Client #1 had been released from the hospital on May 9, 2007. According to the HM, the client was diagnosed with having seizures and was prescribed an anticonvulsant. The aforementioned information was verified through the review of incident reports.</p> <p>Further interview with the HM on May 10, 2007 at</p>	W 125	See W. 104, and W. 125	6/1/07

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W 125	<p>Continued From page 6</p> <p>12:00 PM revealed that none of the clients in the home received one to one staffing supports, but Client #1 was in the process of getting approval for a one to one staff. According to the HM, the attending physician at the hospital recommended that Client #1 receive one to one. The HM revealed that staff were trained on checking on the client every 15 minutes until the one to one staff was approved. Continued discussion with the HM revealed that the practice had not been reviewed by the facility's Human Rights Committee.</p> <p>Interview with the facility's Director on May 11, 2007 at 2:09 AM revealed that staff were trained to provide line of site supervision and 15 minute checks whenever the client was in her bedroom. Observation of staff and Client #1 in the client's bedroom and interview with staff on May 11, 2007 at 4:34 PM however, revealed that the staff person was Client #1's one to one. The staff member indicated that he/she was Client #1's one to one for that shift (2:00 PM - 12:00 AM) and was relieved by the overnight staff. The staff member revealed that he/she remained by Client #1's side because the client may get up and fall. At the time of the survey, the facility failed to provide evidence that Client #1's rights were protected by ensuring the aforementioned practice was approved by the client and/or a legally sanctioned representative.</p> <p>2. Interview with the facility's House Manager (HM) on May 10, 2007 at 8:32 AM revealed Client #2 was not able to give informed consent for the use of her medication, finances or treatment plans. According to the HM, Client #2 had a guardian to assist her with those decisions.</p>	W 125		

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W 125	<p>Continued From page 7</p> <p>Continued interview with the HM and observations conducted at 9:25 AM revealed Clients #1, #2, and #3 received in-home day programming services. Client #2 was seated in her wheelchair at the dining room table stringing beads, while Client #1 was looking at a magazine. Client #3 was seated in her wheelchair in the dining room (away from the table).</p> <p>At 10:04 AM, while still at the table, Client #2 revealed she had to use the bathroom. Staff was overheard asking Client #2 if she needed to urinate or have a bowel movement. Client #2 revealed she had to have a bowel movement. After their dialogue, staff revealed that Client #2 could not use the toilet in the bathroom. Further discussion with the staff revealed that the facility's practice was to allow the client to urinate and defecate on herself, then clean her up. The staff was interviewed to ascertain how long the facility had been participating with the aforementioned practice. It was revealed that the client began attending in-home day program in December 2006 and that was the practice at that time (over 5 months). It should be noted that the aforementioned practice was implemented due to the staff's inability to safely transfer the client to the toilet or commode. (See also W159)</p> <p>At the time of the survey, the facility failed to provide evidence that Client #2's rights were maintained and the client encouraged to exercise her right to use the restroom.</p>	W 125		
W 130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p>	W 130		

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W 130	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure client's rights to privacy, for one of the two clients (Client #2) included in the sample.</p> <p>The finding includes:</p> <p>Interview with the House Manager (HM) and observations conducted on May 10, 2007 at 9:25 AM revealed Clients #1, #2, and #3 received in-home day programming services. Client #2 was seated in her wheelchair at the dining room table stringing beads, while Client #1 was looking at a magazine. Client #3 was seated in her wheelchair in the dining room (away from the table).</p> <p>At 10:04 AM, while still at the table, Client #2 revealed she had to use the bathroom. Staff was overheard asking Client #2 if she needed to urinate or have a bowel movement. Client #2 revealed she had to have a bowel movement. After their dialogue, staff revealed that Client #2 could not use the toilet in the bathroom. Further discussion with the staff revealed that the facility's practice was to allow the client to urinate and defecate on herself, then clean her up. The staff was interviewed to ascertain how long the facility had been participating with the aforementioned practice. It was revealed that the client began attending in-home day program in December 2006 and that was the practice at that time (over 5 months). It should be noted that the aforementioned practice was implemented due to the staff's inability to safely transfer the client to the toilet or commode. (See also W159)</p>	W 130	<p>See W. 104 and W. 125</p> <p>The staff were trained on privacy on 5/10/2007. All staff have been trained on appropriate toileting protocol.</p>	6/15/07
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W 130	Continued From page 9 At the time of the survey, the facility failed to provide evidence that Client #2's rights to privacy relating to personal elimination (bladder and bowel) were maintained. (See also W159)	W 130		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment.  The findings include:  1. The QMRP failed to ensure services for Client #2 were monitored and integrated to ensure the client's rights and dignity were not violated when having to eliminate waste.  Interview with the facility's House Manager on May 10, 2007, at 8:32 AM, revealed Clients #1, #2, and #3 receive in home day programming services. Observations conducted at 9:25 AM revealed Client #2 was seated in her wheelchair at the dining room table with her two housemates. Client #1 was looking at a magazine, Client #2 was stringing beads, and Client #3 was seated in her wheelchair in the dining room (away from the table).  At 10:04 AM, while still at the table, Client #2 revealed she had to use the bathroom. Staff was	W 159	See. W. 104	

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W 159	<p>Continued From page 10</p> <p>overheard asking Client #2 if she needed to urinate or have a bowel movement. Client #2 revealed she had to have a bowel movement. After their dialogue, staff revealed that Client #2 could not use the toilet in the bathroom. Further discussion with the staff revealed that the facility's practice was to allow the client to urinate and defacate on herself, then clean her up. The staff was interviewed to ascertain how long the facility had been participating with the aforementioned practice. It was revealed that the client began attending in-home day program in December 2006 and that was the practice at that time.</p> <p>At 10:10 AM, staff was overheard asking Client #2, who was still seated at the table, if she had already had a bowel movement. At approximately 10:35 AM, staff was overheard asking the client if she was "wet yet." Client #2 responding by saying no. Later that day, at 3:21 PM, Client #2 was overheard thanking a staff member. Client #2 reported that the staff member changed her.</p> <p>Interview with the House Manager (HM) on May 11, 2007, at 12:45 PM revealed that staff use a manual hooyer lift when transferring Client #2. The HM revealed that Client #2 had a stroke in March or April 2006 that caused the client to lose her ability to stand and therefore, was not able to be transferred using a two person transfer. The HM further revealed that staff had been either injured or complained of back pain related to transferring the client without the use a hooyer lift due to her weight.</p> <p>Additional discuss on with the HM on May 11, 2007 revealed that Client #2's manual hooyer was not an appropriate lift to transfer the client to the commode or toilet. The HM revealed that the</p>	W 159		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/11/2007
NAME OF PROVIDER OR SUPPLIER  ST JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016	
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W 159	<p>Continued From page 11</p> <p>hoyer lift placed Client #2 in a cradled position when elevated and did not allow for the client to be transferred to a seated position safely. According to the HM, the hoyer lift's carry bar prohibited the client from transferring to the toilet (seated) without potential injury. Furthermore, the HM revealed that the client leans and had a problem with maintaining a seated position.</p> <p>Discussion with the HM further revealed that the facility's Physical Therapist (PT) was made aware of the restriction the manual hoyer lift placed on Client #2. The HM revealed that the PT recommended an electric hoyer lift that would allow for Client #2 to safely transfer to the toilet or commode. However, according to the HM, the facility attempted to secure the recommended electric hoyer lift but the client's insurance would not pay for it. The HM revealed that the client had to weigh 300 lbs or greater before the lift would be approved by the client's insurance and therefore, nothing else could be done.</p> <p>Review of Client #2's Physical Therapy Assessment dated May 11, 2006 revealed recommendations including the use of a hoyer lift and a chest harness. The HM was interviewed to ascertain if the PT was made aware of the issue with the hoyer lift and/or re-evaluated the client and made alternative recommendations. The HM revealed that the PT was aware of the hoyer lift issue but no supplementary recommendations were made. Review of Client #2's habilitation record failed to provide evidence that the initial hoyer lift was problem and/or a plan to rectify the issue.</p> <p>2. The QMRP failed to ensure clients were provided with opportunities for choice and</p>	W 159		

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

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W 159	Continued From page 12 self-management. (See W247)	W 159	2. In the future, the QMRP will ensure that all clients are provided with opportunities for choice and self-management in accordance with needs and policies of St. John's Community Services.	6/15/07
W 247	3. The QMRP failed to ensure continuous active treatment service (See W249).  4. The QMRP failed to ensure that client's were provided with the recommended adaptive equipment. (See V1436) 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN  The individual program plan must include opportunities for client choice and self-management.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure clients were provided with opportunities for choice and self-management, for one of the two clients (Client #2) included in the sample  The finding includes:  The facility failed to ensure Client #2 was afforded opportunities for choice and/or self-management when needing to use the bathroom.  Interview with the facility's House Manager on May 10, 2007, at 8:32 AM, revealed Clients #1, #2, and #3 receive in home day programming services. Observations conducted at 9:25 AM revealed Client #2 was seated in her wheelchair at the dining room table with her two housemates. Client #1 was looking at a magazine, Client #2 was stringing beads, and Client #3 was seated in her wheelchair in the dining room (away from the table).	W 247	3. The QMRP has revised all necessary program plans and will ensure proper implementation and monitoring.  4. All necessary equipment to utilize the restroom are in place. The splint was replaced.	6/1/07  5/15/07

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

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W 247	<p>Continued From page 13</p> <p>At 10:04 AM, while still at the table, Client #2 revealed she had to use the bathroom. Staff was overheard asking Client #2 if she needed to urinate or have a bowel movement. Client #2 revealed she had to have a bowel movement. After their dialogue, staff revealed that Client #2 could not use the toilet in the bathroom. Further discussion with the staff revealed that the facility's practice was to allow the client to urinate and defecate on herself, then clean her up. The staff was interviewed to ascertain how long the facility had been participating with the aforementioned practice. It was revealed that the client began attending in-home day program in December 2006 and that was the practice at that time.</p> <p>At 10:10 AM, staff was overheard asking Client #2, who was still seated at the table, if she had already had a bowel movement. At approximately 10:36 AM, staff was overheard asking the client if she was "wet yet." Client #2 responding by saying no. Later that day, at 3:21 PM, Client #2 was overheard thanking a staff member. Client #2 reported that the staff member changed her.</p> <p>Interview with the House Manager (HM) on May 11, 2007, at 12:45 PM revealed that staff use a manual hooyer lift when transferring Client #2. The HM revealed that Client #2 had a stroke in March or April 2006 that caused the client to lose her ability to stand and therefore, was not able to be transferred using a two person transfer. The HM further revealed that staff had been either injured or complained of back pain related to transferring the client without the use a hooyer lift due to her weight.</p> <p>Additional discussion with the HM on May 11, 2007 revealed that Client #2's manual hooyer was</p>	W 247	<p>Sec. 104</p> <p>Additionally, attempts to secure the hooyer lift of need and choice were rejected.</p> <p>Client #2 is currently using an alternative method of meeting toileting needs.</p>	6/15/07

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

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W 247	Continued From page 14 not an appropriate lift to transfer the client to the commode or toilet. The HM revealed that the hoyer lift placed Client #2 in a cradled position when elevated and did not allow for the client to be transferred to a seated position safely. According to the HM, the hoyer lift's carry bar prohibited the client from transferring to the toilet (seated) without potential injury. Furthermore, the HM revealed that the client leans and had a problem with maintaining a seated position.  Discussion with the HM further revealed that the facility's Physical Therapist (PT) was made aware of the restriction the manual hoyer lift placed on Client #2. The HM revealed that the PT recommended an electric hoyer lift that would allow for Client #2 to safely transfer to the toilet or commode. However, according to the HM, the facility attempted to secure the recommended electric hoyer lift but the client's insurance would not pay for it. The HM revealed that the client had to weigh 300 lbs or greater before the lift would be approved by the client's insurance and therefore, nothing else could be done.  Review of Client #2's Physical Therapy Assessment dated May 11, 2006 revealed recommendations including the use of a hoyer lift and a chest harness. The HM was interviewed to ascertain if the PT was made aware of the issue with the hoyer lift and/or re-evaluated the client and made alternative recommendations. The HM revealed that the PT was aware of the hoyer lift issue but no supplementary recommendations were made. Review of Client #2's habilitation record failed to provide evidence that the initial hoyer lift was problem and/or a plan to rectify the issue.	W 247		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

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

FORM APPROVED  
OMB NO. 0938-0391

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W 249	<p>Continued From page 15</p> <p>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.</p> <p>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 (IDT) formulated each client's Individual Program Plan (IPP), clients received continuous active treatment, consisting of needed interventions and services, for two of the two clients (Clients #1 and #2) included in the sample.</p> <p>The findings include:</p> <p>1. Observation of the evening medication administration on May 10, 2007 at 5:16 PM revealed the nurse gave Client #2 evening medications. The nurse was observed punching out the medications and handing the client the medication cup (to independently take). Additionally, the nurse was observed obtain a cup of water then hand Client #2 the cup of water to drink during the medication administration.</p> <p>Review of Client #2's Individual Support Plan (ISP) dated May 31, 2006 at 3:00 PM on May 11, 2007 revealed the IDT made a recommendation for the client to participate with a program to increase her personal care skills. According to</p>	W 249	<p>The nurse has reviewed the individualized program plan for all the individuals that lives in the home to ensure proper implementation.</p>	5/15/07

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

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FORM APPROVED  
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W 249	<p>Continued From page 16</p> <p>the ISP, Client #2's objective, in that domain, required her to get her water/juice to take her medications with verbal assistance. At the time of the survey, the facility failed to ensure Client #2 was given an opportunity to participate in her program to increase her personal skills.</p> <p>2. Observation of the evening medication administration on May 10, 2007 beginning at 5:16 PM revealed the nurse gave Client #1 an evening medication. The nurse was observed punching out the medication and handing the client the medication cup. Additionally, the nurse was observed obtain a cup of water then hand Client #1 the cup of water to drink during the medication administration.</p> <p>Review of Client #1's Individual Support Plan (ISP) dated February 16, 2007 at 1:34 PM on May 11, 2007 revealed the IDT made a recommendation for the client to participate with a program to increase her personal care skills. According to the ISP, Client #1's objective, in that domain, required her to get her water/juice to take her medications with verbal assistance. At the time of the survey, the facility failed to ensure Client #1 was given an opportunity to participate in her program to ncrease her personal skills.</p> <p>3. Continued Review of Client #1's ISP (February 16, 2007) on May 11, 2007 revealed the additional recommended programs objectives including the following:</p> <ul style="list-style-type: none"> <li>- Client #1 will buff her nails independently on 80% of recorded trials per month.</li> <li>- Client #1 will use the pump toothbrush to apply toothpaste on with her battery operated</li> </ul>	W 249	<p>3. All goals have been revised by the QMRP to reflected actual materials used. Client # 1 does have a nail buffer.</p>	

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

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FORM APPROVED  
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W 249	Continued From page 17 toothbrush with verbal assistance on 80% of recorded trials per month.  Observation of the facility's environment on May 11, 2007 beginning at 12:06 PM revealed Client #1 did not have a nail buffer, toothpaste, or a battery operated toothbrush. The House Manager and staff were interviewed on May 11, 2007 and verified the client did not have a nail buffer or the items required for her toothbrushing program. It should be further noted that interview revealed the client uses toothettes and mouthwash to clean her mouth because she was edentulous. At the time of the survey, the facility failed to ensure the aforementioned programs were implemented as recommended.	W 249		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE  The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Client #1's one to one staffing had been reviewed and approved by the Human Rights Committee (HRC).  The finding includes:  The facility failed to ensure Client #1's one to one staff had been approved by its HRC prior to its implementation. (See W125, 1)	W 262	See W. 124  In addition, the purpose of the one to one is not to manage inappropriate behavior but to supply support and monitoring of a changed medical condition to determine future needs and to protect Client #1.	6/15/07
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE	W 264		

PRINTED: 05/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

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

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W 264	Continued From page 18  The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide evidence that its Human Rights Committee (HRC) thoroughly monitored and made suggestions about the facility's practices relating to restroom usage, for one of the two clients (Client #2) included in the sample.  The finding includes:  (Cross Refer W159) The facility failed to provide evidence that Client #2's rights were maintained relating to personal elimination (bowel and bladder). Additionally, at the time of the survey, the facility failed to provide evidence that its HRC had monitored its practices related to the client and made suggestions.	W 264	Sec. 104  Sec. 159	
W 424	482.470(d)(1) CLIENT BATHROOMS  The facility must provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate toileting facilities	W 424		

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

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W 424	Continued From page 19 were made accessible to, one to the two clients (Client #2) included in the sample.  The finding includes:	W 424	See. W. 104, W. 159.  Client #2 has an established alternative bathroom.	6/1/2007
W 436	The facility failed to provide toileting facility's that were accessible to Client #2. (See W159) 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, interview and record review, the facility failed to ensure that clients were provided with necessary adaptive equipment, for one of the two clients (Client #2) included in the sample.  The finding includes:  1. The facility failed to secure necessary equipment for Client #2 to safely use the bathroom. (See W159)  2. Review of Client #2's habilitation records on May 11, 2007 revealed the client's Occupational Therapy Assessment dated May 20, 2006. The assessment documented recommendations including the following:  Client #2 would benefit from a splint on her left wrist to prevent further deformity.	W 436	Sec. W. 104, W. 159	6/1/07

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

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W 436	Continued From page 20  Observations throughout the survey revealed Client #2 did not have the recommended splint. Interview with the House Manager on May 11, 2007 revealed the splint was never obtained for the client. At the time of the survey, the facility failed to ensure the recommended splint had been obtained.	W 436			

PRINTED: 05/22/2007  
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/11/2007
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1 000	INITIAL COMMENTS  A recertification survey was conducted from May 10, 2007 through May 11, 2007. A random sample of two residents was selected from a residential population of three females with mental retardation and other disabilities. The findings of the survey were based on observations, interviews, and the review of resident and administrative records including incident reports.	1 000		
1 082	3503.10 BEDROOMS AND BATHROOMS  Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.  This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure bathrooms were equipped with needed items.  The finding includes  Observations of the GHMRP's environment and interview with the House Manager on May 11, 2007 beginning at 12:06 PM revealed there was no toilet paper holder in the hallway bathroom closest to the living room. Additionally, the cup dispenser did not dispense individual cups in a sanitary manner. The dispenser was observed to have cups stacked in it and residents could take one from the top of the stack.	1 082	All bathrooms in the home have toilet paper and cup dispensers.	5/12/07
1 090	3504.1 HOUSEKEEPING  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive,	1 090		

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TITLE

(X6) DATE  
6/15/07

Health Regulation Administration

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1090	<p>Continued From page 1</p> <p>and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner.</p> <p>The findings include:</p> <p>Observation and interview with the House Manager (HM) during the environmental walkthrough on May 11, 2007 beginning at 12:06 PM revealed the following.</p> <p>Living Room</p> <p>There were stains observed on the chair covering of the chair located closest to the dining room.</p> <p>Bathroom</p> <p>The light was not working in the shower of the hallway closest to the living room.</p> <p>Bedroom</p> <p>The bar that secured the sliding glass doors in Resident #2's bedroom was observed to have a sharp end that was potentially a safety hazard.</p> <p>Exterior</p> <p>The wood was chipped on the lower left exterior frame of the sliding glass door next to Resident #2's bedroom.</p>	1090	<p>Maintenance requests have been submitted to both internal maintenance and landlord.</p>	6/14/07

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I 203	Continued From page 2	I 203		
I 203	<p>3509.3 PERSONNEL POLICIES</p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at east annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter.</p> <p>The finding includes:</p> <p>Review of the personnel files on May 10, 2007 revealed the GHMRP failed to provide evidence that six staff had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter.</p>	I 203	<p>All personnel records were reviewed by HR and found to have the requested information and/or requests to the appropriate personnel for the necessary information.</p>	6/15/2007
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her</p>	I 206		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G173</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/11/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST JOHN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20018</b>		
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1206	Continued From page 3 to perform the required duties.  The finding includes:  Review of the personnel records on May 10, 2007 revealed that the GHMRP failed to ensure that current health certificates were on file for three staff and five consultants.	1206	Current health certificates are on file or have been requested of the staff and consultants. Copies attached to POC. The governing body audits the files on a monthly basis to ensure compliance as evidenced by the letters in the file.	6/15/07
1271	<b>3513.1(b) ADMINISTRATIVE RECORDS</b>  Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:  (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request;  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of all staffs personnel records.  The finding includes:  Interview with the House Manager and review of the personnel files on May 10, 2007 revealed that the GHMRP failed to provide evidence of personnel files for the Director of Nursing, one Licensed Practical Nurse, one nutritionist consultant and one direct care staff.	1271	Files for the Medical Coordinator and the LPN are present. The nutritionist was included in the consultant book. All direct care staff have personnel records.	6/15/07
1274	<b>3513.1(e) ADMINISTRATIVE RECORDS</b>  Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:	1274		

Health Regulation Administration

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1274	<p>Continued From page 4</p> <p>(e) Signed agreements or contracts for professional services;</p> <p>This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded (GHMRP) failed to provide evidence of an established contracts each of their consultants.</p> <p>The finding includes:</p> <p>Review of the personnel records on May 10, 2007 revealed the GHMRP failed to have contract on file for the psychologist, the podiatrist, the pharmacist, the nutritionist, the Director of Nursing and one Licensed Practical Nurse (LPN).</p>	1274	<p>The psychologist is a full time employee. All consultant agreements or personnel records are on file. See attached.</p>	6/15/07
1379	<p>3519.10 EMERGENCIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was notified of unusual incidents that substantially interfered with a resident's health, for two of the three residents (Residents #1 and #2) that resided in the facility.</p>	1379		

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Health Regulation Administration

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1379	Continued From page 5  The finding includes:  1. Review of the GHMRP's incident reports and/or summaries on May 10, 2007 at approximately 4:30 PM revealed the following incidents:  a. On September 15, 2006, staff documented that they overheard a sound in Client #1's bedroom. Client #1 was found lying down on the floor. Staff reported that there was urine and blood on the floor when she assisted the resident up. The resident was taken to the emergency room and received staples to the head.  b. On April 3, 2007, staff reported observing Resident #3 groaning and vomiting. Resident #3 was taken to the emergency room for evaluation.  Review of the Department of Health's incident management records revealed the aforementioned incidents were not reported. At the time of the survey, the GHMRP failed to provide evidence that the aforementioned incidents were reported to DOH as required.	1379	All QMRP's, Incident Management Coordinator, and RTL's have been inserviced on incident reporting. In the future all incidents will be faxed to the appropriate personnel/parties.	6/15/07
1396	3520.2(f) PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:	1396		

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Health Regulation Administration

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1396	Continued From page 6  (f) Occupational Therapy:  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the Occupational Therapist secured by the group home to monitor interventions in accordance with the goals and objectives of every Individual habilitation plan, was licensed.  The finding includes:  Review of the personnel records on May 10, 2007 revealed the GHMRP failed to have a current license on file for the Occupational Therapist.	1396	License of the OT was requested and will be on file.	6/15/07
1422	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s).  The finding includes:  (See Federal Deficiency Report Citations W249)	1422	See. W 249	
1500	3523.1 RESIDENTS 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	1500		

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Health Regulation Administration

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I 500	Continued From page 7  chapter, and other applicable District and federal laws.  This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights.  The findings include:  (See Federal Deficiency Report - Citations W104, W125, W130, and W262)	I 500	See W. 104, W. 125	

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Health Regulation Administration

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R 000	INITIAL COMMENTS  A recertification survey was conducted from May 10, 2007 through May 11, 2007. A random sample of two residents was selected from a residential population of three females with mental retardation and other disabilities. The findings of the survey were based on observations, interviews, and the review of resident and administrative records including incident reports.	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 the review of records, 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 has worked or resided within the seven (7) years prior to the check.  The finding includes:  Review of the personnel records on May 10, 2007 revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for the House Manager and	R 125	Review of personnel records by HR found that all staff hired at the initiation of the new law had the appropriate background check. Staff hired prior to the law had the police clearance.	6/15/07

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

TITLE

(X6) DATE

STATE FORM

DU8011

If continuation sheet 1 of 2

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R 125	Continued From page 1 one direct care staff.	R 125		