

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MFD12-0069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 4434 SPRINGDALE RD NW WASHINGTON, DC 20016		
(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
1000	INITIAL COMMENTS A licensure survey was conducted on August 4, 2009 through August 5, 2009. A random sample of two residents was selected from a resident population of four women with various disabilities. The findings of the survey were based on observations, interviews with staff in the home, as well as a review of resident and administrative records, including incident reports.	1000	The governing body seeks to show that they meet the standards as outlined in the policies and procedures as indicated regarding the maintenance of the homes.	
1090	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 ensure the interior and exterior was maintained in a safe, clean, orderly, attractive, and sanitary manner. The findings include: During the environmental inspection of the GHMRP's environment on August 4, 2009, at approximately 11:00 a.m., the following deficient practices were identified: 1. The carpet throughout the facility was soiled with stains. 2. The living room as well as the bedrooms and bathrooms had dust on the window ledges. 3. The kitchen floor had dirty spots around the	1090	1. The carpet identified was cleaned immediately. 2. The staff and house manager did a thorough cleaning of the living area.	8/4/09

Received 9/14/09

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

LABORATORY DIVISION OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
STATE BOARD OF HEALTH

[Signatures]

Case: _____ Date: _____

If continuation sheet 1 of 12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 4434 SPRINGDALE RD NW WASHINGTON, DC 20016		
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1090	Continued From page 1 bottom of the cabinets. Additionally, the burners on top of the stove were greasy and dirty. 4. The bathtub located in the second floor bathroom was extremely dirty, filled with scum and mildew. At the time of the survey, it was determined that the tub was unsanitary for use. The facility's residential team leader (RTL) verified the tub was unsanitary for use and instructed the staff to clean it. Additionally, the toilet in the same location was dirty and unsanitary. The RTL was present at the time of the environmental inspection and acknowledged the problems.	1090	3. The kitchen was cleaned and the burners were replaced. 4. The bathtub and toilet were cleaned. A meeting was held with the staff on the unsanitary conditions identified.	8/4/09
1185	3507.4(c) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to implement their Incident Management Policy as written. The finding includes: Review of the GHMRP's incident reports on August 4, 2009 beginning at 10:18 a.m., revealed an incident report dated April 22, 2009. According to the incident report, an allegation of abuse/mistreatment was reported involving Resident #1.	1185	Training with the staff was completed by the Incident Management Coordinator on the	9/24/09

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 4434 SPRINGDALE RD NW WASHINGTON, DC 20016		
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1185	Continued From page 2 Interview with the GHMRP's Incident Management Coordinator (IMC) on August 5, 2008 at 1:47 p.m. revealed that the aforementioned incident report was completed by the Residential Team Leader (RTL) after she had been informed by one of the residents of the incident. Continued interview with the IMC revealed that the incident actually occurred on April 21, 2008. The surveyor asked the IMC what was their incident management protocol. The IMC indicated that all staff witnessing an incident was responsible for completing an incident report. Review of the incident management policy on August 5, 2008, revealed a section entitled "Procedures." Further review of the policy revealed "incident reports are to be written by staff members by the end of the shift or workday during which the incident occurred." The GHMRP's policy also revealed that if in the event the incident involved "suspected abuse, the incident report would be immediately completed." Additionally, "incident reports are to be filled out by all staff present at the incident or witnessing the incident, and any other relevant witnesses willing to complete an incident report." At the time of the survey, the GHMRP failed to ensure their policy and procedures on Incident Management was implemented as written.	1185	reporting policy and instructions. Please review the attachment for details.	
1225	3810.6(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents;	1225	Staff was trained on the infection control policy and procedures. the ladies in the home also received training too.	8/21/09

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 4434 SPRINGDALE RD NW WASHINGTON, DC 20016		
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1226	Continued From page 3 This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to maintain a sanitary environment to avoid sources and transmissions of infection for one of the two residents (Resident #1) included in the sample. The finding includes: On August 4, 2009, Resident #1 was observed at 6:28 PM sitting at the dining room table eating her dinner. When she finished eating, the resident was observed to wipe the table off with her paper towel. Further observation of Resident #1 revealed that she took the same paper towel used to wipe the table and wiped her mouth with it. At the time survey, the GHMRP failed to teach the resident not to wipe her mouth with the same paper towel used to wipe other surfaces to ensure a sanitary environment.	1226	Training was completed with the ladies of the home on appropriate cleaning practices after meals. Please see attached documentation for details.	8/21/09
1379	3619.10 EMERGENCIES In addition to the reporting requirement in 3619.5, 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 interview and review of the incident	1379		

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 4494 SPRINGDALE RD NW WASHINGTON, DC 20016		
(04) 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)	(05) COMPLETE DATE
1379	Continued From page 4 reports, the GHMRP failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH), Health Regulation Administration, for one of the four residents (Resident #1) residing in the facility. The finding includes: Review of the GHMRP's incident reports on August 4, 2009 beginning at 10:19 a.m., revealed an incident report dated April 22, 2009. According to the incident report, an allegation of abuse was reported involving Resident #1. Continued review of the report revealed Resident #2 informed the residential team leader (RTL) that she witnessed Staff #1 hitting and pushing Resident #1. Additionally, Resident #4 told another staff (Staff #2) that Staff #1 hit Resident #1 in the face. At the time of the survey, there was no documented evidence that the GHMRP notified the Department of Health (DOH) of all unusual incidents that substantially interfered with Resident #1's welfare and being at risk.	1379	The staff were trained on the reporting procedure for all incidents reportable and serious reportable. Please review the attachments for details.	9/24/09
1410	3520.11 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall ensure that when another agency assumes responsibility for services to a resident, a summary of the appropriate record is forwarded to that agency. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure the Individual Support Plan (ISP) was forwarded to the residence for one of the two residents (Resident #2) included in	1410	The governing body received the ISP for Resident #2. Please see	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0069	020 MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED 08/05/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 4434 SPRINGDALE RD NW WASHINGTON, DC 20018		
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1410	Continued From page 5 the sample. The finding includes: Interview with the GHMRP's Qualified Mental Retardation Professional (QMRP) on August 5, 2009, at 5:48 PM revealed that she was no longer responsible for completing the ISP. According to the QMRP, the resident's case manager completed their ISP. Review of Resident #2's habilitation record on the aforementioned date revealed the resident had an ISP dated January 29, 2008. The QMRP verified that there was no evidence of a current ISP and indicated that she had not received the plan from the resident's case manager. At the time of the survey, there was no documented evidence of a current ISP for Resident #2.	1410	For details. The current ISP was obtained and is available for review. All staff will be trained on the ISP no later than 9/14/09.	8/7/09	
1412	3520.13 PROFESSION SERVICES: GENERAL PROVISIONS If a resident evidences the need for a professional service for which arrangements do not exist, the GHMRP shall have fourteen (14) days to show evidence of arrangements for provision of the professional services, except that in life threatening situations, arrangements must be made immediately. This Statute is not met as evidenced by: Based on observation, interview and record review, the (GHMRP) failed to ensure the provision of psychological and psychiatric services, for two of the two residents (Resident #1 and #2) included in the sample.	1412			

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1412	<p>Continued From page 6</p> <p>The findings include:</p> <p>1. During the entrance conference on August 4, 2009 at approximately 9:30 AM, an interview with the GHMRP Licensed Practical Nurse (LPN) revealed that Resident #1 was prescribed psychotropic medications in conjunction with a Behavior Support Plan (BSP) to manage her behaviors.</p> <p>Review of the resident's habilitation record on August 4, 2009 at 1:51 p.m. revealed an expired behavioral support plan dated April 21, 2008. Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the record on August 6, 2009 at approximately 5:08 p.m. revealed that the resident had a medical waiver preauthorization for a behavior support plan (BSP) to be conducted with a start date of August 1, 2008 and an ending date of July 31, 2009.</p> <p>Additionally, continued review of the record revealed a medical assessment dated April 21, 2009. According to the assessment, the resident had been diagnosed with obsessive compulsive disorder, bipolar disorder and intermittent explosive disorder and there was no psychiatric assessment available for review.</p> <p>At the time of the survey, the GHMRP failed to make an arrangement for Resident #2 to receive services for a revised BSP and a psychiatric evaluation.</p> <p>2. During the entrance conference on August 4, 2009 at approximately 9:30 AM, an interview with the GHMRP Licensed Practical Nurse (LPN) revealed that Resident #2 was prescribed psychotropic medications in conjunction with a</p>	1412	<p>Resident # 1 BSP had expired. She just had her ISP on 8/5/09 and the service coordinator needed the psychological assessment that indicates the recommendation for BSP and continued services to submit for waiver authorization for services.</p> <p>A request was made to obtain the psychiatric assessment for resident#1 to [REDACTED], her new psychiatrist, at Seton House. Please review the attached assessment.</p> <p>2. See next page</p>

9/30/09

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1412	Continued From page 7 Behavior Suppor. Plan (BSP) to manage her behaviors. Observation of the administration of medication on August 4, 2009 at 6:02 p.m. revealed that Resident #2 had a locked box for her individual medications. She proceeded to unlock the box and get each of her medications. The resident was observed to independently punch her medications in a cup. Continued observation revealed that she self-administered Risperdal 1 mg and Cogentin 1 mg. Interview with the qualified mental retardation professional (QMRP) and review of the resident's habilitation record on August 4, 2009 at 8:11 p.m., revealed psychotropic medication reviews was conducted on a monthly basis. Review of the psychotropic medication reviews revealed that there was no documented evidence of medication reviews for the months of September 2008, November 2008, and December 2008. At the time of the survey, the GHMRP failed to make an arrangement for Resident #2 to receive services from a psychiatrist.	1412	Resident #2 had a BSP but was dropped because she no longer displays the behaviors identified and a new BSP will be implemented to reflect the changes. A review of her current medication regimen will be completed, too. The QMRP contact the attending psychiatrist to obtain the missing med reviews and was informed that resident #2 to did not attend her scheduled reviews for the month. Her Rx refills were forwarded to the home.	8/14/09 9/1/09
1420	3521.8 HABILITATION AND TRAINING Each GHMRP Director shall arrange for each resident to be reevaluated and to receive an individual Habilitation Plan, which is updated appropriately at least annually. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to have a current Individual Support Plan for one of the two residents (Resident #2) included in the sample.	1420		

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 4434 SPRINGDALE RD NW WASHINGTON, DC 20016		
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1429	Continued From page 8 The finding includes: Interview with the GHMRP's qualified mental retardation professional (QMRP) on August 5, 2009, at 5:48 PM revealed that she was no longer responsible for completing the ISP. According to the QMRP, the resident's case manager completed their ISP. Review of Resident #2's habilitation record on the aforementioned date revealed the resident had an ISP dated January 29, 2008. The QMRP verified that there was no evidence of a current ISP and indicated that she had not received the plan from the resident's case manager. At the time of the survey, there was no documented evidence of a current ISP for Resident #2.	1429	The current ISP was obtained and is available for review. All staff will be trained on the ISP no later than 9/14/09.	8/7/09
1500	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, § 7-1305.05(h), formerly § 8-1965(h)] that governs the care and rights of persons with mental retardation for one of the two residents (Resident #2) included the sample. The findings include:	1500		

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1500	Continued From page 11 her." At the time of the survey, there was no evidence that the facility's specialty constituted committee ensured that the written informed consent had been obtained from Resident #2's guardian prior to the administration of her psychotropic medication.	1500			