

Health Regulation Administration

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/29/2009 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

1 000 INITIAL COMMENTS

A licensure survey was conducted on July 29, 2009. A random sample of two residents was selected from a resident population of four men with various disabilities.

1 000

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.

Received 9/3/09
 GOVERNMENT OF THE DISTRICT OF COLUMBIA
 DEPARTMENT OF HEALTH
 HEALTH REGULATION ADMINISTRATION
 825 NORTH CAPITOL ST., N.E., 2ND FLOOR
 WASHINGTON, D.C. 20002 8/15/09

1 090 3504.1 HOUSEKEEPING

1 090

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 and interview, the GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner.

The findings include:
 On July 29, 2009, at approximately 10:30 AM observation of the environment and interview with the Qualified Mental Retardation Professional (QMRP) revealed the following deficiencies:
 1. The door to the GHMRP's first floor bathroom cabinet was detached from it hinges
 2. The GHMRP's front storm door had a gap between the bottom of the door and the threshold. Light was observed underneath the of the door.

It is the Policy of St. John's Community Services to maintain in a safe, clean, orderly and attractive and sanitary manner and be free of accumulations of dirt, rubbish and objectionable odors.

1. The door to the first floor bathroom has be repair on 8/15/09.
2. The Gap at the bottom of the front storm doors has had strips placed to cover the strips placed to cover the gap between the bottom of the door and the threshold.
3. The carpet strip near the entrance to the kitchen has been straightened to remove the buckled.

In the future all doors will be repair in a timely manner.

8/15/09

| | | |
|---|-----------------|---------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | TITLE CLC-DC | (X8) DATE 9/3/09 |
|---|-----------------|---------------------|

Health Regulation Administration

| | | | | | |
|--|---|--|--|--------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/29/2009 |
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 | |
| I 090 | Continued From page 1 3. The carpet strip near the entrance to the GHMRP's kitchen had buckled in a raised position, presenting a trip hazard. | I 090 | | | |
| I 161 | 3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the governing body approved and reviewed its policies and procedures annually. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on July 29, 2009 at 2:49 PM, revealed that the policy and procedures manual was reviewed by the GHMRP's Director. At the time of the survey the GHMRP failed to provide evidence that the manual had been reviewed and approved by the governing body as required since October, 2006. | I 161 | It is the policy of St John's Community Services to provide evidence that the governing body approved and reviewed its policies and procedures annually. The Policy and Procedure manual has been revised for 2009. A copy of the revised page is attached for your review. In the future, the Policy and Procedure manual will be revised timely. | | |
| I 165 | 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: | I 165 | | | |

Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/29/2009 | |
|---|---|--|--|------------------------|
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 |
| I 165 | <p>Continued From page 2</p> <p>Based on interview and record review, the GHMRP failed to implement their Human Rights Committee (HRC) policy on medication and infection control.</p> <p>The findings include:</p> <p>The GHMRP failed to implement their HRC policy to advocate for the resident's rights as evidenced below:</p> <p>Interview with the GHMRP's Qualified Mental Retardation Professional (QMRP) and review of the policies and procedures manual on July 29, 2009, revealed a HRC policy. Continued review of the policy revealed the committee was to ensure the representation and advocacy of the resident's rights to include the review of behavior intervention procedures used in crisis situations. At the time of the survey, the GHMRP failed to ensure Resident #1 had received informed consent for his psychotropic medication (Paxil 12.5 mg). [Also See 0500]</p> <p>2. Cross Refer to 3510.5 (c). The Governing Body failed to ensure the implementation of infection control procedures to prevent communicable infectious diseases for one of one of the residents included in the sample (Resident #1).</p> | I 165 | <p>It is the Policy of SJCS to implement their Human Rights Committee (HRC) policy on medication and infection control. The informed consent for the Paxil 12.5mg was signed by the individual and a written consent obtained from the individual's Legal Guardian on 7/30/09. A copy of the signed consent has been attached for review. In the future, all consents for medications will be sought from the Legal Guardian in a timely manner</p> <p>2. It is the policy of SJCS to ensure the health and safety of all of its residents. Staffs were trained on infection control on 8/24/09. A copy of the signature sheet is attached for review. The staffs were also informed they need to be diligent in encourage in Sample #1 to cover mouth when coughing and wash his hands to prevent communicable infectious diseases.</p> | 7/30/09 8/24/09 |
| I 226 | <p>3510.5(c) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(c) Infection control for staff and residents;</p> <p>This Statute is not met as evidenced by:</p> | I 226 | | |

Health Regulation Administration

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/29/2009 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|---------|
| I 226 | <p>Continued From page 3</p> <p>Based on observation and staff interview, the GHMRP failed to maintain a sanitary environment to avoid sources and transmissions of infection.</p> <p>The finding includes:</p> <p>Observation on July 29, 2009, at approximately 6:08 PM revealed Resident #1 entered the GHMRP after the completion of a medical appointment. Continued observation revealed the resident was experiencing a runny nose with mucous hanging from his nostrils. Additionally, he was also observed to be drooling with the saliva hanging from his mouth extending to his chin. At 6:15 PM, the resident was observed to walk in the vestibule area of the GHMRP, where two administrative staff were seated. The two administrative staff failed to verbally prompt and/or assist the resident with wiping his nose and his mouth. At 6:16 PM, when Resident #1 was observed to point at the GHMRP's radio, one of the administrative staff turned the radio on for him, however, was not observed to verbally prompt and/or assist the resident with wiping his nose or his mouth. At 6:25 PM, although the Qualified Mental Retardation Professional (QMRP) was observed to verbally prompt the resident to get a napkin to wipe his mouth, eleven minutes later (6:36 PM) Resident #1's nose was observed to be running again.</p> <p>At 6:37 PM, Resident #1 was observed standing face to face with one of the GHMRP's direct care staff. The client was overheard making a loud noise that sounded like he was trying to cough up some mucous from his throat. At no time did the GHMRP's staff encourage the resident to put his hands over his mouth or to redirect the client to the GHMRP's bathroom.</p> | I 226 | <p>In the future, continuous training will be conducted to ensure staffs encourage individuals to cover their mouth when they cough and wash their hands thereafter to prevent the spread of communicable infectious diseases. A program has been put in place to encourage the individual to learn to cover his mouth and wash hands once they cough.</p> | 8/24/09 |
|-------|---|-------|--|---------|

Health Regulation Administration

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/29/2009 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

I 226 Continued From page 4

At the time of the survey, the GHMRP failed to provide documented evidence that the GHMRP's staff had been trained in the area of infection control.

I 226

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 record review, the GHMRP failed to ensure that staff received training on nutrition to address the needs of two of two residents (Residents #2 and #3) residing in the GHMRP.

The findings include:

I 229

The GHMRP failed to ensure that staff received effective and efficient training on the implementation of the resident's therapeutic diets.

Observation of the dinner meal on July 29, 2009, beginning at 6:40 PM revealed that each of the residents' food texture (chopped) appeared to be the same. Interview with the staff was conducted to ascertain information regarding the resident's diets. According to the staff and verification of the menus, Residents #2 and #3 was prescribed mechanical soft diets.

On the aforementioned evening the resident's

It is the Policy of St. John's Community Service to ensure staffs are trained on nutrition to address the needs of its residents residing in its facilities. The Speech Pathologist conducted training on Texture of Diet, clarification on mechanical soft diet and a host of others to include a full DVD presentation. A copy of signature sheet is attached for review. In the future, staffs will be trained on the diets and the diet will be implemented of the appropriate dietary orders in a timely manner.

8/24/09

Health Regulation Administration

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/29/2009 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|---------|
| I 229 | <p>Continued From page 5</p> <p>meal consisted of pork chops, broccoli and pasta. It should be noted that the resident's pork chops was chopped, but not observed to be mechanically soft. An interview was conducted with the GHMRP's Qualified Mental Retardation Professional (QMRP) regarding the description/instruction given to the staff for a mechanically soft diet. The QMRP indicated that there had been some questions in the past regarding clarity between the chopped and mechanically soft diets.</p> <p>On July 29, 2009, at 6:53 PM, the surveyor spoke with the GHMRP's Speech & Language Specialist via telephone. The interview with the Speech & Language Specialist was conducted to ascertain information regarding her definition of a mechanically soft diet. According to the specialist, a mechanically soft diet was one that "requires minimal chewing." The specialist informed the surveyor that the nutritionist decides the calorie intake and the speech and language specialist prescribes the texture of the resident's diet.</p> <p>Further interview with the specialist revealed that she had trained the staff on numerous occasions. The review of the training records on July 29, 2009, at approximately 7:00 PM revealed documentation to verify that staff had received training on nutrition and modified diets (July 2008), however, at the time of the survey, there was no documented evidence that mechanically soft diets was included in the GHMRP's inservice agenda.</p> <p>At the time of the survey, the GHMRP failed to ensure that staff received training in nutrition for the accurate implementation of the client's diets.</p> | I 229 | <p>It is the Policy of St. John's Community Service to ensure staffs are trained on nutrition to address the needs of its residents residing in its facilities. The Speech Pathologist conducted training on Texture of Diet, clarification on mechanical soft diet and a host of others to include a full DVD presentation. A copy of signature sheet is attached for review. In the future, staffs will be trained on the diets and the diet will be implemented of the appropriate dietary orders in a timely manner.</p> | 8/24/09 |
|-------|---|-------|--|---------|

Health Regulation Administration

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/29/2009 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

I 404 Continued From page 6

I 404

I 404 3520.6 PROFESSION SERVICES: GENERAL PROVISIONS

I 404

Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRP so that relevant professional instructions can be implemented through-out the resident ' s programs and daily activities.

This Statute is not met as evidenced by:
Based on staff interview and record review, the GHMRP failed to ensure that all staff working with residents received relevant professional instructions to ensure correct implementation for appropriate dietary orders for two of the two residents (Residents #2 and #3) residing in the facility.

The findings include:

[Cross Refer 3510.5(f)] The GHMRP failed to ensure staff received accurate professional instruction to ensure correct implementation of appropriate dietary orders.

St. John's Community Services in its efforts to provide training for staffs working with the residents relevant professional instruction to ensure correct implementation for appropriate dietary orders for the residents residing in its facility requested and the Speech Pathologist conducted a training on the appropriate dietary orders on 8/24/09.

8/24/09

I 412 3520.13 PROFESSION SERVICES: GENERAL PROVISIONS

I 412

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 service, except that in life threatening situations, arrangements must be made immediately.

This Statute is not met as evidenced by:
Based on interview and record review, the(GHMRP) failed to ensure the provision of

Health Regulation Administration

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/29/2009 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

1412 Continued From page 7

speech and language services, for two of the two residents (Residents #1 and #2) included in the sample.

The findings include:

1. During the entrance interview on July 29, 2009, at approximately 11:25 AM revealed that Resident #1 received medicaid waiver services. Review of the resident's medicaid waiver authorization on the aforementioned date revealed that an initial "Speech, Hearing and Language Therapy" assessment had been approved. Review of Resident #2's habilitation record on July 29, 2009, at 4:24 PM revealed a Speech-Language Evaluation dated February 7, 2008. At the time of the survey, the GHMRP failed to make an arrangement for Resident #1 to obtain a revised speech-language assessment.

2. During the entrance interview on July 29, 2009, at approximately 11:25 AM revealed that Resident #2 received medicaid waiver services. Review of the resident's medicaid waiver authorization on the aforementioned date revealed that an initial "Speech, Hearing and Language Therapy" assessment had been approved. Review of Resident #2's habilitation record on July 29, 2009, beginning at 6:20 PM revealed a Speech-Language Evaluation dated February 7, 2008. At the time of the survey, the GHMRP failed to make an arrangement for Resident #2 to obtain a revised speech-language assessment.

1412

It is the Policy of St John's Community Services to ensure the provision of the Speech and languish services for Residents #1 and #2. The Speech assessment for both residents was updated in July 2009. A copy is attached for review.

7/09

1500 3523.1 RESIDENT'S RIGHTS

1500

Each GHMRP residence director shall ensure that the rights of residents are observed and

Health Regulation Administration

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/29/2009 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|---------|
| I 500 | <p>Continued From page 8</p> <p>protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>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.</p> <p>The findings include:</p> <p>The facility failed to ensure that written informed consent was obtained from Resident #1 or his legal guardian prior to the administration of psychotropic medication on July 28, 2009.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on July 29, 2009, at 11:25 AM revealed Resident #1 was prescribed psychotropic medications in conjunction with a Behavior Support Plan (BSP) to manage his behaviors.</p> <p>Interview with the Licensed Practical Nurse (LPN) on July 29, 2009, at 1:05 PM revealed Resident #1 had been seen by a new psychiatrist on July 24, 2009. Continued interview with the nurse and review of the psychiatric consult dated July 24, 2009 revealed that the psychiatrist prescribed Paxil 12.5 mg. Review of the resident's medical record on July 29, 2009, at approximately 12:51 PM revealed that there was not a physician's order for the aforementioned prescribed medication. The facility's LPN informed the surveyor that Resident #1 did have a physician's</p> | I 500 | <p>It is the Policy of St. John's Community Services to obtain informed consent from Resident #1 or his Legal Guardian prior to the administration of the Psychotropic Medication on July 28, 2009. The written informed consent was obtained on 7/30/09. A Copy of the informed consent is attached for review.</p> | 7/30/09 |
|-------|---|-------|--|---------|

| | | | | | |
|--|---|--|---|--------------------|--|
| Health Regulation Administration | | | | | |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/28/2009 |
| NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5518 SHERIER PLACE 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 | |
| I 500 | Continued From page 9 order for the Paxil, however, it was not available for review. The LPN reported the the physician's order was included with the resident's medical passport while on a medical appointment that afternoon. According to the LPN, the medication (Paxil 12.5 mg) was started and administered to Resident #1 beginning July 28, 2009. Review of the resident's Medication Administration Record (MAR) verified that Paxil did start on the aforementioned date. Interview with the QMRP revealed that Resident #1 was not capable of giving informed consent for the use of medications and habilitation services. The QMRP further revealed the resident had a guardian to assist him in decision making. Review of the resident's habilitation record on July 29, 2009, revealed a psychological evaluation dated August 9, 2008. Further review of the assessment revealed "due to cognitive and adaptive deficits in the profound range of mental retardation, the resident does not evidence the capacity to make decisions on his own behalf with respect to residential placement, day program placement, medical treatment, finances, and life planning." The GHMRP's Registered Nurse provided a copy of an informed consent that had been completed and dated July 24, 2009, however, at the time of the survey, there was no evidence that the facility's specially constituted committee ensured that the written informed consent had been obtained from Resident #1's guardian prior to the administration of his psychotropic medication. | I 500 | It is the Policy of St. John's Community Services to obtain inform consent from Resident #1 or his Legal Guardian prior to the administration of the Psychotropic Medication on July 28, 2009. The written informed consent was obtained on 7/30/09. A Copy of the informed consent is attached for review. | 7/30/09 | |