

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2007
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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 5027 FULTON STREET, NW WASHINGTON, DC 20016
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R 000	INITIAL COMMENTS A re-licensure survey was conducted on November 16, 2007. A random sample of two residents was selected from a residential population of four males with mental retardation and other disabilities. The survey findings were based on observations in the group home, interviews and a review of records.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: Interview with the House Manger and review of the personnel records on November 16, 2007 at 3:00 PM revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for three staff.	R 125	It is the policy of St John's Community Services to complete a criminal background on all employees. The backgrounds of all employees were check in accordance with the regulation. All staffs hired prior have the criminal background as required. A copy of clarification correspondence received by St. John's has been attached	

Health Regulation Administration
N. [Signature] for Precious Myers-Brown
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 STATE FORM
 (X6) DATE **1/2/08**

PRINTED: 11/26/2007
FORM APPROVED

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION

7001 JAN - 3 A 11:50

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1 000 INITIAL COMMENTS
A re-licensure survey was conducted on November 16, 2007. A random sample of two residents was selected from a residential population of four males with mental retardation and other disabilities. The survey findings were based on observations in the group home, interviews and a review of records.

1 000 It is the Policy of St. John's Community Services to maintain its facilities (interior and exterior) in a safe, clean, orderly attractive and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.
11/19/07

1 090 3504.1 HOUSEKEEPING
The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner.

The findings include:

Observation through the survey and interview with the House Manager during the environmental walkthrough on November 16, 2007 revealed the following:

1. The wall in Client # 2's bedroom, adjacent to his bed, was cracked and had a hole in it.

2. The bottom of the refrigerator was observed with dust hanging from the vent.

3. The front door was observed to be open at 10:30 AM. It should be noted that there was no one in the group home. At approximately 12:36

1 090
1. On 11/19/07 the wall in Individual sampling as #2's bedroom, adjacent to his bed had been repair of the cracked and hole observed during the survey by the DOH Surveyors.
11/22/07

2. On 11/22/07, the bottom of the refrigerator observed with dust hanging from the vent was cleaned and has continued to be maintained in a clean manner.
11/19/07

3. On 11/19/07 the front door to the facility was repair and the lock changed to prevent a repeat of the door flying open. The Police was called on 11/16/07; the Police checked the home, the Residential Team Leader and the QMRP along with the staff checked all belongings at the facility and found everything remained in tact. In the future steps will be taken to maintain security on all doors to the facility.

Step I
Staffs will secure the door properly before departing the facility.
Step II
Staffs will double check the door before departing the facility.
Step III
During the Monthly Quality Assurance Checklist the RTL will check all doors and submit her findings in her monthly report

Health Regulation Administration

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

TITLE

(X8) DATE

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1090	Continued From page 1 AM, a house manager from another group home entered the facility. The house manager was observed to walk around the main floor of the home and then exit and close the front door. Shortly, upon his/her exiting, the front door was observed to blow open. At 12:57 PM, another representative from the provider agency was observed to close the facility's door. The door was again observed to open, shortly after it was closed. It should be noted that the aforementioned representative went back to the facility's front door and closed the door again. The representative explained that the door opened because it was not tightly closed. At the time of the survey, the GHMRP failed to ensure the facility was secured and maintained in a safe manner.	1090		
1203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, 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. The finding includes: Review of the GHMRP's personnel files on November 16, 2007, revealed the GHMRP failed to provide evidence that four direct care staff had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter.	1203	It is the policy of St. John's Community Services to discuss the contents of job descriptions with each employee at the beginning of employment and at least annually thereafter. The personnel files of four direct care staff has been updated to include an up-dated signed job descriptions. The job description of each employee was discussed with them at the beginning of employment and has again been discussed with them in order to update the files. In the future, the Supervisor will discuss the contents of the job description of each employee and maintain an annual update thereafter. Step I The RTL/QMRP will review the job description with all staffs assigned to the facility and have each staff sign the job description after the review. Step II The personal assistant to the Director has been assigned to review the personnel files monthly to ensure all job descriptions remained updated.	11/17/07

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1206	Continued From page 2	1206		
1206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based 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 to perform the required duties. The finding includes: Review of the GHMRP's personnel files on November 16, 2007, revealed the GHMRP failed to provide evidence that current health certificates were on file for four direct care staff and one consultant.	1206	3509.6 PERSONNEL POLICIES It is the policy of St. John's Community Services to obtain, prior to employment a physician's certification from anyone intending to be employed before allowing the employee to commence work and perform required duties. The Health Certificate for all employees at the facility and one consultant has been updated and a copy attached for your records. In the future, the RTL and QMRP will review the health certificates of all staff and request an annual update thereafter. The Personal assistant to the Director will review the records monthly to ensure all health certificates are current.	11/28/07
1228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident's rights; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that staff were	1228	3510.5 (e) STAFF TRAINING All staffs assigned to the 5027 Fulton Street were trained on Resident's Rights on 11/28/07. A copy of the training evidence signature sheet is attached for review. In the future all staffs will be trained on Rights on an annual basis.	11/28/07

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I 228	Continued From page 3 trained in the area of resident's rights. The finding includes: Interview with the House Manager and review of the in-service records on November 16, 2007 at 5:24 PM revealed that there was no evidence staff were trained in resident's rights. It should be noted that the in-service training record had hand-outs for resident rights maintained on file however, there was no evidence of an attendance sign-in sheet for the training.	I 228	It is the policy of St. John's Community Services to maintain for each authorized agency's inspection, at anytime, a log in which emergencies and other unusual occurrence involving residents.	
I 276	3513.1(g) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (g) A log in which emergencies and other unusual occurrences involving residents This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that a log in which emergencies and other unusual occurrences involving residents were maintained and available for review. The finding includes: During the entrance conference on November 16, 2007 at 11:56 AM and additionally throughout the survey, the GHMRP's House Manager (HM) and Qualified Mental Retardation Professional (QMRP) were asked to provide incident reports for the past year to the surveyors for review. The HM and QMRP revealed that the incident reports	I 276	The Book containing the incident reports at the 5027 facility was carried to the Head Office for review by another body of inspectors. The book was not returned to the home. The Residential Team Leader and the QMRP asked the Incident Coordinator to supply copies of incidents for the 5027 facility and have created a new log of incidents for this facility. In the future, St John's Community Services will take steps to secure the log of incidents especially after it has been review by anyone monitoring the log to in order to secure its safe return to the facility. The following steps have been put into place: Step I The Incident Report Book will remain at the facility at all times. Step II All monitoring agents will be supplied copies not originals of incidents reports. The originals to incident reports will be kept at the home at all times.	

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1276	Continued From page 4 were at the main office and that they would be to delivered to the facility for review. At the time of the survey, the GHMRP failed to provide the aforementioned records for review.	1276		
1374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical services were secured, prompt notification of the resident's status would be made as soon as possible to the resident's guardian, his or her next of kin if the resident had no guardian, or the representative of the sponsoring agency, followed by written notice and documentation no later than forty-eight (48) hours after the incident, for two of the two residents (Resident #1 and #2) included in the sample. The findings include: Interview with the Facility Coordinator (FC) and review of resident records on November 16, 2007, revealed the following: a. According to the review of Resident #1's records at 3:21 PM, the resident was seen in the emergency room on three separate occasions; April 13, 2007, for evaluation after a motor vehicle accident, January 22, 2007, for staple	1374	3519.10 EMERGENCIES It is the policy of St. John's Community Services to inform 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. The GHMRP did notify the Department of Health of all incidents involving the Samples # 1 and #2. One such notification was on 4/13/07. A copy of the fax confirmation is attached for your review. The log Book containing all incidents was taken to the Head Office for review by another monitoring body. The record did not get returned to the facility. A request was made and the Incident Coordinator at SJCS is in the process of compiling a book of records of incident for the facility. It is the policy of St John's Community Services to promptly notify the Department of Health of any 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. The Department of Health was informed of all incidents involving individuals. The incident report book was taken to the Head Office for review by another monitoring body and did not get returned upon completion. A request has been made and a new incident book is being compiled by the Incident Management Coordinator. In the future only copies of the incident reports will be sent for review.	12/19/07 12/19/07

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1276	Continued From page 4 were at the main office and that they would be delivered to the facility for review. At the time of the survey, the GHMRP failed to provide the aforementioned records for review.	1276	3519.10 EMERGENCIES It is the policy of St. John's Community Services to inform 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. The GHMRP did notify the Department of Health of all incidents involving the Samples # 1 and #2. <i>Review of signed documentation revealed DOH notified 4/16/07, 5 days later.</i>	
1374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical services were secured, prompt notification of the resident's status would be made as soon as possible to the resident's guardian, his or her next of kin if the resident had no guardian, or the representative of the sponsoring agency, followed by written notice and documentation no later than forty-eight (48) hours after the incident, for two of the two residents (Resident #1 and #2) included in the sample. The findings include: Interview with the Facility Coordinator (FC) and review of resident records on November 16, 2007, revealed the following: a. According to the review of Resident #1's records at 3:21 PM, the resident was seen in the emergency room on three separate occasions, April 13, 2007, for evaluation after a motor vehicle accident, January 22, 2007, for staple	1374	The log Book containing all incidents was taken to the Head Office for review by another monitoring body. The record did not get returned to the facility. A request was made and the Incident Coordinator at SJCS is in the process of compiling a book of records of incident for the facility. It is the policy of St John's Community Services to promptly notify the Department of Health of any 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. The Department of Health was informed of all incidents involving individuals. The incident report book was taken to the Head Office for review by another monitoring body and did not get returned upon completion. A request has been made and a new incident book is being compiled by the Incident Management Coordinator. In the future only copies of the incident reports will be sent for review.	12/19/07 12/19/07

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1379	Continued From page 6 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 immediately verbally notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for two of the two residents (Residents #1 and #2) included in the sample. The finding includes: On November 16 2007, at 11:55 AM the House Manager (HM) was asked to provide any documented incident reports (for the past year) for the surveyors to review. At the time of the survey, no incident reports were provided for review. It should be noted however, that review of Residents #1 and #2's records revealed that within the past year, both residents were seen for emergency medical care (See 3519.5). At the time of the survey, there was no evidence that the Department of Health was notified of the incidents.	1379	It is the policy of St. John's Community Services to inform 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. The GHMRP did notify the Department of Health of all incidents involving the Samples # 1 and #2. <i>See 3519.5</i> The log Book containing all incidents was taken to the Head Office for review by another monitoring body. The record did not get returned to the facility. A request was made and the Incident Coordinator at SJCS is in the process of compiling a book of records of incident for the facility. It is the policy of St John's Community Services to promptly notify the Department of Health of any 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. The Department of Health was informed of all incidents involving individuals.	11/19/07	
1456	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety). This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the	1456			

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1436	Continued From page 8 medication administration however, Resident #1 was not observed to be given fluids to drink. Review of Resident #2's medication data collection sheet revealed the TME documented that the resident obtained his water/juice independently. At the time of the medication administration, the TME was observed to get the water for the resident and give it to him during the medication administration. It should be further noted that the medication sheet for both Resident #1 and #2 documented that the residents were not able to remove medication from the blister pack. At the time of the survey, the TME failed to give them an opportunity to perform the aforementioned task. The facility failed to provide evidence that the residents were provided consistent habilitation services in the domain of self-medication administration. Additionally, the facility failed to provide evidence of a self medication administration program that identified established criteria to achieve.	1436	It is the policy of St John's Community Services to train all its employees in the areas of Health Care (including skills related to nutrition, use and self administration of medication, first aid, care and use of prosthetic and orthotic devises, preventive health care and safety. All staffs responsible for medication administration have been retrained on the self medication goal and observed during medication administration when such goals are implemented; All Staffs responsible for medication administration have been trained on proper medication administration and documentation. The Self Medication program has revised with established criteria for the residents to achieve. In the future, St John's Community Services will ensure staffs a monitor at least once a month to ensure all self medication goals are completed accurately and medication administered according to the stated criteria for the habilitation and training of its residents in the area of self-medication administration	
1484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to promptly destroy prescribed medication that was expired. The finding includes: Observation during the environmental inspection and interview with the House Manager on November 16, 2007 beginning at 5:44 PM revealed Resident #'s hygiene kit had a container	1484		

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1484	<p>Continued From page 9</p> <p>of Tollnaffate Powder that was expired (September 17, 2007). At the time of the survey, the GHMRP failed to ensure the expired treatments were discarded.</p>
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1484	<p>It is the policy of St John's Community Services to promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date or has worn, illegible, or missing label. The expired container of Tollnaffate Powder found in hygiene kit has been discarded following the policy and procedure of SJCS in discarding expired medication. The Nurse has been trained on the policy.</p> <p>In the future all expired medication will be discarded in a timely manner.</p> <p>The following steps have been put into place:</p> <ol style="list-style-type: none"> 1. All medications were checked for expiration date in order to ensure all medication is within the required time. 2. All staffs were in-serviced on checking medication for expiration dates especially open containers at the beginning of each month. 3. Policy related to discarding medication was review with all staff. 	12/11/07
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