

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

PRINTED: 03/25/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:  
  
09G149

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING \_\_\_\_\_  
B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED  
  
R  
03/18/2009

NAME OF PROVIDER OR SUPPLIER  
  
ST JOHN'S COMMUNITY SERVICES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE  
2715 12TH STREET, NE  
WASHINGTON, DC 20018

(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)  
COMPLETION  
DATE

{W 000} INITIAL COMMENTS

{W 000}

A follow-up survey was conducted from March 17, 2009 to March 18, 2009 to assess the facility's level of compliance with the condition level deficiencies cited during the monitoring survey completed on February 6, 2009. A random sample of three clients was selected from a residential population of four clients with mental retardation and other disabilities.

The findings of this survey were based on observations at the group home and one day program, interviews with staff and a review of clinical and administrative records to including the facility's unusual incident reports.

The survey findings determined that the facility was in substantial compliance with the condition of Client Protections, however, standard level deficiencies were cited.

{W 104} 483.410(a)(1) GOVERNING BODY

{W 104}

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by: Based on interviews and record reviews the governing body failed to ensure that the facility exercised general policy, and operating direction over the facility, for three of the four clients residing in the facility. (Clients #1, #2, and #3)

The findings include:

1. Cross Refer to W159. The Federal Deficiency Report dated March 13, 2009, included findings that the facility's Qualified Mental Retardation

*Received  
4/6/09*

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 DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/18/2009
NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018	

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{W 104} Continued From page 1  
Professional (QMRP) had not ensured that:

- (a) client mealtime protocols were being implemented as written; and
- (b) that behavior data was recorded accurately.

The facility submitted a Plan of Care (POC) dated March 13, 2009, that indicated all of these deficient practices had been resolved. However, the March 18, 2009, follow up survey findings revealed that governing body failed to address the noted deficiencies as documented in the Plan of Correction dated March 13, 2009.

{W 104} (a.) It is the Policy of St. John's Community Services to exercise general policy, budget and operating direction over the facility. The mealtime protocol of all residents were review with staff and in-serviced on 3/31/09. In the future all staffs will be trained on mealtime protocols for individuals continuously and reviewed during the monthly meetings which will be attended by staff, Nurses, House Manager and the QMRP.

2. Cross-refer to W393. The governing body failed provide evidence that certification to conduct glucose testing had been obtained.

{W 159} 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

(b.) It is the policy of St John's Community Services to ensure the safety and protection of all of the Individuals in its care. The Staffs were in-serviced on the behavior data for all individuals on 3/31/09. 6/23/08

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, staff interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate services, for two of the four clients included in the sample. (Clients #1 and #2)

{W 159} (2.) It is the Policy of SJCS to apply for certificate of waiver for the facility in which blood glucose testing is being conducted. A form for said certificate was completed and faxed to the Department of Health on 4/3/09. In the future the certificate for such laboratory will 4/3/09 be requested timely.

The findings include:

1. The QMRP failed to ensure Client #1 was fed in accordance with her feeding protocol.

On March 17, 2009 at 8:45 AM, staff was

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

PRINTED: 03/25/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/18/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  ST. JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
--	---

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

(W 159) Continued From page 2  
observed giving Client # 1 her breakfast. The meal consisted of corn flakes and toast in milk. The staff physically assisted the client to eat her meal. At 9:05 AM, Client #1 completed her meal. The staff provided the client with a sippy cup of Ensure that was thickened to honey consistency. During day program observation on March 17, 2009 at 12:30 PM, Client #1 was observed to receive a double portion purified diet. Staff was observed to provide her thin liquids prior to the meal and during the meal. The client required hand over hand assistance to complete her meal.

Review of Client #1's physician order dated March 2009 on March 17, 2009 at 2:00 PM confirmed that the client was prescribed a regular purified diet with double portions. Review of the client Speech /Language Assessment revealed a Swallowing Evaluation (SE) dated September 27, 2008. According to the SE, staff was encouraged to begin and end each meal with liquids and to alternate liquids/solids throughout the meal to facilitate swallowing.

Observations at the day program, however, revealed that staff did encourage Client #1 to alternate between liquids and solids as prescribed in her SE guidelines.

2. The facility's QMRP failed to demonstrate ensure staff demonstrated competency on the proper usage of a client's adaptive mealtime equipment (cuff). [See W 154]

3. The facility's QMRP failed to ensure that as soon as the interdisciplinary team (IDT) formulated client's Individual Program Plans (IPP), each client received continuous active treatment services, in sufficient number and

(W 159)  
1. It is the Policy of St. John's Community Services to exercise general policy, budget and operating direction over the facility. The staffs were in-serviced on the feeding protocol of resident #1 on 3/31/09. In the future the staffs will be trained on the feeding protocol for residents continuously and reviewed during the monthly meetings which will be attended by staff, Nurses, House Manager and the QMRP.

2. It is the policy of St. John's Community Services to ensure staffs demonstrate competency on the proper usage of the resident's adaptive equipment. The Staffs were in-serviced on the proper usage of the hand cuff and spoon of resident #2 on 3/31/09. The proper use of the cuff and spoon.

3. It is the policy of St John's Community Services to ensure the residents IPP is implemented in a timely manner after the interdisciplinary team meeting. The QMRP has implemented the IPP for resident #4 has been implemented and staff trained on 3/18/09. In the future all programs will be implemented in a timely manner.

3/31/09

3/18/09

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

PRINTED: 03/25/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST JOHN'S COMMUNITY SERVICES INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2715 13TH STREET, NE</b> <b>WASHINGTON, DC 20018</b>		
(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) COMPLETION DATE	
{W 159}	Continued From page 3 frequency to support the achievement of the objectives identified in the IPP. [See W249]  4. The facility's QMRP failed to ensure that data was collected in the form and required frequency. [See W252]	{W 159}		3/18/09	
W 194	483.130(e)(4) STAFF TRAINING PROGRAM  Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure staff demonstrated competency on the proper usage of hand cuff during meals for one of the four clients in the facility. (Client #2)  The finding include:  On March 18, 2009 at 8:36 AM, a direct care staff was observed placing a cuff on Client #2's left hand. After several minutes, the staff was observed placing the cuff on the client's right hand, and inserting a regular, metal tablespoon between the cuff and the back of her hand. The spoon was not within her hand grasp. The client looped her thumb over the spoon handle, just behind the scoop. The client was showing difficulty eating in that manner, staff was observed to pick up the plate and place it under her mouth. The staff provided hand over hand assistance to the client during the entire meal. A plate riser was observed in the client's place setting.	W 194	4. It is the policy of St. John's Community Services to ensure the data for all programs are collected in the form and required frequency. The staffs were in-serviced on the Data for resident #1 Behavior Support Plan on 3/18/09. In the future the staffs will receive continuous training on the data collection during the monthly meetings.		

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

PRINTED: 03/25/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>06G149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/18/2009</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ST JOHN'S COMMUNITY SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2715 13TH STREET, NE WASHINGTON, DC 20015</b>
--	---

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 194 Continued From page 4  
Later that day, at 6:30 PM, Client #2 was observed using a similar cuff while eating her dinner. The spoon, however, had been inserted between the cuff and her palm. The client was observed gripping the spoon and was able to eat her lunch independently.

W 194  
It is the policy of St. John's Community Services to ensure staffs demonstrate competency on the proper usage of the resident's adaptive equipment. The Staffs were in-serviced on the proper usage of the hand cuff and spoon of resident #2 on 3/31/09. The proper use of the cuff and spoon.

Review of the facility's training records on March 18, 2009 at 10:00 AM revealed that staff were in-serviced on the cuff during mealtime on February 11, 2009 as well as mealtime protocols.  
The facility failed to provide evidence that all staff demonstrated the necessary techniques to use Client #2's adaptive feeding equipment.  
(W 249) 483.440(d)(1) PROGRAM IMPLEMENTATION

(W 249) 6/23/08

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.

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 client's Individual Program Plan (IPP), each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the IPP, for one of the four clients included in the sample. (Client #4)

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

PRINTED: 03/25/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/18/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
---	---

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

(W 249) Continued From page 5  
The finding includes:

Review of Client #4's records on March 18, 2009 at 10:00 AM revealed the client had an Individual Support Plan (ISP) dated July 25, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on March 18, 2009 at 10:30 AM and further review of Client #1's record revealed that at the time of the ISP meeting, the Interdisciplinary Team (IDT) recommended the following program objectives:

- a. [the client], will tolerate passive range of motion to bilateral upper extremities for 15 repetitions at the shoulder on 80% of trials for three consecutive months;
- b. [the client], will tolerate passive range of motion to bilateral upper extremities for 15 repetitions at the elbow on 80% of trials for three consecutive months;
- c. [the client], will tolerate passive range of motion to bilateral upper extremities for 15 repetitions at the wrists on 80% of trials for three consecutive months;
- d. [the client], will tolerate passive range of motion to bilateral upper extremities for 15 repetitions at the digits on 80% of trials for three consecutive months;
- e. Given physical assistance, [the client] will tolerate sitting on side of her bed 10 repetitions three days per week for 12 consecutive months.

Interview with the QMRP and review of the client's records on March 18, 2009 at approximately 11:00 AM, revealed there was no

(W 249)

It is the policy of St. John's Community Services to ensure its residents received continuous active treatment as soon as the individual's interdisciplinary team has formulated the resident individual program plan. The IPP for sample #4 has been implemented and staff trained on 3/18/09. In the future all programs will be implemented timely.

- a. The Program for resident #4 for passive range of motion to bilateral upper extremities for 15 repetitions at the shoulder on 80% of the trials for three consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner.
- b. The Program for resident #4 for passive range of motion to bilateral upper extremities for 15 repetitions at the elbow on 80% of the trials for three consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner.
- c. The Program for resident #4 for passive range of motion to bilateral upper extremities for 15 repetitions at the wrist on 80% of the trials for three consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner.

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

PRINTED: 03/25/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/18/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
---	---

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{W 249} Continued From page 6  
evidence that the aforementioned program objectives had been developed or implemented.

{W 252} 483.140(e)(1) PROGRAM DOCUMENTATION

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that data was collected in the form and required frequency, for one of the four clients in the sample. (Client #1)

The finding includes:

On March 18, 2009 at 8:32 AM, Client #1 was observed spitting at the breakfast table. At 4:40 PM, Client #1 was observed spitting during snack. During the dinner observation from 6:25 PM until 7:10 PM, Client #1 was heard screaming throughout the entire meal. Interview with direct care staff at 7:20 PM indicated that the client had a Behavior Support Plan (BSP) to address maladaptive of screaming and tantruming.

Record verification of Client #1's BSP dated September 15, 2008 on March 18, 2009, at 10:00 AM revealed the plan identified maladaptive behaviors: screaming, spitting and tantrums. According to the instructions, staff were to record behaviors on the Antecedent Behavior Consequence (ABC) chart. Further review of the data chart on March 19, 2009 at 11:00 AM, revealed that Client #1 had no behaviors on March 18, 2009. There was no evidence that

{W 249}

{W 252} 6/23/08

d. The Program for resident #4 for passive range of motion to bilateral upper extremities for 15 repetitions at the digits on 80% of the trials for three consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner.

e. The Program for resident #4 for tolerating sitting on side of her bed 10 repetitions three days per week for 12 consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner

It is the policy of St. John's Community Services to ensure the data for all programs are collected in the form and required frequency. The staffs were in-serviced on the Data for resident #1 Behavior Support Plan on 3/18/09. In the future the staffs will receive continuous training on the data collection during the monthly meetings.

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

PRINTED: 03/25/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/18/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
---	---

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{W 252} Continued From page 7  
data had been collected in accordance with the Client #1's BSP.

\*\*\*\*\*

Previously, the February 6, 2009, the federal deficiency report cited the facility for not accurately documenting of client's progress on an approved habilitation plan.

{W 252}

{W 393} 483.60(n)(1) LABORATORY SERVICES

If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for clients in the facility whose blood glucose was being tested by facility staff, for one of the four clients in the facility. (Client #2)

{W 393}

The finding includes:

On March 17, 2009 at approximately 2:00 PM, review of Client #2's physician's orders (POs) for the period from July 2008 through March 2009 indicated that the client had an order for in-home finger sticks (fasting) "twice daily AM PM every two days." Interview with the Trained Medication Employee (TME) confirmed that she performed finger sticks on Client #2 every two days. The RN was in the facility at the time of the interview and she confirmed that TMEs were performing finger sticks on Client #2.

Interview with the Qualified Mental Retardation Professional (QMRP) on March 18, 2009 at

It is the Policy of SJCS to apply for certificate of waiver for the facility in which blood glucose testing is being conducted. A form for said certificate was completed and faxed to the Department of Health on 3/30/09. In the future the certificate for such laboratory testing will be requested in a timely manner.

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

PRINTED: 03/25/2009  
FORM APPROVED  
CMS NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/18/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018
---	---

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{W 393} Continued From page 8  
approximately 2:00 PM revealed that the Program Director had submitted an application form for obtaining a Clinical Laboratory Improvement Act (CLIA) certificate of waiver. She did not, however, know the status of the application. She further indicated that she faxed an application to the appropriate office but failed to provide evidence. No additional information was made available for review before the survey ended.

{W 393}

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/18/2009
NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018	
(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 follow-up survey was conducted from March 17, 2009 to March 18, 2009, to assess the facility's level of compliance with the condition level deficiencies cited during the monitoring survey completed on February 6, 2009. A random sample of three residents was selected from a residential population of four residents with mental retardation and other disabilities.  The findings of this survey were based on observations at the group home and one day program, interviews with staff and a review of clinical and administrative records to including the facility's unusual incident reports.  The survey findings determined that the facility was in substantial compliance with the condition of Client Protections, however, standard level deficiencies were cited.	(1 000)	
1 232	351(c)(5)(i) STAFF TRAINING:  Each training program shall include, but not be limited to, the following:  (i) Training of the resident in the maintenance of oral health and hygiene.  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure effective training was provided to each staff.  The finding includes:  On March 18, 2009 at 8:36 AM, a direct care staff was observed placing a cuff on Resident #2's left hand. After several minutes, the staff was observed placing the cuff on the resident's right	1 232	It is the policy of St. John's Community Services to ensure staffs demonstrate competency on the proper usage of the resident's adaptive equipment. The Staffs were in-serviced on the proper usage of the hand cuff and spoon of resident #2 on 3/31/09. The proper use of the cuff and spoon. 3/31/09

Health Regulation Administration

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

TITLE

(X6) DATE

STATE FORM

0000

P90313

If continuation sheet 1 of 4

PRINTED: 03/25/2009  
FORM APPROVED

## Health Regulation Administration

STATEMENT OF DEFICIENCIES (AND) PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IIFD03-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/18/2009
NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
(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 232	Continued From page 1  hanc, and inserting a regular, metal tablespoon between the cuff and the back of her hand. The spoon was not within her hand grasp. The client looped her thumb over the spoon handle, just behind the scoop. The resident was showing difficulty eating in that manner, staff was observed to pick up the plate and place it under her mouth. The staff provided hand over hand assistance to the resident during the entire meal. A plate riser was observed in the resident's place setting.  Later that day, at 6:30 PM, Resident #2 was observed using a similar cuff while eating her dinner. The spoon, however, had been inserted between the cuff and her palm. The resident was observed gripping the spoon and was able to eat her lunch independently.  Review of the facility's training records on March 18, 2009 at 10:00 AM revealed that staff were in-serviced on hand cuff during mealtime on February 11, 2009 as well as mealtime protocols.  The facility failed to provide evidence that all staff demonstrated the necessary techniques to use Resident #2's adaptive feeding equipment.	I 232	It is the policy of St. John's Community Services to ensure staffs demonstrate competency on the proper usage of the resident's adaptive equipment. The Staffs were in-serviced on the proper usage of the hand cuff and spoon of resident #2 on 3/31/09. The proper use of the cuff and spoon.	3/31/09
(I 422)	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 residents in accordance with their Individual Habilitation Plan (IHP), for one of the four residents residing in the	(I 422)		6/23/08

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 03/18/2009
NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
(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 422)	Continued From page 2 facility. (Resident #4)  The findings include:  Review of Resident #4's records on March 18, 2009 at 10:00 AM revealed: the resident had an Individual Support Plan (ISP) dated July 25, 2008. Interview with the Qualifier: Mental Retardation Professional (QMRP) on March 18, 2009 at 10:30 AM and further review of Resident #1's record revealed that at the time of the ISP meeting, the Interdisciplinary Team (IDT) recommended the following program objectives:  a. [the resident], will tolerate passive range of motion to bilateral upper extremities for 15 repetitions at the shoulder on 80% of trials for three consecutive months;  b. [the resident], will tolerate passive range of motion to bilateral upper extremities for 15 repetitions at the elbow on 80% of trials for three consecutive months;  c. [the resident], will tolerate passive range of motion to bilateral upper extremities for 15 repetitions at the wrists on 80% of trials for three consecutive months;  d. [the resident], will tolerate passive range of motion to bilateral upper extremities for 15 repetitions at the digits on 80% of trials for three consecutive months;  e. Given physical assistance, [the client] will tolerate sitting on side of his bed 10 repetitions three days per week for 12 consecutive months.  Interview with the QMRP and review of the	(I 422)	It is the policy of St. John's Community Services to ensure its residents received continuous active treatment as soon as the individual's interdisciplinary team has formulated the resident individual program plan. The IPP for sample #4 has been implemented and staff trained on 3/18/09. In the future all programs will be implemented timely.  a. The Program for resident #4 for passive range of motion to bilateral upper extremities for 15 repetitions at the shoulder on 80% of the trials for three consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner.  b. The Program for resident #4 for passive range of motion to bilateral upper extremities for 15 repetitions at the elbow on 80% of the trials for three consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner.  c. The Program for resident #4 for passive range of motion to bilateral upper extremities for 15 repetitions at the wrist on 80% of the trials for three consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner.	3/18/09	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HF003-0124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 03/18/2009
NAME OF PROVIDER OR SUPPLIER  ST JOHN'S COMMUNITY SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 13TH STREET, NE WASHINGTON, DC 20018		
(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 422)	Continued From page 3  resident's records on March 18, 2009 at approximately 11:00 AM, revealed there was no evidence that the aforementioned program objectives had been developed or implemented.	(I 422)	d. The Program for resident #4 for passive range of motion to bilateral upper extremities for 15 repetitions at the digits on 80% of the trials for three consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner.  e. The Program for resident #4 for tolerating sitting on side of her bed 10 repetitions three days per week for 12 consecutive months was implemented on 3/18/09 and staff trained on 3/18/09. In the future, all programs for resident #4 will be implemented in a timely manner		