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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G168	A. BUILDING _____ B. WING _____	02/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	3012 MILITARY RD, NW WASHINGTON, DC 20015

(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 A recertification survey was conducted from January 30, 2007 through February 3, 2007. The survey was initiated using the fundamental survey process. A sample of two clients was selected from a resident population of four men with various disabilities. On February 1, 2007, the survey was extended in the Conditions of Client Protections and Health Care, following review of (1) Client #2's ongoing emergency room visits with no pulse; (2) Client #2's medication regimen (including PRN sedation and drugs with potential for producing serious cardiovascular side effects); (3) monitoring and coordination of Client #2's treatment needs, safety and due process rights with his parents; and (4) monitoring and coordination of Client #2's health care services, across disciplines. Also on February 1, 2007, Immediate Jeopardy was declared after the facility failed to demonstrate that it had ensured the safety of Client #2 at all times including weekend visits with his parents. The survey was extended to a full survey later in the day on February 1, 2007. The findings of the survey were based on observations and staff interviews in the home and at one day program, interviews with one client, as well as a review of client and administrative records, including incident reports. The determination was made that the facility was not in compliance with the Conditions of Participation in Governing Body and Health Care Services.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Precious N Brown Director CLS-DC		3/13/07

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

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W 102	Continued From page 1 This CONDITION is not met as evidenced by: Cross-refer to W318 On February 1, 2007, Immediate Jeopardy was declared after the facility failed to demonstrate that it had ensured the safety of Client #2 at all times, including weekend visits with his parents. The primary concerns identified were as follows: 1. The governing body failed to establish and implement a system of documenting a thorough review of clients' treatment plan and options, to include clear explanation of potential risks and benefits of proposed medication regimens. Client #2's prescribing psychiatrist had conducted monthly psychotropic medication reviews (PMR). However, review of the monthly PMR documentation failed to show evidence that the potential risks associated with the client's medication regimen (possible side effects from individual medications as well as the potential for negative drug interactions) had been clearly identified and explained to the client's parents. Review of the client's records also failed to show evidence that the full interdisciplinary team had weighed the benefits and risks associated with the treatment plan, including but not limited to the use of Chloral Hydrate sedation during home visits, to ensure the client's health and safety. 2. The governing body failed to ensure that the facility implemented a system to document Client #2's behaviors and administration of medications during weekend visits with his parents.	W 102	1. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. 2. During the treatment plan meeting the parents received training on how to properly document the medication they are administering to their child while in the home. The parents will be provided MAR forms to sign off on the prescribed medication at the appropriated time. The parents reported that they understood the importance in relation to their son's health.	2/23/07

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W 102	Continued From page 2 A bottle of Chloral Hydrate sedative had been prescribed and filled on October 11, 2006. Interviews and record review revealed that the Chloral Hydrate had not been administered in the facility; it was used during home visits with his parents. The bottle was approximately 55% full at the time of the survey. There was no documentation, however, of the date, time or amount administered of this and other medications he received during the family visits. It should be noted that Chloral Hydrate is a Schedule 3 drug. The disposition (use/ administration) of the medication was not being recorded in accordance with federal law. 3. The governing body failed to ensure that Client #2's medical team thoroughly investigated health emergencies, to include comprehensive and timely evaluations to determine the etiology of fainting and pulse-less episodes. Staff interviews and review of Client #2's medical chart revealed ongoing trips to hospital emergency rooms. He experienced two fainting episodes in September 2006. Staff interviews indicated that the cause had not been determined . Inspection of the hospital discharge summaries indicated low blood pressure and dehydration; however, the precise cause of the low blood pressure was not identified. On January 29, 2007, Client #2 was again rushed to the emergency room after he lost consciousness at his day program. The client was described as non-responsive and the day program nurse reportedly was unable to detect a pulse. Nobody in the facility had determined whether or not the client had received Chloral	W 102	3. The PCP and the Medical Team completed a thorough evaluation of #2's medical record on 2/1/2007. The evaluation went back to 2004. A diagnosis of syncope was the result and he was prescribed Fludrocortisone. The etiology of the fainting spells is still being investigated. #2 saw the cardiologist recommended an event monitor for 30 days. He still has another week with the monitor and then he will follow-up with the cardiologist.	

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W 102	Continued From page 3 Hydrate during the weekend immediately preceding the incident. The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the condition of Health Care Services.	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the governing body exercised operating direction over the facility except for in the following areas: The findings include: 1. Cross-refer to W153. The governing body failed to implement an internal Quality Assurance system to detect the following: a. Facility staff failed to notify the Department of Health of all incidents that presented a risk to the clients' health and safety. b. Facility staff failed to complete an incident report after being informed by day program staff that Client #3 made an allegation of verbal abuse by a staff person. c. The facility's charge nurse failed to complete incident reports upon discovery of injuries of unknown origin.	W 104	1. Staff will be trained by the Incident Management Coordinator on the completing incident reports, the reporting protocol and all parties that need notification. This training will include all staff and nurses to ensure that everyone has an understanding of the reporting protocol.	

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W 104	Continued From page 4 2. The governing body failed to establish and implement a system to document that Client #2's parents, and other legally-authorized healthcare decision-makers, received all pertinent information regarding the benefits and risks of proposed treatments, including potential side effects and drug interactions.	W 104	2. At the treatment plan meeting on 2/23/07 the parents of #2 was provided the limited guardianship paperwork. The parents provided the signed notarized guardianship paperwork on 3/6/07 for #2. It has been placed in the medical and ISP book. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications.	
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to maintain a record keeping system that contained all pertinent client information in the active client files, for three of the four clients residing in the facility. (Clients #1, #2 and #4) The findings include: 1. Following observation of the morning medication pass on January 30, 2007, Client #1's records were reviewed. His Medication Administration Record (MAR) for January 2007 indicated that aspirin had been discontinued on on January 15, 2007 and another medication, Aggrenox, had been started, the following day. His record contained a physician order (PO), dated January 16, 2007, for the Aggrenox; however, there was no PO for stopping the aspirin. Interviews with the LPN Charge Nurse and the primary care physician later that day confirmed that the aspirin had been discontinued. Upon review of the chart, the Charge Nurse	W 111	1. #1 went to the ER on 1/13/07 and discharged on 1/15/07. The attending physician recommended that aspirin be discontinued and prescribed Aggrenox 200mg. The information was communicated to the PCP and annotated on the Physician's order on 1/19/07. There is a P.O. in the medical book indicated the discontinuance.	

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W 111	Continued From page 5 confirmed that there was no PO for d/c'ing the aspirin. 2. Review of Client #1's chart revealed that he had undergone a colonoscopy on September 7, 2006. The hospital records indicated that 3 polyps had been removed, with biopsies to be performed. Further review of the record and interviews with the LPN Charge Nurse revealed that the facility had not sought to obtain the results of the biopsies for the record. [Note: Interview with the primary care physician on January 31, 2007 revealed that he had received a letter indicating that the polyp tissues were benign .] 3. On a bi-weekly basis, the facility was releasing Client #2 to his parents for home visits. His parents administered medications during the home visits but were not documenting the date, time or amounts of any of the medications administered. The facility had not established a system for keeping the client's chart current, for medications administered outside the home. 4. The facility had not documented in Client #2's chart a full review of the risks associated with his current medication regimen and treatment plan, and potential for drug interactions, with the client's parents, who served as his designated surrogate healthcare decision-makers. 5. A nursing progress note dated July 5, 2006 indicated that "swelling" was observed in Client # 2's sacral area. The client had just returned from an overnight visit with his parents. The nurse did not describe in detail what he observed on the sacral area and did not report it up the chain of command; therefore the injury was not further	W 111	2. The Director of Nursing will check with the PCP to see if he has the results of the biopsy or request for the results from Sibley Hospital to have in the medical record. 3. During the treatment plan meeting the parents on 2/23/07, they received training on how to properly document the medication they are administering to their child while in the home. The parents will be provided MAR forms for all home visits to sign off on the prescribed medication at the appropriated time. The parents reported that they understood the importance in relation to their son's health. This training will be completed with all the families.	

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W 111	Continued From page 6 investigated by the QMRP, as per the facility's policies. Further review of the client's chart revealed that the primary care physician (PCP) examined him two days later, on July 7, 2006. The PCP recommended "surgery clinic IND." The client went to a surgery clinic 19 days later, on July 26, 2006, at which time the clinician wrote "no drainage noted." On February 1, 2007, at 11:43 AM, interview with the LPN Charge Nurse revealed that he thought it had "looked like an abscess." Moments later he said it had been a pressure sore. He was unable, however, to find a full description in the client's chart to indicate the nature of the "swelling." Client #2's record did not provide sufficient information to ensure accuracy in what was being reported. 6. Client #4's January 2007 POs included " Anusol Suppositories, 1 suppository rectally as needed for hemorrhoids." The House Manager/ TME said he thought this had been a "temporary use." Hospital discharge papers, dated April 24, 2006, indicated they had recommended the suppositories for 7 days. There was no evidence, however, that the original order had been time-limited and/or that the PCP discontinued the PRN suppositories since receiving treatment in April 2006. 7. Client #2's Individual Support Plan (ISP) record book was observed onsite during the first 2 days of survey. Some of its contents, such as Pyschotropic Medication Review sheets, were examined initially. However, when it was time to conduct the record verification process on the third day, the entire book was deemed "missing." While copies of documents were later retrieved and placed in a 'reconstituted' ISP record book, the facility's administrators acknowledged that	W 111	4. A complete chart review was completed on 2/1/07 that included all the risks associated with #2 current medication regimens. This information was also shared with his family. The family has completed the limited guardianship paperwork to be the surrogate decision-maker on #2's behalf. 5. The nurse identified swelling in #2's sacral area on July 5, 2006 and request that he see his PCP. He saw the PCP on July 7, 2006 because that was when the PCP was in the office. The PCP examined him and called the surgery clinic to make an appointment. The earliest day #2 could be seen was July 26, 2006. 6. Anusol Suppositories are in the home for as needed basis for #4 hemorrhoids. 7. The original ISP book was located on 3/7/07. It was found in the van of another home with all its contents.	

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W 111	Continued From page 7 they could not verify with certainty that all documentation was available for review.	W 111		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to document that each client and/or their legal representative received a thorough review of the client's treatment plan and alternative options, to include a clear explanation of the benefits potential risks of treatment, including psychoactive drugs, and the right to refuse treatment, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. On January 30, 2007, beginning at 10:13 AM, the recently-hired Qualified Mental Retardation Professional (QMRP) and the House Manager (HM) were interviewed at the onset of the survey. They indicated that none of the clients had court-appointed guardians. The immediate-past QMRP and the newly-assigned QMRP were interviewed the following morning. The past QMRP confirmed that none of them had guardians. Client #1 was without anyone legally-authorized to represent his rights. The past QMRP further stated that Client #1 had the capacity to process	W 124	1. #1's psychological assessments specifically states "he require guidance when making major life decisions". It also states that he " may be able to understand the concept of a "durable power of attorney" if it is explained in concrete terms that are relevant to his prior experiences and are broken down into small units of information to which he can give brief verbal responses, and if someone in his life appropriate to serve in this capacity."	

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W 124	Continued From page 8	W 124		

information and could make informed decisions if/ when things are explained to him. This was reportedly outlined in the Individual Support Plan (ISP). The new QMRP concurred, saying that the psychologist thought the client had the capacity to process information and ability to sign a power of attorney.

On January 31, 2007, beginning at approximately 12:55 PM, review of Client #1's records revealed contradictory documentation as to the client's capacity to process information, and a failure to obtain written consents prior to surgical procedures, as follows:

- Face sheet (not dated) indicated "Guardianship: Need to be acquired."

- There were several standardized consent forms for such issues as "Community Participation," " Medical Consent" and others; however, they were all left blank and unsigned.

- There was a contract for funeral/burial arrangements that among other things, had "no autopsy" checked off. The contract was signed by Client #1 (only) on 6/26/00.

- Hospital discharge papers dated 9/7/06 had his signature, indicating "I the undersigned have read and understand the above instructions." No other persons representing the client had signed the form. The client had 3 polyps removed during a colonoscopy performed earlier that day. There was no evidence that the benefits ans risks associated with performing a colonoscopy had been explained to Client #1 or that he or someone else had signed a written consent for the procedure.

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W 124	Continued From page 9 - Court documents dated 10/13/06 indicated that his commitment to services under the State MR statute was continued. -His ISP, dated 5/3/06, included the following: "I am unable to provide independent/informed decisions concerning my habilitation, planning, placement or financial matters due to my cognitive level. However, these matters should be explained to me on the level that I understand and consideration should be given to my input..." - Psychological Evaluation Update, dated 5/2/06, indicated moderate mental retardation cognitively, and moderate/severe retardation adaptively. The evaluation also included the following: "... requires guidance when making major life decisions. If clear explanation of his options in concrete terms that are relevant to his prior experiences and are broken down into smaller units of information, he may be able to make independent decisions about his residential placement and day habilitation. However, he can be expected to require direction from others who represent his best interests when it comes to making decisions about his finances, medical treatment and end-of-life planning... may be able to understand the concept of durable power of attorney..." The client's record did not reflect further evaluation or timely discussion by the interdisciplinary team regarding the client's ability to process information, make informed decisions and/or his legal status and guardianship needs. Later in the survey, interview with the QMRP revealed that Client #'s psychologist and primary care physician had both signed sworn affidavits indicating that because of his mental retardation,	W 124		

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W 124	Continued From page 10 he would benefit from having a guardian for medical decisions. The affidavits were not available for review in the client's record. Review of the affidavits, which were submitted via fax transmittal on 2/5/07, later revealed that they were achieved more than 6 months after his 5/3/06 ISP meeting; the psychologist's was dated 11/20/06 and the primary care physician's was dated 12/5/06. To date, there was no person or entity identified to represent the client's rights. It should be noted that Client #1 was taken to a hospital ER on January 13, 2007 after he and staff determined that he could not stand up or raise his right arm. The hospital diagnosed the event as a transient ischemic attack, or TIA, and recommended a change in his medications. When interviewed on January 30, 2007, at 6:52 AM, the client acknowledged that the hospital had run many tests. Further interview, however, revealed that to date, he had not been informed of the results of the tests, the diagnosis of TIA, or the change from aspirin to Aggrenox to prevent strokes. 2. On January 30, 2007, beginning at 10:13 AM, the recently-hired Qualified Mental QMRP and the House Manager (HM) were interviewed at the onset of the survey. They indicated that Client #2 lacked the capacity to process information effectively to provide informed consent. His parents were actively involved in his care and treatment planning and were recognized as their son's surrogate health care decision-maker. When asked if the potential risks associated with the client's medication regimen (possible side effects from individual medications as well as the potential for negative drug interactions) had been fully explained to the client's parents, they were	W 124	2. A medical and psychological affidavit had completed in the evident #1 is ever in a state where he is unable to state whether or not he wants to have a medical procedure done. The documents were re-submitted to the assigned case manager to be submitted and have a limited medical guardian appointed.	

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W 124	Continued From page 11 not sure. They also did not know whether the parents had signed written consent for the current medication regimen They did, however, indicate that the parents attended most of his medical appointments, team meetings and monthly visits to the psychiatrist's office. The following medications were included in Client #2's January 2007 physician's orders (POs): Diphenhydramine 25 mg cap (Benadryl) 1 cap at bedtime; Docusate Sodium 100 mg cap (Colace) 1 cap daily; Benztropine MES 2 mg tab (Cogentin) 1 tab once a day for excessive drooling; Trileptal 300 mg tab 1 tab twice a day for seizure prevention; Fludrocortisone 0.1 mg tab (Florinef) 1 tab daily for eczema; Clonazepam 2 mg tab (Klonopin) 1 tab 3 times a day "for symptoms related to psychotropic dx"; Guaifenesin Syrup 240/ml (Robitussin) 2 teaspoons twice daily treatment; Guaifenesin Syrup 240/ml (Robitussin) 2 teaspoons twice daily, as needed (PRN); Clozapine 100 mg tab (Clozaril) 2 tabs every morning, 2 tabs at noon and 3 tabs at bedtime. In addition, there was a hand written order for Choral Hydrate 500 mg/5 ml take 5 ml at bedtime as needed for sleep. In addition to the medications, the client's plan included one-on-one staff supervision, 16 hours daily, for behavior intervention and safety. Client #2's prescribing psychiatrist had conducted monthly psychotropic medication reviews (PMR). However, review of the monthly PMR documentation failed to show evidence that the potential risks associated with the client's medication regimen (possible side effects from individual medications as well as the potential for negative drug interactions) had been clearly identified and explained to the client's parents.	W 124	A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. The Chloral Hydrate was discontinued on 2/5/07. The parents indicated in the treatment plan meeting that the psychiatrist reviews with them the current medications along with the risks and the benefits. #2 continues to receive one-on-one services for behavior intervention and safety. The Director of Nursing called the Psychiatrist and asked that documentation be provided that the current medication regimen along with the risks and side effects are included in the medication review.	

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	09G168		02/03/2007

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W 124	Continued From page 12 Review of the client's records also failed to show evidence that the full interdisciplinary team had weighed the benefits and risks associated with the treatment plan, including but not limited to the use of Chloral Hydrate sedation during home visits, to ensure the client's health and safety. Additional interviews with the immediate-past QMRP and other facility staff revealed no evidence that the parents had been fully informed of the potential risks associated with their son's treatment plan. It should be noted that there was no evidence that Client #2's parents had provided written consent for the use of the aforementioned treatment plan, including medications and one-on-one staffing. In addition, review of the facility's Human Rights Committee minutes for meetings held during the previous 12 months showed no evidence that the subject of medication side effects, drug interactions or obtaining written consent from Client #2's parents for his treatment plan had been addressed. [See W263]	W 124		
W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the use of sedatives (Chloral Hydrate, PRN, during weekend visits with his parents) had been incorporated into Client #2	W 128		

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W 128	Continued From page 13 's Individual Program Plan (IPP) and Behavior Support Plan (BSP) The findings include: 1. On a bi-weekly basis, the facility was releasing Client #2 to his parents for home visits. His parents administered medications during the home visits but were not documenting the date, time or amounts of any of the medications administered. A bottle of Chloral Hydrate sedative had been prescribed and filled on October 11, 2006, at the request of the parents. Interviews with the LPN Charge Nurse and the RN Nursing Director both indicated that the client received 25 mg Benadryl every evening and did not have trouble sleeping in the facility. The Chloral Hydrate was used only during the home visits with his parents. The bottle was approximately 55% full at the time of the survey. On February 1, 2007 review of Client #2's behavior support plan (BSP), dated 7/10/06, and psychological evaluation, dated 5/2/06, showed no evidence that the client had difficulty falling asleep. The BSP was not revised to reflect the 10/11/06 proposed addition of the Chloral Hydrate It should be noted that on January 29, 2007, Client #2 was rushed to the emergency room after he lost consciousness at his day program. The client was described as non-responsive and the day program nurse reportedly was unable to detect a pulse. Nobody in the facility had determined whether or not the client had received Chloral Hydrate during the weekend immediately	W 128	1. The parents are no longer administering medications without the MAR forms. The parents were trained on how to properly document the medication administered and will turn in the Mar's to the home after the visit. The Choral Hydrate was discontinued on 2/5/07. 2. The Psychiatrist, psychologist, pharmacist, and PCP were all in concurrence that the Choral Hydrate was not needed. The Director of DC-CLS, QMRP, house manager, and parents met to discuss the current regimen and they have been informed of the risks and benefits of all medications administered. They also signed an informed consent acknowledgement form.	2/23/07

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	09G168		02/03/2007

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W 128	Continued From page 14 preceding the incident. 2. Client #2's routine, daily medication regimen included Klonopin, Clozaril, Cogentin, Benadryl and Trileptal. Although the prescribing psychiatrist had conducted monthly psychotropic medication reviews (PMR), review of the monthly PMR documentation failed to show evidence that the potential risks associated with the client's medication regimen (possible side effects from individual medications as well as the potential for negative drug interactions) had been clearly identified and explained to the client's parents. Review of the client's records also failed to show evidence that the full interdisciplinary team had weighed the benefits and risks associated with the treatment plan, including but not limited to the use of Chloral Hydrate sedation during home visits, to ensure the client's health and safety.	W 128		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to consistently implement policies and procedures to protect the health, safety and welfare of the five clients residing in the facility. The findings include: 1. Cross-refer to W153 and W154. The facility failed to implement its policies on reporting and investigating incidents	W 149	1. The Incident Management Coordinator/QA will provide training to all staff and nurses on incidents and incident reporting.	3/31/07

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W 149	Continued From page 15 Interview with the facility's Incident Management Coordinator (IMC) on 1/31/07 revealed that their agency requires that the home prepare an incident report regardless of where the incident takes place (day program, for example). Staff who witness or first learn of an incident must prepare an incident report during the same shift. The report gets forwarded to the Qualified Mental Retardation Professional (QMRP) via the House Manager. The QMRP is then responsible for sending a copy of the incident report to her, and to notify the DOH. The survey revealed that out of 13 incidents that presented a risk to clients' health or safety, only 1 incident was reported to the State agency/DOH. During the 1/31/07 interview with the facility's IMC, at 4:26 PM, she indicated that Client #3 made an allegation of verbal abuse on 3/23/06. The client told staff at his day program that he was verbally abused by a staff person in his home . Further interviews with the IMC and the then-QMRP revealed that although the QMRP was made aware of the allegation the same day, he did not report it after talking with day program staff and the client. The IMC stated that she first learned of the incident in October 2006, after an outside office asked her about the incident. The IMC, however, also failed to report the allegation to DOH upon receiving the (late) information. 2. The facility failed to implement its Human Rights Committee policy to ensure Client #2 had informed consent prior to the use of a behavior support plan that incorporates intrusive/restrictive strategies, such as psychotropic medications and one-on-one staff supervision. [See W124 and W 263]	W 149	2. The Human Rights committee meets quarterly to review BSP plans and the administration of psychotropic medications. The guardian/family members are provided consents forms to complete indicating whether they agree or disagree with the BSP developed and/or medications prescribed. The Human Rights committee meeting is also involved in the one-on-one services for	

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W 149	Continued From page 16 3. The facility failed to implement its policy to ensure the records of the receipt and disposition of all controlled drugs were maintained for one of the two clients in the sample. (Client #2). [See W 365 and W386]	W 149	individuals. 3. All controlled drugs are locked under double locks. The medication is counted before administration to ensure remaining is concurrent with the record. Only the nurses and TME's administer medication.	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to document that all allegations of abuse and/or injuries of unknown origin were reported to the designated administrator and to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: DC regulation (22 DCMR Chapter 35 Section 3519.10) requires the group home to "notify the <State agency, DOH> 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... by telephone immediately and shall be followed up by written notification within 24 hours or the next work day." The DOH received notification of one incident (Client #1, on 1/13/07) during the 12-month period since the last survey.	W 153	The Incident Management Coordinator/QA will provide training to all staff and nurses on incidents and incident reporting as required by DC regulation (22 DC Chapter 35 Section 3519.10).	3/31/07

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W 153	Continued From page 17 On January 30, 2007, beginning at approximately 5:27 PM, review of the facility's incident reports, followed by interviews with the Qualified Mental Retardation Professional (QMRP), revealed that the facility failed to document having reported the following incidents immediately to their designated administrator and to the DOH: 1. An incident report dated 10/18/06 indicated that staff observed on Client #2 "a scratch and swelling on the left cheek" at 6:00 AM. The incident report further indicated a "cut" on the " face" and "Emergency Inpatient Hospitalization." Staff notified the House Manager; however, there was no documentation available to verify that the administrator was promptly notified. Client #2's nursing progress notes indicated that he went to a hospital ER on 10/20/06 for a "mandibular abscess." No additional information was available and the ER visit was not documented on an incident report, in accordance with facility policies. In addition, the facility failed to notify the DOH of the ER visit. 2. A nursing progress note dated 7/5/06 indicated that "swelling" was observed in Client #2's sacral area. The client had just returned from an overnight visit with his parents. The nurse did not describe in detail what had been observed on the sacral area. There was no evidence that an incident report was prepared following the discovery of this injury of unknown origin. 3. During a 1/31/07 interview in the facility with the facility's Incident Management Coordinator (IMC), at 4:26 PM, she indicated that Client #3 made an allegation of verbal abuse on 3/23/06. The client told staff at his day program that a staff person in his home had called him ugly and	W 153		

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W 153	Continued From page 18 cursed at him. Further interviews with the IMC and the then-QMRP revealed that the incident had been reported by the day program but not by the residence. The QMRP was called on the day that the client made the allegation and he reportedly went to the day program to discuss it. The QMRP said he had not viewed this as an " incident" because the client admitted having fabricated the story and recanted. The facility failed to notify their MC or the designated administrator at the time. The IMC stated that she first learned of the incident in October 2006, after an outside office asked her about the incident. The allegation of abuse was not reported to the DOH prior to this survey.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all injuries were thoroughly investigated, for one of the two clients in the sample (Client #2). The findings include: 1. An incident report dated 10/18/06 indicated that staff observed on Client #2 "a scratch and swelling on the left cheek" at 6:00 AM. The incident report further indicated a "cut" on the " face" and "Emergency Inpatient Hospitalization." Staff notified the House Manager. There was no evidence, however, that the incident was reported up the chain of command or that the injury was further investigated.	W 154	The Incident Management Coordinator/QA will provide training to all staff and nurses on incidents and incident reporting as required by DC regulation (22 DC Chapter 35 Section 3519.10). The Director of Nursing will ensure that all charge nurses receive the necessary training following orientation. This includes detailed documentation of all treatments, observations, and concerns noted.	

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W 154	Continued From page 19	W 154		
	2. A nursing progress note dated 7/5/06 indicated that "swelling" was observed in Client #2's sacral area. The client had just returned from an overnight visit with his parents. The nurse did not describe in detail what he observed on the sacral area and did not report it up the chain of command; therefore the injury was not further investigated by the QMRP, as per the facility's policies. [Note: Further review of the client's chart revealed that the primary care physician (PCP) examined him two days later, on 7/7/06. The PCP recommended "surgery clinic IND." The client went to a surgery clinic 19 days later, on 7/26/06, at which time the clinician wrote "no drainage noted." No additional information was available.]			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		
	Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.		The day programs are informed of ER visits, medical appointments, and hospitalizations. They are also provided doctor release slips and physician orders with changes, if needed. This is usually done by the house	3/9/07
	This STANDARD is not met as evidenced by: Based on observation, staff and client interviews and record review, the facility's Qualified Mental Retardation Professional (QMRP), failed to adequately monitor integrate and coordinate clients' active treatment and health services, for two of the two clients in the sample. (Clients #1 and #2).			
	The findings include:			
	1. The QMRP failed to ensure that Client #1's day program was informed of a significant change			

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W 159	Continued From page 20 in his health status and new medication orders. On January 30, 2007, at 6:49 AM, interview with an overnight staff person revealed that Client #1 had been taken to an emergency room (ER) approximately 3 weeks earlier. The client was described as being unable to stand up or move his right arm. At 6:52 AM, interview with Client #1 confirmed that he had recently gone to the ER. He said they had run many tests at the hospital, however to date, he had not been told the results/ findings. At approximately 8:30 AM, interview with the House Manager indicated that the primary care physician was aware of the ER findings, a transient ischemic attack (TIA) and had added a new medication ("Aggrenox 200/25 cap, 1 cap twice daily to prevent strokes"), effective January 16, 2007. [Note: While the House Manager said the client's aspirin (one a day) had been discontinued on the same date, there was no order showing it had been d/c'd in the client's chart.] Review of an incident report later that day also confirmed that he had been taken to the ER on Saturday, January 13, 2007. An visit to Client #1's day program was conducted on January 30, 2007, between 12:55 PM and 2:24 PM. Interviews with the Program Director and the Nurse/Health Manager revealed that they were previously unaware that he had been to the ER that month or that his medications had been changed. They reported (and had documented) having received a telephone call from the home on Tuesday, January 16, 2007 indicating the client would be out that day for "multiple medical" appointments. They both repeatedly said they were previously unaware that he had been to the ER, experienced a TIA or that his medications had changed. Inspection of the client's chart	W 159	manager and followed –up by the QMRP to provide additional information and address any concerns they may have. The previous QMRP informed the day programs in December of 2006 that a new QMRP would be taking over the home. The new QMRP has been to all the day programs for the individuals in the home and the last visit was in February 2007.	

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W 159	Continued From page 21 there revealed that the most recent physician's orders (POs) on record were dated September 2007. Further interviews revealed that they were previously unaware that a new QMRP had been assigned in Client #1's home and did not know that the client was now prescribed Aggrenox instead of aspirin. Back in the facility, the QMRP and Charge Nurse said they thought that the day program had been notified of the ER visit and the TIA; however, no documentation was made available for review to substantiate their account. 2. Cross-refer to W 24.1. Client #1's ISP, dated 5/3/06 indicated that the client was unable to make informed decisions. The psychologist, however, indicated in a 5/2/06 evaluation that the client could process some information when explained in simple terms. The psychologist, however, used the term "may be able to..." when discussing the "concept of power of attorney...." The QMRP failed to elicit timely guidance and instruction from Client #1's interdisciplinary team regarding the client's capacity to process information, make informed decisions and whether or not to pursue a court review of the client's mental capacity and guardianship needs, to ensure that his rights were protected. 3. The QMRP failed to ensure that Client #2's BSP was revised to reflect the addition of a new psychotropic medication. The most recent BSP in his record, and the one being implemented by staff, was dated 5/3/06. Review of the client's POs, however, revealed that Chloral Hydrate (PRN, at bedtime for sleep) had been added to his medication regimen on 10/11/06.	W 159	2. A medical and psychological affidavit had completed in the evident #1 is ever in a state where he is unable to state whether or not he wants to have a medical procedure done. The documents were re-submitted to the assigned case manager to be submitted and have a limited medical guardian appointed. 3. A current BSP for #2 has been obtained and filed in the record that reflects the current medication regimen for the individual. The chloral hydrate was discontinued on 2/5/07 and the physician's orders reflect the discontinuance of medication.	3/6/07

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

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W 159	Continued From page 22 4. The QMRP failed to ensure that Client #2's record included evidence of an interdisciplinary team (IDT) review of potential side effects associated with his medication regimen, and analysis of sign/symptoms of possible side effects that the client might be currently exhibiting. On January 31, 2007, at approximately 8:22 AM, the immediate-past QMRP was asked whether Client #2 was exhibiting any signs/symptoms of side effects. He replied "Not to my knowledge... no known adverse side effects at this time." The QMRP said his white blood cell count was being monitored closely. He said the client burned excessive calories by remaining in constant motion, "like an Olympic marathon runner." Throughout the survey, Client #2 was observed to continuously fidget with his pants, belt and socks. He stayed in constant motion and appeared restless. Staff described him as agitated at times, and in constant motion, which was also documented in the record. The client was prescribed Cogentin for excessive drooling. In September 2006, he experienced two episodes of fainting with low blood pressure and dehydration. He became unconscious without a pulse on January 29, 2007. The client's chart did not include a listing of known side effects of his prescribed medications (which included Klonopin, Clozaril, Cogentin, Benadryl, Trileptal as well as Chloral Hydrate PRN). In addition, the QMRP failed to recognize that the aforementioned list of medications had potential to cause drooling, restlessness, loss of appetite, inability to control movements and mood swings. 5. The QMRP failed to show evidence that Client #2's parents, who served as his designated surrogate health care decision-makers, had	W 159	4. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. 5. At the treatment plan meeting on 2/23/07 the parents of #2 was provided the limited guardianship paperwork. The parents provided the signed notarized guardianship paperwork on 3/6/07 for #2. It has been placed in the medical and ISP book. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications.	2/23/07 2/23/07

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	09G168		02/03/2007

NAME OF PROVIDER OR SUPPLIER: ST JOHN

STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW, WASHINGTON, DC 20015

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W 159	Continued From page 23 received a full review of the risks associated with his medication regimen and treatment plan, and potential drug interactions. 6. The QMRP failed to document an interdisciplinary team discussion of weighing the benefits and risks associated with Client #2's treatment plan. 7. Cross-refer to W153 and W154. The QMRP failed to implement the facility's incident management policies, to include reporting allegations of abuse and injuries of unknown origin. According to interviews and review of the facility's policies, the QMRP was responsible for reporting incidents to outside entities, including the Department of Health. The survey revealed 10 incidents from the past 12 months that were not reported outside of the agency. In addition, the QMRP failed to complete an incident report following a client's allegation that staff had verbally used him. Several injuries of unknown origin were not investigated, due in part to the failure to ensure that incident reports were prepared and sent up the chain of command, in accordance with policies.	W 159	6. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. The minutes, agenda, and the attendees are in the client's record.	2/23/07 3/31/07
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC)	W 263	7. The Incident Management Coordinator/QA will provide training to all staff and nurses on incidents and incident reporting as required by DC regulation (22 DC Chapter 35 Section 3519.10).	

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W 263	Continued From page 24 failed to ensure that restrictive programs were used only with written consents, for one of the two clients in the sample. (Client #2) The findings include: Cross-refer to W124 During the January 30, 2007 observation of the medication administration, Client #2 received Clonazepam 2 mg and Clozapine 200 mg. Interview with the House Manager/TME and LPN Charge Nurse and record verification revealed that these medications were prescribed in conjunction with a behavior support plan (BSP). The client was also assigned one-on-one supervision for 16 hours during awake hours for behavior intervention and safety. There was no evidence of written consent for the aforementioned behavior intervention program. Review of Human Rights Committee minutes for the past 12 months revealed no evidence that the committee had determined whether the parents had been asked to provide written consent. The survey revealed no evidence that the HRC had advised the facility on how to ensure that written consent was obtained prior to the use of restrictive strategies.	W 263	Written consent for the BSP and one-on-one services for behavioral intervention and safety has been obtained from the parents of #2.	2/23/07
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to employ sufficient safeguards to	W 285	The PCP and the Medical Team completed a thorough evaluation of #2's medical record on 2/1/2007. The evaluation went back to 2004. A diagnosis of syncope was the result and he was prescribed Fludrocortisone for treatment. The etiology of the fainting spells is still being investigated. #2 saw the cardiologist recommended an event monitor for 30 days. He still has another week with the monitor and then he will follow-up with the cardiologist.	2/1/07

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

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W 285	Continued From page 25 ensure the safety and welfare of one of the two clients in the sample. (Client #2) The findings include: Cross-refer to W318.A. Immediate Jeopardy was called on Thursday, February 1, 2007. The facility was not able to demonstrate that it had ensured Client #2's safety at all times, including weekend visits with his parents. His parents administered medications during the home visits but were not documenting the date, time or amounts of any of the medications administered. The client returned to the facility with some pills or capsules remaining in the containers. The client's record and interviews failed to show documented evidence that the team had considered whether or not his pulse-less episodes were caused by his medication regimen. His medication regimen included routine daily Klonopin, Clozaril, Cogentin, Benadryl, Trileptal as well as Chloral Hydrate PRN (at his parents' home). Chloral Hydrate was prescribed in October 2006 as a sleep aid during his home visits. The facility had no documented evidence that Client #2's parents, who served as his designated surrogate healthcare decision-makers, had received a full review of the risks associated with the medications and treatment plan, and potential for drug interactions. The facility failed to document an interdisciplinary team discussion of weighing the benefits versus risks of the treatment plan. In general, the facility deferred decision-making to the parents, without evidence of oversight and establishment of safeguards. There was potential for negative drug interactions between the Chloral Hydrate, Clozaril and Cogentin (among the others). The facility failed to determine the cause of the	W 285	A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. The parents have completed and signed the limited medical guardian paperwork. The forms were notarized and have been placed in #2's medical and ISP book. The choral hydrate was discontinued and the parents have been trained on documenting the medication on the MAR form. They were informed that this form needs to be completed with every home visit and returned to the home when the visit is completed.	2/23/07 3/6/07 2/5/07 2/23/07

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W 285	Continued From page 26 2 pulse-less episodes in September 2006 in the 4 months that passed (prior to the 1/29/07 episode) and whether the Chloral Hydrate PRN might place the client at risk, including acute low blood pressure events and/or cardiac failure.	W 285		
W 311	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence that drugs used as a sleep aid were approved by the interdisciplinary team and were used in conjunction with an active treatment program, for one of the two clients in the sample. (Client #2) The finding includes: Cross-refer to W124 and W285. Client #2's medication regimen included routine daily Klonopin, Clozaril, Cogentin, Benadryl, Trileptal as well as Chloral Hydrate PRN (at his parents' home). Chloral Hydrate was prescribed in October 2006 as a sleep aid during his home visits. The facility failed to document an interdisciplinary team discussion of weighing the benefits versus risks of the treatment plan. In addition, the facility had no documented evidence that Client #2's parents, who served as his designated surrogate health care decision-makers, had received a full review of the risks associated with the medications and treatment plan, and potential for drug interactions.	W 311	The IDT team were aware that Benadryl was being used a sleep aid for #2. The IDT team opposed the use of chloral hydrate (as a sleep aid) and made their concerns known to the prescribing physician. The choral hydrate was discontinued and the parents were informed that the medication would no longer be used. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications.	2/1/07 2/5/07 2/23/07
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care	W 31		

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W 318	Continued From page 27 services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to establish systems to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [See W 331]; failed to ensure an individual medication record was maintained for one client [See W365]; failed to ensure that clients reeived medications in accordance with physician's orders and without error [See W3368 and W369]; failed to periodically reconcile a schedule 3 drug [See W 386]; and failed to remove from use outdated drugs [See W390]. Immediate Jeopardy was called on Thursday, February 1, 2007. The facility was not able to demonstrate that it had ensured Client #2's safety at all times, including weekend visits with his parents. 1. On a bi-weekly basis, the facility was releasing Client #2 to his parents for home visits. His parents administered medications during the home visits but were not documenting the date, time or amounts of any of the medications administered. The client returned to the facility with some pills or capsules remaining in the containers. 2. Client #2 was rushed to an emergency room on January 29, 2007. He returned from a home	W 318	1. The parents are no longer administering medications without the MAR forms. The parents were trained on how to properly document the medication administered and will turn in the Mar's to the home after the visit. The medications are pre packed for the duration that the individual will be out the home. The parents were informed that all medication provided to them is needed by the individual and should be administered accordingly. The treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents	

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W 318	Continued From page 28 visit that morning and collapsed later that day while at day program, with no pulse. This had happened twice in September 2006 and according to staff, nobody had determined the cause of these health emergencies. The client's record and interviews failed to show documented evidence that the team had considered whether or not these episodes were caused by the medication regimen. His medication regimen included routine daily Klonopin, Clozaril, Cogentin, Benadryl. Trileptal as well as Chloral Hydrate PRN (at his parents' home). 3. Client #2 had been taking Clozaril since 2005; however, the Chloral Hydrate was started in October 2006. Nobody could say how often or how much Chloral Hydrate he received. Clozaril has potential for heart complications and while medical literature suggests that an ECG should be performed approximately every 3 months (along with blood work), the Charge Nurse said his most recent ECG was performed in 2003. 4. The facility had no documented evidence that Client #2's parents, who served as his designated surrogate healthcare decision-makers, had received a full review of the risks associated with the medications and treatment plan, and potential for drug interactions. 5. Interview with the primary care physician revealed that he routinely deferred to the prescribing psychiatrist for monitoring and review of the client's psychotropic medications. The primary care physician also indicated that the medications might be causing the pulse-less manifestations, if there was nothing determined to be wrong with his heart. A complete cardiology work-up was scheduled for February 7, 2007.	W 318	signed off on the Informed Consent for the Use of Medications. 2. #2 has a diagnosis of syncope and is currently receiving adequate treatment. He is also seeing a cardiologist who currently has him on an event monitor to see if the fainting spells are related to his heart condition (mitral valve prolapsed and pulmonary outflow murmur) He will follow-up with the cardiologist when the monitoring is complete. 3. The physicians are taking another approach with #2 because the ECG requires an individual to sit still for 45 minutes. In #2's case that will be impossible. 4. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. 5. #2 has [illegible]	

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W 318	Continued From page 29 6. The facility failed to document an interdisciplinary team discussion of weighing the benefits versus risks of the treatment plan. 7. In general, the facility deferred decision-making to the parents, without evidence of oversight and establishment of safeguards. There was potential for negative drug interactions between the Chloral Hydrate, Clozaril and Cogentin (among the others) and the facility was not acting quickly enough to determine the cause of the pulse-less episodes and whether the Chloral Hydrate PRN might place the client at risk, including acute low blood pressure events and/or cardiac failure. The results of these systemic practices results in the demonstrated failure to provide health care services.	W 318	receiving adequate treatment. He is also seeing a cardiologist who currently has him on an event monitor to see if the fainting spells are related to his heart condition (mitral valve prolapse and pulmonary outflow murmur) He will follow-up with the cardiologist when the monitoring is complete. 6. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. The agenda, meeting minutes, and informed medication consent form from the meeting have been filed in #2's record.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with its clients' needs, for three of the four clients residing in the facility. (Clients #1, #2 and #4) The findings include: 1. Nursing staff failed to establish an effective system to ensure the availability of prescribed PRN and routine daily medications, as follows:	W 331	7. The safeguards for #2 have been put in place. The parents will be documenting medication administered on the MAR and providing the record back to the home after the visit. The parents completed and had notarized the limited medical guardian form. The chloral hydrate was discontinued as a sleep aid	

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W 331	Continued From page 30 a. Cross-refer to W368. During the medication administration observation on January 30, 2007, the House Manager/TME did not have Fluticasone Nasal Spray 50 mcg (Flonase) available for treating Client #4. The Flonase was prescribed for treatment of allergy symptoms. In addition, the client did not receive his prescribed Nasonex spray that morning. The House Manager/TME said he mistakenly thought the Nasonex spray was PRN. b. The clients' Medication Administration Records (MARs) and physician's orders (POs) were reviewed after the morning medication administration on January 30, 2007. The House Manager/TME was unable to locate the following PRN medications in the facility that morning: (1) Client #1's Loratadine D-24 Hr, 1 tab as needed for allergies; (2) Client #2's Tylenol 325 mg, 2 tabs (650 mg) every 8 hours for pain; (3) Client #4's Anusol Suppositories, 1 suppository rectally as needed for hemorrhoids. The House Manager/TME said he thought this had been a "temporary use." Hospital discharge papers dated April 24, 2006 indicated they had recommended the suppositories for 7 days. There was no evidence, however, that the original order had been time-limited and/or that the PCP discontinued the PRN suppositories since receiving treatment in April 2006. (4) Client #1's Combivent Inhaler 15/GM Inhale 2 puffs 4 times daily PRN for asthma had expired in November 2006. No other Combivent Inhaler cartridges were available for use in the	W 331	team and the physician's order reflects the discontinuance. 1. The Director of Nursing will ensure that all prn meds for each individual is in the homes. 2. DDS will be contacted to get a referral for another dentist that is able to render the care needed by the individuals. 3. The charge nurse will ensure that result of tests and outcomes are obtained in a timely fashion. A record of examinations and procedures will be maintained in the records. 4. The Director of Nursing will ensure that all her staff is documenting properly all changes on the physician's order.	3/31/07

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W 331	Continued From page 31 facility. 2. Cross-refer to W356. Nursing staff failed to ensure that Client #1's dental needs were addressed timely. The client's chart did not reflect any monitoring or follow-up regarding the status of the carries found in teeth #13 and #32 in November 2005, 14 months before the survey. 3. Nursing staff failed to maintain Client #1's chart timely to reflect results of diagnostic procedures, as follows: On January 31, 2007, at approximately 2:27 PM, review of Client #1's chart revealed that he had 3 polyps removed during a colonoscopy performed on September 7, 2006. The discharge instructions said to "call 9/15/06 re: biopsy and plan repeat exam." A nursing quarterly update reflected the 9/7/06 colonoscopy and "cold biopsy ." The assessment did not, however, reflect the instructions to call back on 9/15/06. Further review of the nurse assessments and progress notes failed to show evidence that the facility had sought the test results for inclusion in the client's chart. At 3:02 PM, interviews with the LPN Charge Nurse and the House Manager revealed that neither individual knew the outcome/findings of the biopsies. Minutes later, the Charge Nurse reviewed Client #1's chart and acknowledged that he could not find the biopsy results documented, more than 4 months. [Note: Interview with the primary care physician later that day by telephone revealed that the clinic had informed him that the tests showed the polyps were benign.] 4. Nursing staff failed to properly document changes in the clients' physician's orders, as follows:	W 331		

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W 331	Continued From page 32 a. Clients #3 and #4 both received Metamucil 1 packet during the January 30, 2007 morning med pass. Client #2 was also administered Docusate Sodium 100 m cap (Colace). Their charts, however, reflected the following telephone order, dated 1/19/07: "discontinue Docusate, start warm prune juice by mouth 4 oz every morning followed by 4 oz water." When asked about this, the House Manager/TME and LPN Charge Nurse both stated the change would take effect February 1, 2007, as per the RN and primary care physician's instructions. They explained that this was why Clients #3 and #4's MARs still included Metamucil, and Client #2 still received Docusate. Similarly, Client #2's January 2007 POs included Certavite Liquid 480/ml, 1 T (15 ml) by mouth daily, which he received that morning. However, there was a telephone order, signed by the RN Nursing Director on 1/19/07, that said to discontinue the Certavite and begin "Berroca Plus by mouth daily." The order did not indicate whether this would be in capsule or liquid form and it did not state the correct dosage. LPN Charge Nurse looked at the aforementioned orders and acknowledged that they were not written to reflect a February 1, 2007 start date. The RN Nursing Director later confirmed that the changes were effective February 1, 2007. b. Client #2's POs from the past 12 months indicated that he was prescribed Fludrocortisone for the treatment of eczema. However, post-survey communications with the facility RN revealed that the Fludrocortisone was prescibed to treat his mitral valve prolapse. The nursing team had not identified these discrepancies prior to the survey.	W 331		

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W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely medical services for one of the two clients in the sample. (Client #1) The findings include Nursing staff failed to ensure that Client #1 received dental care in a timely manner, as follows: 1. On January 31, 2007, at approximately 3:15 PM, review of Client #1's record revealed that on November 23, 2005, the dentist diagnosed"large carries... need extract teeth #13, #20 and #32." The client waited 10 months before additional dental services were provided. He returned to the dentist on September 27, 2006 and had one tooth (#20) extracted. 2. The client's chart did not reflect any monitoring or follow-up regarding the status of the carries found in the two teeth (#13 and #32) 14 months earlier, in November 2005.	W 338		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental	W 356	DDS will be contacted to get a referral for another dentist that is able to render the care needed by the individuals.	

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W 356	Continued From page 34 health. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure timely dental services, for one of the two clients in the sample. (Client #1) The finding includes: 1. On January 31, 2007, at approximately 3:15 PM, review of Client #1's record revealed that on November 23, 2005, the dentist had diagnosed" large carries... need extract teeth #13, #20 and # 32." The client returned to the dentist 10 months later, on September 27, 2006 and had tooth #20 extracted. 2. The client's chart did not reflect any monitoring or follow-up regarding the status of the carries found in the two teeth (#13 and #32) 14 months earlier, in November 2005. It should be noted that Client #1 replied "no" when he was asked on January 31, 2007, at 4:24 PM, whether his mouth or teeth hurt.	W 356		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that an individual medication record was maintained for one of the two clients in the sample. (Client #2). The finding includes:	W 365	The parents are no longer administering medications without the MAR forms. The parents were trained on how to properly document the medication administered and will turn in the Mar's to the home after the visit. A treatment plan meeting was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

NAME OF PROVIDER OR SUPPLIER: ST JOHN

STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW, WASHINGTON, DC 20015

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W 365	Continued From page 35	W 365		
	On a bi-weekly basis, the facility was releasing Client #2 to his parents for home visits. The weekend visits were reflected as blank spaces on his monthly Medication Administration Records (MARs). Staff thought that his parents administered medications during the home visits but were not documenting the date, time or amounts of any of the medications administered. In a January 31, 2007 interview, at approximately 7:51 AM, the immediate-past Qualified Mental Retardation Professional (QMRP) indicated that the parents had refused earlier requests to document medications. Further interviews and record review revealed no system had been established whereby the facility could account for the medications Client #2 received. It should be noted that on January 30, 2007, at 9:35 AM, the House Manager stated that the LPN Charge Nurse "packs the medication" for the home visits and leaves them with the House Manager in a large ziploc bag. During the January 31, 2007 interview, at approximately 7:58 AM, the immediate-past QMRP was asked whether the parents had administered Chloral Hydrate each night (a typical visit includes Saturday and Sunday nights). He replied "I'm not 100% sure... the nurse packs the medications for the family." Approximately 50 ml of a 160 ml bottle had been used, to date. It should be further noted that during the February 5, 2007 Exit teleconference, the facility denied that the LPN was dispensing medications, which is not allowable under District pharmacy regulations.		held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications.	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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W 368	Continued From page 36 the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a system that all drugs were administered in compliance with the physician's orders, for one of the four clients residing in the facility. (Client #4) The findings include: 1. The morning medication pass was observed on January 30, 2007. At 7:41 AM, the House Manager/Trained Medication Employee (TME) presented a bottle of Fluticasone Nasal Spray 50 mcg (Flonase) and stated that the bottle was empty. Client #4's orders said to administer 2 inhalations twice daily, for treatment of allergies. The House Manager/TME further stated that Client #4 had received the Flonase spray during the morning and evening med passes the day before and that it had just run out. It should be noted that a review of the client's January 2007 Medication Administration Record (MAR) revealed no documentation that Flonase had been administered at any time during the month. 2. Client #4's POs included Nasonex 50 mcg Nasal Spray, 2 sprays once daily, each nostril, treatment 7 AM. The House Manager/TME said he thought they were PRN. He further stated that he administered medications on most (but not all) mornings. Review of the client's January 2007 MAR revealed no documentation that Nasonex had been administered on any morning during the month.	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	3012 MILITARY RD, NW WASHINGTON, DC 20015

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W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that prescribed nasal spray was administered as prescribed, for one of the two clients in the sample. (Client #4) The finding includes: The morning medication pass was observed on January 30, 2007. Review of clients' physician's orders (POs) afterwards revealed that Client #4's POs included Nasonex 50 mcg Nasal Spray, 2 sprays once daily, each nostril, treatment 7 AM. The client had not received Nasonex spray that morning. The House Manager/TME was interviewed immediately. He said he thought the spray was PRN, not treatment. He further stated that he administered medications on most (but not all) mornings. Review of the client's January 2007 MAR revealed no documentation that Nasonex had been administered on any morning during the month.	W 369		
W 386	483.460(l)(4) DRUG STORAGE AND RECORDKEEPING The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).	W 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

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W 386	Continued From page 38	W 386		

This STANDARD is not met as evidenced by:
Based on observation, staff interview, and record verification, the facility failed to maintain records of the disposition of all controlled drugs, for one of the two clients in the sample. (Client #2)

The finding includes:

On January 30, 2007, Client #2's physician's orders (POs) were reviewed in order to verify observations made during the morning medication pass. At approximately 9:15 AM, a hand written order, dated 10/11/06, was observed that read as follows: "Chloral Hydrate 500 mg Take one table <sic> by mouth in evening as needed." The order did not indicate a purpose or use for the medication. When asked to locate it, the Trained Medication Employee (TME) searched through the medication (file) cabinet and a locked nurse's closet but could not locate the Chloral Hydrate (a Schedule III Drug). Review of Client #2's January 2007 Medication Administration Records (MARs) and typed POs (pharmacy) failed to show evidence that Chloral Hydrate was a current medication. The client's December 2006 POs (typed by the pharmacy) reflected the Chloral Hydrate order. There was no order, however, since then to discontinue the medication.

At approximately 9:35 AM, a plastic bag filled with prescription medication containers (some empty, others still held medications in them) was observed in the file cabinet. The House Manager/TME explained that the LPN Charge Nurse routinely packed Client #2's medications in the bag before his weekend visits with his parents. The House Manager/TME would then give the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

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W 386	Continued From page 39 bag of medications to the parents when they came to the facility for their son. Inspection of the contents of the plastic bag revealed a bottle of liquid Chloral Hydrate. The label read as follows: "10/11/06 500 mg/5 ml. Take 5 ml by mouth at bedtime PRN for sleep." Upon visual inspection, the recently-assigned QMRP agreed that approximately 45% of the bottle had been dispensed. The QMRP and House Manager/ TME were unsure at that time whether the parents were documenting the administration of the Chloral Hydrate. Interviews later with the LPN Charge Nurse and the immediate-past QMRP confirmed that the parents were not documenting the medications they administered during the weekend visits. On February 1, 2007, at approximately 5:30 PM, the RN Nursing Director examined the Chloral Hydrate bottle and determined that approximately 55 cc's had been administered, with another 110 cc's remaining in the bottle. The survey revealed that facility staff did not know when, how often, or in what amount the Chloral Hydrate was being administered. There was no evidence that the facility had a system to monitor the disposition of the Controlled Schedule III Drug, Chloral Hydrate. It should be noted that the original telephone order for Chloral Hydrate, dated 10/11/06, was for "30 table." On February 1, 2007, the RN Nursing Director confirmed that there were no POs, nursing progress notes or any other documentation in the record to indicate why the Chloral Hydrate was sent as liquid rather than tablet form. At 6:05 PM, she stated that she had asked the LPN Charge Nurse if he could recall	W 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

NAME OF PROVIDER OR SUPPLIER: ST JOHN

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W 386	Continued From page 40	W 386		
	why the change from tablet to liquid, and he reportedly said he had faxed the order to the pharmacy and "that's what they sent us." A post-survey query on the internet revealed that Chloral Hydrate comes in capsules as well as liquid form.			
W 390	483.460(m)(2)(i) DRUG LABELING	W 390		
	The facility must remove from use outdated drugs		All outdated medications were discarded by the nurse by following the medication policy and protocol for discarding medication	
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to remove from use, out dated medication.			
	The findings include:			
	While verifying the medication pass observations made on January 30, 2007, the House Manager/ Trained Medication Employee (TME) was asked to locate the following 2 medications that were listed on Client #1's January 2007 physician's orders:			
	1. Combivent Inhaler (order: 15/GM Inhale 2 puffs 4 times daily PRN for asthma"). At approximately 8:35 AM, the House Manager/TME searched through the medication (file) cabinet and could not locate the inhaler. At 8:41 AM, he found it in a locked nurse's closet nearby. The label indicated that the medication (cartridge) had expired November 2006.			
	2. The TME also found Fluticasone 0.05% nasal spray (Flonase). The label indicated the medication had also expired in November 2006.			
	The TME examined the labels and confirmed that the medications had expired. At 8:47 AM, the			

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	09G168		02/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	3012 MILITARY RD, NW WASHINGTON, DC 20015

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W 390	Continued From page 41 House Manager/TME stated that the facility's Charge Nurse routinely checked medications in the medicine cabinet and the closet. He then added "We don't use anything over there" while pointing to the nurse's closet. It should be noted that the pharmacist documented having inspected the facility's medication supplies on 12/27/06. It should be further noted that this is a repeat deficiency. See Federal Deficiency Report dated 2/25/05.	W 390		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G168	A. BUILDING _____ B. WING _____	02/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	3012 MILITARY RD, NW WASHINGTON, DC 20015

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I 000	INITIAL COMMENTS A licensure survey was conducted from January 30, 2007 through February 3, 2007. A random sample of two residents was selected from a resident population of four men with various degrees of disabilities. The findings of this survey were based on observations at the group home and one day program, interviews with residents, day program and residential staff and the review of clinical and administrative records, including incident reports.	I 000		
I 044	3502.3 MEAL SERVICE / DINING AREAS All food and drink shall be clean, wholesome, free from spoilage, and properly prepared. This Statute is not met as evidenced by: Facility staff failed to consistently prepare Resident #2's foods in accordance with his prescribed dietary texture (pureed), as follows: 1. The breakfast meal was observed on January 30, 2007, beginning at approximately 7:30 AM. Resident #2's hash browns were prepared to a ground texture. He was also served lumpy scrambled eggs, standard cream of wheat cereal and a can of Ensure Plus nutritional supplement. At 7:33 AM, the resident coughed while eating the hash browns, which prompted staff to instruct him to slow down. 2. The dinner meal was observed later on January 30, 2007, beginning at approximately 5:55 PM. Resident #2 had a plate with lasagna (cut into bite-sized pieces), a whole slice of garlic toast, chopped spinach and a side serving of pineapple tidbits.	I 044	All staff will be trained by the nutritionist on how to properly prepare pureed foods. This training will be quarterly/as needed to ensure all staff has an adequate understanding of pureed meals. The training will also include the dysphagia and what it means in regards to individuals who suffer from aspiration.	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Director CLSDC (X6) DATE 3/13/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
NAME OF PROVIDER OR SUPPLIER ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 044	Continued From page 1 3. On January 31, 2007, at 12:19 PM, Resident # 2 was served a lunch that had been pureed. On January 31, 2007, at 12:50 PM, the House Manager and the LPN Charge Nurse were interviewed in the basement. They both stated that the resident had been prescribed a pureed diet -for several months. Review of the clients chart confirmed that the resident's foods were to be served pureed, as per physician's orders (5/26 /06).	I 044		
I 074	3503.3(c) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (c) Drawer space; and... This Statute is not met as evidenced by: The GHMRP failed to ensure that Resident #2 had his own drawer space for storing underclothes, as follows: On February 3, 2007, at approximately 5:20 PM, inspection of the bedroom shared by Residents # 1 and #2 revealed that Resident #2's supply of underwear and socks were being stored in a plastic bag in the closet. The House Manager indicated that this was routine, standard practice, explaining that there was insufficient space to accommodate another dresser in the bedroom. The one dresser that was in the room was being used solely by Resident #1.	I 074	St. John's has ensured that a dresser was provided for #2 to place his clothing items.	
I 077	3503.5 BEDROOMS AND BATHROOMS Each bedroom shall contain sufficient storage	I 077	A storage bin was purchased to store out of season clothing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
NAME OF PROVIDER OR SUPPLIER: ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 077	Continued From page 2 space for each resident's seasonal, personal clothing and personal effects. This Statute is not met as evidenced by: Resident #2's bedroom did not provide sufficient storage space to accommodate his personal clothing. See I077	I 077		
I 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: Exterior: On January 30, 2007, at approximately 6:10 AM, two sections of concrete on the front walkway were broken and in disrepair. One broken section (hole), measuring approximately 5 inches by 9 inches, had a chunk of original concrete loosely sitting in the hole. This was situated in the center of the walkway and presented a potential trip hazard. Next to the front walkway was a rusted can of paint. The rusted can and broken concrete remained in that condition throughout the remainder of the survey. Dining room: On January 30, 2007 at approximately 6:30 AM, a 7-inch tear was observed in the dining room carpet, just inside the door leading to the deck outside. The torn carpet remained in that condition throughout the remainder of the survey.	I 090	A contractor has been contacted to make the necessary repairs needed to the side walk. The work will begin on Saturday, March 10, 2007. The same contractor will clean and make the necessary repairs to the carpet.	3/10/07

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
NAME OF PROVIDER OR SUPPLIER: ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 180	Continued From page 3	I 180	1. The Incident Management Coordinator/QA will provide training to all staff and nurses on incidents and incident reporting.	
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: 1. The GHMRP failed to provide sufficient administrative oversight to ensure that internal policies on the reporting and investigation of incidents, including allegations of abuse, were implemented. See I379 Also see Federal Deficiency Report - Citations W 104, W149, W153 and W154 2. The GHMRP failed to establish and implement a system of documenting a thorough review of residents' treatment plans and options, to include clear explanation of potential risks and benefits of proposed medication regimens with the resident's legally authorized healthcare decision-maker. See I500.3 Also see Federal Deficiency Report - Citations W 104, W124, W128, W263 and W285 3. There was no system established to document Resident #2s behaviors and the administration of medications during weekend visits with his parents. See I474.1/.2 Also see Federal Deficiency Report - Citations W 104, W111, W128, W365 and W386 4. The survey revealed inadequate supervision of the nursing staff. See I292, I401, I474, I484 Also see Federal Deficiency Report - Citations W 104, W331, W365 and W368	I 180	2. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. 3. The parents are no longer administering medications without the MAR forms. The parents were trained on how to properly document the medication administered and will turn in the Mar's to the home after the visit. 4. The Director of Nursing takes full responsibility in ensuring that adequate supervision of the charge nurses is in place.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
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I 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff; and... This Statute is not met as evidenced by: On January 30, 2007, review the facility's Organizational Chart, dated December 2006, revealed that the box designated "Group Home" staff did not distinguish the categories and numbers of supportive and direct care staff. It was stated that the chart was being further revised, however, no additional information was presented before the survey ended.	I 186	The Director of DC-CLS will ensure that each home has an organizational chart to reference too. The chart will include categories and number of supportive and direct care staff for each home.	4/1/07
I 187	3508.5(d) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: On January 30, 2007, review the facility's Organizational Chart, dated December 2006, revealed that the chart did not reflect lines of authority of staff within the GHMRP, and within the nursing department. It was stated that the chart was being further revised, however, no additional information was presented before the survey ended.	I 187	The Director of DC-CLS will ensure that each home has an organizational chart that reflects the authority of staff within the home and the nursing department.	4/1/07
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control	I 202	All personnel records were updated to reflect the correct job description for all St. John's employees.	3/1/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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I 202	Continued From page 5	I 202		
	This Statute is not met as evidenced by: Review of personnel records on February 3, 2007 revealed no evidence of current job descriptions for the following: - the House Manager/Residential Team Leader. His file included a job description for a previous position he held (Resident Support Specialist) and - the QMRP/Team Leader 3.			
I 206	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.	I 206	All personnel records have current health certificates that indicated that they are health and capable of completing their assigned duties.	
	This Statute is not met as evidenced by: Review of personnel records on February 3, 2007 revealed no evidence of a current health certification/inventory for the following: - 1 of the 10 direct support staff (FN), and - the recently-hired QMRP/Team Leader3			
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff	I 223	Most training is completed annually or as needed. There is a training schedule completed by the homes and are maintained by the Director of DC-CLS and is posted in the homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	3012 MILITARY RD, NW WASHINGTON, DC 20015

(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 223	Continued From page 6 participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: On February 3, 2007, review of staff training records revealed no agendas for recent trainings, including: - Pureed Diets/dysphagia (6/21/06) - Seizures/Infection Control (7/26/06) and - Aspiration/Infection Control (12/18/06)	I 223		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: On February 3, 2007, review of staff training records revealed no evidence that staff had received ongoing training (in 2005, 2006 or thus far in 2007) on the GHMRP's disaster plans.	I 227	Infection control is reviewed monthly with all staff in the monthly house meetings. This is done by the nurse and reiterated by the QMRP.	On going
I 228	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: On February 3, 2007, review of staff training records revealed no evidence that staff had received ongoing training (in 2005, 2006 or thus far in 2007) on resident rights.	I 228	The residents of the homes have self direction meetings weekly. The review of the resident's rights is on the agenda for the meeting. This is done to ensure that all individuals are aware of their rights.	2/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

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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: On February 3, 2007, review of staff training records revealed no evidence that staff had received ongoing training (in 2005, 2006 or thus far in 2007) on human sexuality, recreation or communication.	I 229	Staff members training is not limited to the needs of the individuals in the home but all individuals that St. John's serve.	
I 232	3510.5(i) STAFF TRAINING Each training program shall include, but not be limited to, the following: (i) Training of the residents in the maintenance of oral health and hygiene. This Statute is not met as evidenced by: On February 3, 2007, review of staff training records revealed no evidence that staff had received ongoing training (in 2005, 2006 or thus far in 2007) on assisting and training residents in the maintenance of oral health and hygiene.	I 232		
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies.	I 261	All personnel records are maintained at the main office for security purposes. They are made readily available to those who are authorized to review them.	On-going

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I 261	Continued From page 8 This Statute is not met as evidenced by: On January 30, 2007, a request was made to access personnel records for all staff employed by the GHMRP. Review of the personnel records on February 3, 2007 revealed no records available for the nursing staff (LPN Charge Nurse, Registered Nurse, Nursing Director). No additional information was received since then.	I 261		
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: On January 30, 2007, a request was made to access personnel records for all staff employed by the GHMRP. Review of the personnel records on February 3, 2007 revealed no records available for the nursing staff (LPN Charge Nurse, Registered Nurse, Nursing Director). No additional information was received since then.	I 271	All personnel records are maintained at the main office for security purposes. They are made readily available to those who are authorized to review them.	On-going
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.). This Statute is not met as evidenced by: 1. D.C. Law 2-137, Section 6-1972 "Complete records for each customer shall be maintained and shall be readily available to	I 292	St. John's maintain the residents records electronically and paper-based. There is also a duplicate copy of the paper-based record maintained at the main office.	On-going

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
NAME OF PROVIDER OR SUPPLIER: ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 292	Continued From page 9 professional persons and to the staff workers who are directly involved... These records shall include: (5) A record of each physical examination which describes the results of the examination" (16) A record of any seizures, illnesses, treatments thereof, and immunizations." a. Review of Resident #1's record and interviews revealed that the GHMRP failed to obtain the results of biopsies performed on tissues of 3 polyps removed during a 9/7/06 colonoscopy. Also see Federal Deficiency Report - Citations W 111 and W331.3 b. Review of Resident #2's record revealed a nursing progress note dated 7/5/06 indicating that swelling was observed in the resident's sacral area. The nurse did not describe in detail what he observed on the sacral area. The primary care physician examined the resident two days later and, without describing what was observed, recommended surgery clinic IND. The resident went to a surgery clinic 19 days later, 7/26/06, at which time the clinician wrote no drainage noted. It was not clear, however, whether the client received treatment at the clinic. When interviewed on 2/1/07, the nurse said the swollen area had looked like an abscess. Moments later, however, he said it had been a pressure sore. Further review of the resident's record failed to clarify what had been observed on 7/5/06 and what, if any, treatments were rendered in the weeks that followed. Also see Federal Deficiency Report - Citations W 153.12 and W154.2 2. D.C. Law 2-137, Section 6-1972 "Complete records for each customer shall be	I 292		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
NAME OF PROVIDER OR SUPPLIER: ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 292	Continued From page 10 maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (8) A medication history and status" Interviews and record review indicated that Resident #2 was administered medications during home visits with his parents, approximately every other weekend. The survey revealed that the GHMRP did not have a record of the status of the medications administered during the home visits. Also see Federal Deficiency Report - Citations W 128, W365 and W386	I 292		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Review of incident reports revealed 9 hospital emergency room (ER) visits and 3 other significant incidents that were not reported to the Department of Health, as follows: 1. An incident report dated 2/26/06 indicated that Resident #1 was taken to an emergency room (ER) after complaining that he did not feel well.	I 379	The Incident Management Coordinator/QA will provide training to all staff and nurses on incidents and incident reporting as required by DC regulation (22 DC Chapter 35 Section 3519.10).	3/31/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
NAME OF PROVIDER OR SUPPLIER: ST JOHN		STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015	

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I 379	Continued From page 11 The hospital diagnosis was pneumonia. 2. An incident report dated 8/31/06 indicated that Resident #1 was taken to an ER at 4:00 PM after he "was having elevated breathing." 3. An incident report dated 9/15/06 indicated that Resident #1 was taken from his day program to an ER via ambulance at 9:30 AM after he"was having difficulty breathing." 4. An incident report dated 2/23/06 indicated that 911 was called because Resident #2 was not well . At approximately 7:00 AM, he did not get out of bed for breakfast and his medications. The incident reportedly occurred at 11:45 AM; however, the report was not clear as to what constituted the "incident." It should be noted that the client's parents took him to the hospital on 2/21/06 where he was diagnosed with pneumonia. The Charge Nurse, QMRP and parents were notified on 2/23/06. There was no evidence that DOH received notification of either incident. 5. An incident report dated 3/3/06 indicated that Resident #2 was taken to a hospital after being weak and unable to talk or eat independently. He was again diagnosed with pneumonia. 6. An incident report dated 3/9/06 indicated that 911 was called at 8:30 AM after Resident #2 displayed prolonged and intense behavioral episodes. Staff described him as "agitated, jumping up and down ... running around the house ... taking off his clothes." The client reportedly sustained a cut to the left foot and was taken to the ER via ambulance. 7. An incident report dated 9/6/06 indicated that 911 was called and Resident #2 was taken to the	I 379		

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I 379	Continued From page 12 ER by ambulance at 8:40 AM after he "was losing consciousness." The hospital determined he was hypotensive (cause of the low blood pressure not indicated) and dehydrated. 8. An incident report dated 9/29/06 indicated that 911 was called at 8:20 AM and Resident #2 was taken to the ER by ambulance after he "lost consciousness." It happened after he got up from the breakfast table and began walking. The hospital again determined that he was hypotensive (cause not indicated) and dehydrated 9. An incident report dated 10/18/06 indicated that staff observed on Resident #2 "a scratch and swelling on the left cheek" at 6:00 AM. The incident report further indicated a "cut" on the " face" and "Emergency Inpatient Hospitalization." 10. Resident #2 had two other health-related incidents, on 7/5/06 and 10/20/06. 11. Resident #3 made an allegation of verbal abuse by staff on 3/23/06. The resident later recanted the allegation. Also see Federal Deficiency Report - Citations W 153 and W154	I 379		
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals	I 391	Current licensures were obtained from the clinicians to have on file at the main office.	2/2007

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
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I 391	Continued From page 13 trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Review of personnel records on February 3, 2007 revealed that the GHMRP failed to maintain evidence of current licenses for the following professional service providers: - physical therapist (exp. 1/31/07) - psychiatrist (exp. 12/31/06) - medical director and primary care physician (exp. 12/31/06)	I 391		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: The GHMRP failed to provide nursing and dental services to prevent deterioration or further loss of residents' function, as follows: 1. Resident #4 did not receive Fluticasone Nasal Spray (Flonase) on January 30, 2007 in accordance with his physician's orders. Nursing staff failed to maintain a supply on hand in the facility. Also see Federal Deficiency Report - Citation W	I 401	The Director of Nursing will ensure that the charge nurse have all prescribed PRN medication on site for the individuals in the home.	3/30/07

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	3012 MILITARY RD, NW WASHINGTON, DC 20015

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I 401	Continued From page 14 368 2. Nursing staff failed to keep PRN ("as needed") medications available in the facility for residents' needs. For example, the trained medication employee was unable to locate the following medications on January 30, 2007: a. Resident #1's Loratadine D-24 b. Resident #2's Tylenol 325 mg c. Resident #4's Anusol suppositories, and d. Resident #1's Combivent Inhaler 15/GM (for asthma). Also see Federal Deficiency Report - Citation W 331 3. Review of Resident #1's record revealed that on 11/23/05, a dentist found cavities in three of his teeth (#13, #20 and #32); the dentist recommended extracting all three. The resident waited 10 months (9/27/06) before one tooth (#20) was extracted. Fourteen (14) months passed since the 11/23/05 discovery of carries and the other two teeth (#13 and #32) had not received treatment. Interviews with nursing staff and further record review failed to show evidence that the nursing staff had detected the unmet need, prior to the survey. 4. Interviews and record review revealed that nursing staff failed to obtain the results of diagnostic tests - biopsies of polyps removed from Resident #1's colon on 9/7/06. Also see Federal Deficiency Report - Citation W 111	I 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
NAME OF PROVIDER OR SUPPLIER: ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 422	Continued From page 15	I 422		
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: 1. On January 30, 2007, Resident #2 was served hash browns that were of a ground texture and lumpy scrambled eggs. At dinner that evening, he was given lasagna cut into bite-sized pieces, a whole slice of garlic toast and pineapple pieces. It was later determined that the resident had been prescribed a pureed diet since 5/26/06. Facility staff failed to consistently prepare Resident #2's foods in accordance with his physician's orders and IHP. See I044 2. On January 30, 2007, Resident #4 did not receive Fluticasone Nasal Spray (Flonase) in accordance with his physician's orders and IHP. Review of the resident's medication administration record for January 2007 showed blank spaces for the Flonase spray, with no evidence that the resident received the treatment for allergies all month. Also see Federal Deficiency Report - Citations W 368 and W369	I 422	All staff will be trained by the nutritionist on how to properly prepare pureed foods. This training will be quarterly/as needed to ensure all staff has an adequate understanding of pureed meals. The training will also include the dysphagia and what it means in regards to individuals who suffer from aspiration.	4/1/07
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: 1. On a bi-weekly basis, the facility was releasing Resident #2 to his parents for home visits. The weekend visits were reflected as blank spaces on	I 474	1. The parents are no longer administering medications without the MAR forms. The parents were trained on how to properly document the medication administered and will turn in the Mar's to the home after the visit. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all	2/23/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
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I 474	Continued From page 16 his monthly Medication Administration Records (MARs). Staff thought that his parents administered medications during the home visits but were not documenting the date, time or amounts of any of the medications administered. In a January 31, 2007 interview, at approximately 7:51 AM, the immediate-past Qualified Mental Retardation Professional (QMRP) indicated that the parents had refused earlier requests to document medications. Further interviews and record review revealed no system had been established whereby the facility could account for the medications Resident #2 received. 2. On January 30, 2007, review of Resident #2's physician's orders (POs) revealed a hand written order, dated 10/11/06, that read as follows: " Chloral Hydrate 500 mg Take one table <sic> by mouth in evening as needed." When asked to locate it 20 minutes later, the Trained Medication Employee (TME) was unable to locate the Chloral Hydrate (a Schedule III Drug). A plastic bag filled with prescription medication containers (some empty, others still held medications in them) was observed in the file cabinet. Inspection of the contents of the plastic bag revealed a bottle of liquid Chloral Hydrate. Upon visual inspection, the recently-assigned QMRP agreed that approximately 45% of the bottle had been dispensed. Further interviews and record review revealed that facility staff did not know when, how often, or in what amount the Chloral Hydrate was being administered. There was no evidence that the facility had a system to monitor the disposition of the Controlled Schedule III Drug, Chloral Hydrate. 3. The morning medication pass was observed on January 30, 2007. At 7:41 AM, the House Manager/Trained Medication Employee (TME)	I 474	medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of 2. Medications. 2. All controlled drugs are locked under double locks. The medication is counted before administration to ensure remaining is concurrent with the record. Only the nurses and TME's administer medication. The chloral hydrate was never used at the group home. Chloral hydrate was discontinued on 2/5/07. 3. The Director of Nursing will ensure that the charge nurse have all prescribed PRN medication on site for the individuals in the home.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
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I 474	Continued From page 17 presented a bottle of Fluticasone Nasal Spray 50 mcg (Flonase) and stated that the bottle was empty. Resident #4 s orders said to administer 2 inhalations twice daily for treatment of allergies. The House Manager/TME further stated that Resident #4 had received the Flonase spray during the morning and evening med passes the day before; however review of the resident's January 2007 MAR revealed no documentation that Flonase had been administered at any time during the month.	I 474		
I 484	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: Inspection of the medication supplies on January 30, 2007 revealed the following: 1. The only canister available of Combivent Inhaler, prescribed "as needed" for Resident #1's asthma, had an expiration date of November 2006. 2. A container of Fluticasone 0.05% nasal spray (Flonase) had a discard after November 2006 date. This is a repeat deficiency. See Federal Deficiency Report dated 2/25/05.	I 484	All discontinued and outdated medications have been discarded by the nurse based on the governing polices and procedures. The nurse will also ensure that the labels are legible and list the proper administration for the medication.	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and	I 500		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

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I 500	Continued From page 18 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: 1. The GHMRP failed to ensure the right of Resident #2 to receive meals in accordance with his specially-prescribed diet. D.C. Law 2-137, Section 6-1965(f) "Each customer has the right to a nourishing... diet, and where ordered by a physician and/or nutritionist, to a special diet." On January 30, 2007, Resident #2 was served hash browns that were of a ground texture and lumpy scrambled eggs. At dinner that evening, he was given lasagna cut into bite-sized pieces, a whole slice of garlic toast and pineapple pieces. It was later determined that the resident had been prescribed a pureed diet since 5/26/06. Facility staff failed to consistently prepare Resident #2's foods in accordance with his physician's orders and IHP. See I044 2. The GHMRP failed to ensure that Resident #1 received dental services timely. D.C. Law 2-137, Section 6-1965(g) "Each customer shall have a right to prompt and adequate medical attention for any physical ailments..." Review of Resident #1's record revealed that on 11/23/05, a dentist found cavities in three of his teeth (#13, #20 and #32). On that date, the dentist recommended extracting all three teeth. The resident waited 10 months before one tooth (#20) was extracted, on 9/27/06. As of 2/3/07, the other two teeth (#13 and #32) had not received	I 500	1. All staff will be trained by the nutritionist on how to properly prepare pureed foods. This training will be quarterly/as needed to ensure all staff has an adequate understanding of pureed meals. The training will also include the dysphagia and what it means in regards to individuals who suffer from aspiration. 2. DDS will be contacted to get a referral for another dentist that is able to render the care needed by the individuals.	3/30/07 3/25/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2007
NAME OF PROVIDER OR SUPPLIER: ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 500	Continued From page 19	I 500		
	treatment and there was no evidence that nursing staff had monitored the resident's dental needs. 3. The GHMRP failed to document that Resident #1's legally-authorized surrogate health care decision-makers (his parents) received a full explanation of the potential risks and benefits associated with the resident's medication regimen, to include securing written consent from the parents. D.C. Law 2-137, Section 6-1965(h) "All customers have a right to be free from unnecessary or excessive medication..." Resident #2's parents administered medications during home visits. They were not documenting the date, time or amounts of any of the medications administered. Chloral Hydrate was prescribed in October 2006, at his parent's request, as a sleep aid for use during the home visits. The facility had no documented evidence that his parents, who served as his designated surrogate healthcare decision-makers, had received a full review of the risks associated with the medications and treatment plan, and potential for drug interactions. The facility failed to document an interdisciplinary team discussion of weighing the benefits versus risks of the treatment plan. There was potential for negative drug interactions between the Chloral Hydrate, Clozaril and Cogentin and other medications he was taking. The facility failed to adequately monitor Resident #2 for signs/symptoms of adverse side effects. Also see Federal Deficiency Report - Citations W 124, W263 and W285 It should be noted that Resident #2 was taken by ambulance to the emergency room twice in September 2006 and again on January 29, 2007.		3. At the treatment plan meeting on 2/23/07 the parents of #2 was provided the limited guardianship paperwork. The parents provided the signed notarized guardianship paperwork on 3/6/07 for #2. It has been placed in the medical and ISP book. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications. 4. At the treatment team meeting on 2/23/07. It was explained to the parents that it is St. John's responsible for ensuring that #2's monies is protected and safeguarded. And as his residential provider we have to account for all his monies. The family was asked to provide receipts of how the money was spent to place in his financial record. The parents provided the receipts	2/23/07 3/6/07 3/6/07

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G168		02/03/2007

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I 500	Continued From page 20 The facility failed to determine whether the Chloral Hydrate PRN might place the resident at risk, including acute low blood pressure events and/or cardiac failure. It should be further noted that this is a repeat deficiency. See Federal Deficiency Report dated 2/25/05 - Citations W124 and W263 4. The GHMRP failed to show evidence that Resident #2's personal funds were spent in accordance with the plan set forth by the interdisciplinary team. Resident #2 received a large payment during 2005 as part of a class action settlement. The interdisciplinary team, under the direction of the D.C. Superior Court, developed a list of items that would benefit the resident. According to a letter dated 12/1/05 that was sent from the GHMRP's Residential Director to Resident #2's parents, the parents were to spend $2,049.53 (check #133) on their son's behalf, and "in accordance with the itemized listing supplied at the Court hearing." Interview with the QMRP revealed that the parents had not furnished receipts to verify how their son's funds were spent. Further interview revealed uncertainty as to whether or not they purchased a piano, that was not on the list originally prepared. There was no evidence that the GHMRP or its administrators had pursued the matter in the year that followed issuance of the check to his parents It should be noted that although Resident #2's parents were recognized as his designated health care decision-makers, there was no evidence that they were appointed by a court to serve as his conservator or legal guardian.	I 500		