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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 _____	R 02/22/2007

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 000)	INITIAL COMMENTS A follow-up survey was conducted on February 22, 2007 to determine the facility's compliance with the condition-level deficiencies that constituted an immediate and serious threat to the health and safety of clients. The findings of the follow-up survey were based on observations and staff interviews in the home as well as a review of client and administrative records, including incident reports. The determination was made that the the client was no longer in Immediate Jeopardy. However, the facility remained not in compliance with the Conditions of Participation in Governing Body, Client Protections and Health Care Services. Previously, a recertification survey was conducted from January 30, 2007 through February 3, 2007. 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	(W 000)		

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 MAR 20 P 2:07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Precious N Brown Director CISDC 3/20/07 Revise and copy.

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 000}	Continued From page 1	{W 000}		2/23/07
	with his parents.			
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT	{W 102}	St. John's Community Services seeks to ensure that the individualized service/treatment plans are comprehensive and all reviewed on a regular basis to ensure that all needs are met.	
	The facility must ensure that specific governing body and management requirements are met.			
	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. St. John's Community Services seeks to ensure that the support/treatment plans are thorough and benefit the individuals served. SJCS has been completing a reviews and developed assessments of the each individuals needs to ensure comprehensive monitoring. A copy of such documentation was provided.	
	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.		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 attend all appointments with the psychiatrist.	
	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.			

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(W 102)	Continued From page 2 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. A bottle of Chlora 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	(W 102)	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. 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. ***It is important to note that the team was in process of completing a comprehensive review of all diagnoses for Client #2. Client #2 syncope goes back to 2004 during long term hospitalization of NMS. Chlor-Hydrate was never administered.	

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{W 102}	Continued From page 3 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 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	{W 104}	St. John's seeks to ensure that all incidents are reported to all appropriate parties. The Incident Management Coordinator is responsible for ensuring that all incidents are completed and reported in accordance with regulations. In the future the IMC will ensure that all incidents are reported to the appropriate entities. 1. The Incident Management Coordinator reviewed the incident reporting protocol on 2/1/2007 with the QMRP, RTL, LPN, and the DON which included incident reports, the reporting protocol and all parties that need notification. Everyone has an understanding of the reporting protocol.	2/1/07

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{W 104}	Continued From page 4 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. 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. This is being done for all individuals served.	2/23/07
{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.	{W 111}	St. John's Community Services seeks to ensure that all records are current as indicated in the Compliance Monitoring Review process.	
	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),		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.	1/19/07

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{W 111}	Continued From page 5 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 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	{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. 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.	

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{W 111}	Continued From page 6 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. 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.	{W 111}	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. 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.		6. Anusol Suppositories are in the home for as needed basis for #4 hemorrhoids. The PRN order is on the Physicians Order.	
	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 Psychotropic Medication Review sheets, were		7. The original ISP book was located on 3/7/07. It was found in the van of another home with all its contents. It was in the van prior to the survey.	3/7/07

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{W 111}	Continued From page 7 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 they could not verify with certainty that all documentation was available for review.	{W 111}	The book that was brought to the facility was the duplicate abbreviated copy of the ISP book that is maintained at the office.	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that a system had been developed to inform each client, parent or legal guardian of the client's behavioral status, risk of treatment, and the right to refuse treatment [See W124]; failed to ensure that the use of sedatives had been incorporated into the client's Behavior Support Plan [See W128]; and facility failed to implement policies that ensure each client's health and safety [See W149]. The effects of these systemic practices results in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being.	W 122	St. John's Community Services seeks to ensure that all client protections and safeguards are in place as indicated in current policies and procedures.	
{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	{W 124}		

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{W 124}	Continued From page 8 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 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 12:56 PM, review of Client #1's records revealed	{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."	2/4/07

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(W 124)	Continued From page 9 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. - 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	(W 124)	The face sheet is updated monthly and dated on the bottom of the sheet. As stated during the survey, the need for guardianship was represented in the documentation to be acquired so that when he is not able to participate in the conversation. St. John's Community Services admits to improving the documentation of what transpires with the individuals served. Client #1 greatly participates in his care and is explained all information about his treatment plan.	2/10/07

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(W 124)	Continued From page 10 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 #1's psychologist and primary care physician had both signed sworn affidavits indicating that because of his mental retardation, 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.	(W 124)		

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(W 124)	Continued From page 11 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 healthcare 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 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 cab (Benadryl) 1 cap at	(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. 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	

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(W 124)	Continued From page 12 bedtime; Docusate Sodium 100 mg cap (Colace) 1 cap daily; Benztropine MES 2 mg tab (Cogentin) 1 tab once a day for excessive drooling; Trilepta 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. 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	(W 124)	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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{W 124}	Continued From page 13 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'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 amount of any of the medications	{W 128}		

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{W 128}	Continued From page 14 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 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	{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.	2/23/2007

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{W 128}	Continued From page 15 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. 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	{W 149}	1. The Incident Management Coordinator/QA will provide training to all staff and nurses on incidents and incident reporting.	

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{W 149}	Continued From page 16 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 W263] 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 W365 and W388]	{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 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	{W 153}		

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{W 153}	Continued From page 17 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. 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	{W 153}	St. John's seeks to ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported as immediately to the administrator or other officials in accordance with State law through established procedures. All staff and nurses will be trained by the Incident Management Coordinator/QA to ensure that reporting protocol is followed by all persons as required by the regulation (22 DC Chapter 35 Section 3519.10). 1. The Incident Management Coordintor will provide training to all staff and nurses on incidents and incident reporting as required by DC regulation (22 DC Chapter 35 Section	3/19/07

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(W 153)	Continued From page 18 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 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 IMC or the designated	(W 153)	2. The Director of Nursing will ensure that the charge nurses trained will document in detail all findings on the individuals under their care. 3. All allegations made by an individual will be reported. The Incident Management Coordinator will provide the necessary training for all staff and nurses to ensure all incidents are reported an administrators are notified. The outcome of the investigation will attached to the report after completion.	On-going 3/19/07

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{W 153}	Continued From page 19 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 DDH 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. 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.	{W 154}	St. John's Community Services seeks to ensure that the staff treament of individuals are in compliance with DC regulation and policy. 1. The Incident Management Coordintor 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) 2. The Director of Nursing will ensure that all charge nurses receive the necessary training following orientaion.	3/19/07 On-going

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(W 154)	Continued From page 20 (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 154)		
(W 159)	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff 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 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,	(W 159)	St. John's Community Services seeks to ensure that each individual treatment plan is integrated, coordinated, and monitored by a qualified mental retardation professional. 1. The day programs are informed of ER visits, medical appointments, and hospitalizations. They are also provided doctor release slips and physicians orders, with changes as needed. This is usually done by the RTL and followed up by the QMRP. The QMRP will provide additional information and address any concerns that may arise.	

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{W 159}	Continued From page 21 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 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	{W 159}	The discontinuance of aspirin from #1's medication regimen was listed on the physician's order. The day program was informed that #1 would be out from the day program. Upon his return the day program was provided a release slip from the PCP. The former QMRP visited the day programs in December and informed the staff that a new QMRP would be taking over the home.	

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(W 159)	Continued From page 22 notified of the ER visit and the TIA; however, no documentation was made available for review to substantiate their account. 2. Cross-refer to W124.1. 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 8/3/06. 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. 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 signs/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	(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. 4. A treatment plan meeting washeld on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all	

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{W 159}	Continued From page 23 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 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	{W 159}	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. 6. A treatment plan meeting	2/23/07 2/23/07

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{W 159}	Continued From page 24 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}	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
{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) 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	{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). St. John's Community Services seeks to ensure that the Human Rights Committee uses programs that have written consents. #2's parents signed a written consent for the BSP and one-on-one services for behavioral interention and safety precautions.	3/19/07

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{W 263}	Continued From page 25 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}		
{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 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	{W 285}	St. John's Community Services seeks to ensure that interventions are in place to manage inappropriate behaviors of individuals. Concerns and issues are discussed with the HRC to ensure that the safety, welfare and civil rights bare protected. 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	2/1/07

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{W 285}	Continued From page 26 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 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}	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.	2/23/07
			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.	3/06/07
{W 311}	483.460(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team.	{W 311}	The choral hydrate was discontinued and the parents have been trained on documenting the medication on 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.	2/5/07

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{W 311}	Continued From page 27 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}	St. John's seeks to ensure that the IDT team stays informed of medications prescribed and their usage. 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 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 318}		

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{W 318}	Continued From page 28 W331]; failed to ensure an individual medication record was maintained for one client [See W365]; failed to ensure that clients received medications in accordance with physician's orders and without error [See W3368 and W369]; failed to periodically reconcile a schedule 3 drug [See W386]; 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 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,	{W 318}	Sthe document. John's Coomunity Services seek to ensure the safety of all individuals at all times, including home vists. 1. This is no longer an issue for #2. A tretament team meeting was held that included the Director of nursing, Director of CLS, QMRP, parents, house manager, and the individual to ensure that the documentation of medications administered are consistent. The partents were trainied on documentation on MARs. 2. The IDT team completed an evaluation of the current medication regimen.	

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(W 318)	Continued From page 29 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. 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	(W 318)	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 team 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.	

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(W 318)	Continued From page 30 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)	5. #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 prolapse and pulmonary outflow murmur) He will follow-up with the cardiologist when the monitoring is complete.	On-going
(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: 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.	(W 331)	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	2/23/07

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{W 331}	Continued From page 31 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 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	{W 331}	. 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. 2. The QMRP will ensure contact with MAA to find status of the authorization as Dr. [redacted] states that MAA did not provide authorization.	3/17/07

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W 331	Continued From page 32 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: 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	W 331	completed however did not reflect the call back on 9/15/06. Discussions with the RN indicated that she had received notice from the PCP. In the future the RN will ensure that the nursing notes and/or assessments document reflect all aspects of the treatment plan. 4. SJCS continues to monitor all charts on a monthly basis inclusive of completing chart assessments for the indivduals served. In fact the home was in the midst of completing the chart assessments for Client # 2. St. John's acknowledges that the orders need to be written more clearly and notes to reflect meetings and instructions. All team members knew of the 2/1/07 start date because this was communicated to them from the RN. The order was supposed to be	

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{W 331}	Continued From page 33 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 #1'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}		
{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:	{W 338}	The fludrocortisone is being used to address issues relating to syncope. During review of the chart, the team addressed the issue. This was reviewed with the surveyor by the Residential Director.	

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{W 338}	Continued From page 34 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, 2006, 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 2006.	{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 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:	{W 356}	St. John's Community Services tries to get dental services for all of the indivdiuals served. The issues continue to be medicaid authorizations as reported by the Dentist. In the future, the QMRP will ensure proper documentation of the chart and all of the follow up. The QMRP is seeking to find another dentist that will accept additional patients so that timely and comprehensive dental coverage will be obtained.	3/20/07

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{W 356}	Continued From page 35 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, or 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 366}	See above.	
{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: 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.	{W 365}	The parents are no longer administering medications without the MAR forms. The parents were trained on how to properly document the medication administration 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 medications on his current regimen with the risks and benefits. The parents were provided a list of all medications being administered along with their risks and benefits. The parents signed off on the Informed consent and use of medications.	2/23/07

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{W 365}	Continued From page 36 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 180 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.	{W 365}		
{W 368}	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with 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)	{W 368}		

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{W 368}	Continued From page 37 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}	The delegating RN reviewed the documentation and provided training to the TME on documentation on the MAR's.	3/15/07
{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	{W 369}		

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{W 369}	Continued From page 38 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). 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:	{W 386}		

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{W 386}	Continued From page 39 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 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	{W 386}	During the survey it was reviewed that the initation of the chlorohydrate order had not follow SJCS policies, procedures and protocols. The chloral hydrate order was discontinued and removed. Protocol for home visits is in place.	2/20/07 2/20/07

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{W 386}	Continued From page 40 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 66 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 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 386}		
{W 390}	483.460(m)(2)(i) DRUG LABELING	{W 390}		

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{W 390}	Continued From page 41 The facility must remove from use outdated drugs. 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 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	{W 390}	1 and 2. All expired medications were removed from the medication cabinet on 2/2/07. The Director of Nursing removed the medications.	2/2/07