

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

PRINTED: 04/22/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009
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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016
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W 000	INITIAL COMMENTS A recertification survey was conducted from March 25, 2009 through March 27, 2009. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a client population of four females with various disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with staff and the review of administrative records, including the facility's incident management system.	W 000	The Governing Body seeks to ensure that recertification of licensing is reissued for the home. This is done in accordance with the agency policy and procedure guidelines. <i>Received 5/4/09</i> GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
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 review, the governing body failed to provide operating directions over the facility to ensure fire drill reports were consistently documented in two of four quarters reviewed. The finding includes: The governing body failed to ensure that each simulated fire drill report was monitored and evaluated in accordance with the agency policy. (See W447)	W 104	The Governing Body seek to maintain the operating direction of all facilities. This is evident in the agency-wide policy and procedures. The Governing Body had the old and new staff were trained on fire and safety awareness. This is an annual requirement for all the homes.	4/16/2009
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.	W 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 159	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for two of the four clients residing in the facility. (Clients #1 and #4)</p> <p>The findings include:</p> <p>1. The QMRP failed to ensure Client #1's Speech and Language expressive language recommendations were implemented as evidenced below:</p> <p>On March 25, 2009 at approximately 5:45 PM, a staff was observed to give Client #1 several crayons and to verbally prompt her to color a picture. At 5:59 PM, the surveyor asked Client #1 if she could look at the picture the client was coloring. Client #4 then commented to the surveyor, "She can't talk!"</p> <p>Interview with Client #1's day program instructor on March 27, 2009, revealed that the frequency of the client's speech had increased, however the volume of the client's speech continued to be barely above a whisper. The instructor indicated that when verbally prompted, the client would repeat the alphabets and numbers. Interview with staff at the group home later that day confirmed that the client did not speak often and that if so, she spoke in a volume "like whispering".</p> <p>On March 27, 2009 at 2:10 PM, the review of a Speech-Language Evaluation dated March 12,</p>	W 159	<p>1. The QMRP contacted the Speech and Language Pathologist regarding the recommendations indicated in her report on 3/27/2009. Client #1 and staff will be participating in signing classes on Mondays and Thursdays at 6pm starting May 4, 2009.</p>	5/1/2009
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W 159	<p>Continued From page 2</p> <p>2008, revealed Client #1 was limited in her expressive language skills. The Speech-Language Pathologist (SLP) noted that she did not witness the client speaking, however the historical records indicated the client occasionally whispered, generally when upset. According to the SLP evaluation, staff reported that the client was learning to do basic signing and staff were also learning basic sign language to improve their communication with the client. The SLP revealed that "The client may benefit from speech - language services, including resident and staff education in signing".</p> <p>The review of recommendations included in the client's August 1, 2008 Individual Support Plan (ISP) failed to evidence that the interdisciplinary team (IDT) reviewed the Speech and Language recommendations. Review of the Individual Program Plan (IPP) failed to evidence a training objective for communication (sign language). Additionally, review of the in-service training log failed to evidence that Client #1 or the direct care staff had received training in the area of expressive communication. At the time of the survey, there was no evidence that Client #1 had received speech and language services and communication training as recommended.</p> <p>2. The QMRP failed to ensure Client #1's Speech and Language dietary recommendations were implemented as evidenced below.</p> <p>On March 25, 2009 at 6:39 PM, Client #1 was given a portion of a fresh orange for a snack. The client was observed to pull a section from the orange. She then quickly placed the orange section in her mouth and began to chew it. After several verbal prompts from the direct care staff,</p>	W 159	<p>2. The Registered Nurse in-serviced the staff on the implementation of #1's dietary plan with the staff as indicated on her nutrition plan and SLP's recommendations. The training was completed also included the house manager.</p>	4/20/2009	

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W 159

Continued From page 4

Observation at the day program of Clients #1 and #4 on March 27, 2009, between the hours of 9:15 AM and 10:10 PM, revealed the clients had not arrive at the day program.

On March 27, 2009, at approximately 9:30 AM, interview with the day program instructor and program director revealed that Clients #1 and #4 attended the day program on most days, however often arrived after 10:00 AM, and usually are picked up by 3:15 PM. Further interview with the day program instructor on March 27, 2009 at 9:50 AM, revealed that the day program scheduled hours of operation were 8:30 AM to 4:30 PM. She also indicated that the clients were expected to arrive at the day program no later than from 9:00 AM and depart at 3:00 PM.

Interview with the Residential Team Leader (RTL) on March 26, 2009 at 8:55 AM, revealed the group home had its own vehicle. Further interview revealed that the group home have scheduled drivers to transport the clients to their respective day programs and other leisure activities in the community. Interview with the QMRP on the same day at approximately revealed that she does not monitor the client departure from the group home on a regular basis. Interview with the driver at approximately 2:45 PM, revealed that if the overnight shift does not completed dressing the clients, toileting of the clients and breakfast has not been served, it will push the day program van run back significantly.

On March 27, 2009 at 4:10 PM, review of transportation logs maintained by the designated group home drivers revealed the daily departure times were recorded each morning. Further review of the logs for March indicated that the

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W 159 Continued From page 5
client were consistently departing after 10:30 when one specified driver was on duty. It should be further noted that the review of day program attendance logs on March 27, 2009 at 9:52 AM, revealed that Clients #1 and #4 arrived at 10:20 AM, or later on at least nine days out of each month for the months of January 2009, February 2009 and March 2009.

At the time of the survey, however, there was no evidence that an effective monitoring system had been established and implemented to ensure the clients arrived timely to their day program and were able to participate in their scheduled active treatment programming.

W 159

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 observation, interview and record review the facility failed to ensure nursing services in accordance with the clients needs of two of four clients residing in the facility. (Clients #1 and #3)

The finding includes:

1. The facility's nursing staff failed to ensure that Client #3's medication was administered as prescribed. (See W369)
2. The facility's nursing staff failed to ensure Client #1's dental appointments were completed as recommended. (See W356)

W 331

All nursing and TME will only use medicine cup for measuring teaspoon and tablespoon liquid or powdered medications. In-service with nursing and TME will be done by 5/8/09.

All Individuals will receive scheduled Dental Consultations (Edentulous Individuals: every year and as needed, for those with teeth: every 6 months and as needed. Following each scheduled Dental Consultation, the house RN and the house QMRP will sign the back of of the dental consult indicating acknowledgement that appointment did take place. Nursing, House Managers, and QMRPs will be In-serviced on this by May 8, 2009.

5/8/2009

W 356 483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT

W 356

5/8/2009

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W 356 Continued From page 6

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 observation, interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health, for one of the two clients in the sample. (Client #1)

The finding includes:

The facility failed to ensure that dental treatment and service recommendations were completed as recommended.

On March 25, 2009 at 5:12 PM, Client #1 was observed to have protruding upper front teeth and also missing teeth. Interview with the staff revealed the client was able to chew regular food which had been cut into small pieces.

On March 27, 2009 at 1:40 PM, the primary Registered Nurse (RN) was interviewed concerning Client #1's dental health. The RN acknowledged that the client had not received comprehensive dental treatments since her admission to the group home on June 27, 2007. Reportedly, Client #1 had an initial dental evaluation on September 21, 2007.

The dental report documented that only one x-ray was taken and described the visual assessment of the client's mouth. According to the report the client had, "Generalized carious lesions, several

W 356 All Individuals will receive scheduled Dental Consultations (Edentulous Individuals: every year and as needed, for those with teeth: every 6 months and as needed. Following each scheduled Dental Consultation, the house RN and the house QMRP will sign the back of of the dental consult indicating acknowledgement that appointment did take place. Nursing, House Managers, and QMRPs will be In-scrviced on this by May 8, 2009.

Client # 1 did receive Dental Consultation on 4/29/09 and is due for next dental follow up on 5/6/09.

5/8/2009

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W 358 Continued From page 7
fractured teeth, retained roots, heavy supra gingival calculus, and inflamed gingival tissues. Deep scaling, several extractions and fillings were recommended to be performed using oral or IV sedation".

Continued interview with the RN revealed that Client #1 was scheduled to see a dentist due to experiencing some bleeding of her gums. The RN also revealed that the scheduled April 2008 appointment was not completed and was rescheduled for September 22, 2008. However, there was no documented evidence that this appointment was completed. Continued discussion with the RN on March 27, 2009 at 3:28 PM, revealed the RN informed the surveyor that the client was evaluated at the emergency room on February 9, 2009 for another condition. At that time, however, during the assessment it was determined that the client also had a dental infection. The client was prescribed anti-biotic by the ER physician to treat the infection and follow up with the dentist was recommended. According to RN, the follow-up dental appointment was scheduled for April 8, 2009.

On March 27, 2009 at 1:30 PM, review of Client #1's Individual Support Plan (ISP) dated August 1, 2008, also revealed a service recommendation to "continue dental services as recommended." At the time of the survey, there was no evidence that Client #1 had received the recommended dental interventions.

W 358

W 359

W 369

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.

W 369

W 369

W 369

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W 369: Continued From page 8

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that prescribed medication was administered without error, for one of the four clients residing in the facility. (Client #3)

The finding includes:

The facility's nursing staff failed to administer Client #3's Natural Vegetable Fiber as prescribed as evidenced below:

Observation of the medication administration of Client # 3 on March 26, 2009 at 8:04 AM, revealed the morning medication nurse measured 1 tablespoon of Natural Vegetable Fiber and mixed it with water. The nurse then gave Client #3 the mixture to drink. The client consumed the entire amount.

Interview with the medication nurse at the same time revealed Natural Vegetable Fiber was prescribed for stools.

The review of the medication administration record at 8:35 AM, revealed Metamucil Powder, Generic (Natural Vegetable Fiber), 1 teaspoonful was prescribed to help stool formation. It should be noted that the nurse gave the client a table spoonful instead of a tea spoon of the mixture. At the time of the survey, there was no evidence that Client #3 received the correct amount of the Natural Vegetable Fiber as prescribed by the physician.

W 369

All nursing and TME will only use medicine cup for measuring teaspoon and tablespoon liquid or powdered medications.

Inservice with nursing and TME will be done by 5/8/09.

5/8/2009

W 393 483.460(n)(1) LABORATORY SERVICES

If a facility chooses to provide laboratory services, the laboratory must meet the requirements

W 393

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W 393	Continued From page 9 specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure it met the requirements for performing glucose testing for one of two clients in the sample. (Client #2) The finding includes: Interview the Licensed Practical Nurse (LPN) and record review of the Physician's order on March 27, 2009 at approximately 5:48 AM, revealed that Client #2's blood glucose level was to be tested by using the finger stick method every Tuesday. Further interview with the LPN revealed that Client #2 had a diagnosis of hypo/hyperglycemia reactions to hypothyroidism condition. According to the nurse, blood glucose levels were to be monitored, using a Glucometer weekly. On March 27, 2009 approximately 4:15 PM, interview with the Program Director (PD) was conducted to determine if the facility had obtained the Clinical Laboratory Certification to test blood glucose level in the facility. Further interview with the PD revealed that the agency was in the process of correcting this area with all the facility who may have client participating in glucose monitoring. However, at the time of the survey, this facility had not completed the required certification process in order to conduct blood glucose testing, as identified by Part 493 of the Clinical Laboratory Improvement Act (CLIA).	W 393	Governing Body applied Clinical Laboratory Certification to test blood glucose level in the facility. We are awaiting a response.	3/30/2009
W 447	483.470(i)(2)(iii) EVACUATION DRILLS The facility must file a report and evaluation on each evacuation drill.	W 447		

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W 447 Continued From page 10

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each fire drill report was monitored and evaluated for the four of the twelve months reviewed.

The finding includes:

The facility failed to ensure the accurate documentation of each fire drills conducted as evidenced below:

On March 27, 2009 at approximately 3:15 PM, interview with the Qualified Mental Retardation Professional (QMRP) and review of the fire drill records provided from the period of January 2008 to March 2009 evidenced the following:

1st Quarter (January - March) - Unable to determine the date and time of several drills due to incomplete fire drill reports.

3rd Quarter- (July - September) - Unable to determine date and time of several drills due to incomplete fire drill reports

4th Quarter - (October - December) - Unable determine date and time of several drills due to incomplete fire drill reports

Although it appeared that the fire drills may have been held, it was difficult to verify the occurrence due to the missing dates and times on the fire drill reports.

Interview with the Program Director and the QMRP on March 27, 2009 at approximately 4:45 PM, revealed the group home is to implement the fire drill as required by the agency policy. Further

W 447 The Governing Body had the old and new staff were trained on fire and safety awareness. This is an annual requirement for all the homes.

4/16/2009

The QMRP will monitor the monthly fire drills to ensure they are being completed as scheduled.

5/1/2009

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W 447	Continued From page 11 interview with the QMRP revealed that the staff were required to conduct a fire drill once per month on each shift. According to the PD the agency has a Quality Assurance (QA) component that monitors the fire drill documentation which should have caught the discrepancies in the documentation of the fire drills. At the time of the survey, there was no evidence that the system of monitoring of the fire drill reports for consistency and accuracy was effective.	W 447		
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1000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from March 25, 2009 through March 27, 2009. A random sample of two clients was selected from a client population of four females with various disabilities.</p> <p>The findings of the survey were based on observations at the group home and two day programs, interviews with staff and the review of administrative records, including the facility's incident management system.</p>	1000	
1090	<p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the facility in a safe, clean, orderly, and attractive manner.</p> <p>The findings include:</p> <p>On March 27, 2009, beginning at 3:15 PM, observation of the environment revealed the following concerns:</p> <p>A. Internal</p> <ol style="list-style-type: none"> 1. A section of the basement had standing water, which appeared to be entering underneath the basement door. 2. The sump pump in the basement was 	1090	<ol style="list-style-type: none"> 1. The basement was cleaned and the water was drained and is no longer an issue. 3/28/09 4/20/09 2. There is no sump pump in the home. N/A

Health Regulation Administration

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

TITLE

(X6) DATE

8899

CDFM11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009
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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016
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1090	<p>Continued From page 1</p> <p>inoperable during the observation of the standing water.</p> <p>3. Mold was observed around the base of the shower floor in bathroom #1 located in the hallway.</p> <p>4. The sink fixture that controlled the hot and cold water in bathroom #1 located in the hallway was loose and moved from side to side.</p> <p>5. The two ceiling light fixtures observed in the shower area were not operable.</p> <p>6. The light fixture near the door leading to the side porch was not operable.</p> <p>7. The ceiling above the washer and dryer in the laundry room was observed freshly plastered and was without paint.</p> <p>8. The mattress pad on the bed in Resident #3's bedroom had an enclave in the middle section of the support pad.</p> <p>9. There was a large crack in the wall beside Resident #3's bed.</p> <p>10. There was a hole in the ceiling, near the sprinkler head in the hallway, outside of Resident #3 bedroom. The ceiling above the sprinkler appeared to have water damage.</p> <p>11. The linoleum flooring leading from the living room to the dining room was ripped and torn, creating a possible trip hazard.</p> <p>B. External</p> <p>1. The outside storm door was missing near</p>	1090	<p>3. The shower floor was cleaned and the mold is no longer in the shower area.</p> <p>4. The faucet was replaced in bathroom #1.</p> <p>5. Light bulbs were placed in the ceiling fixtures.</p> <p>6. All light fixtures are operable.</p> <p>7. The ceiling has been re-plastered but still needs painting.</p> <p>8. The mattress was replaced with a new one.</p> <p>9. The crack was repaired by maintenance.</p> <p>10. This area was repaired by maintenance.</p> <p>11. The linoleum was repaired.</p> <p>1. A storm door will be put on.</p>	<p>4/17/2009</p> <p>4/17/2009</p> <p>4/17/2009</p> <p>4/17/2009</p> <p>3/27/2009</p> <p>4/17/2009</p> <p>4/17/2009</p> <p>4/17/2009</p> <p>5/1/2009</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HI1003-0163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1090	Continued From page 2 pantry area. 2. The stairwell leading into the basement door had particles of lint from the dryer vent. 3. The drain at the base of the stairwell leading into the basement had about six inches of dirty, standing water. 4. The sliding door leading into Resident #1's bedroom could not be opened. 5. Bed rails, several mattress, electric bed pads and old linen were being stored on the wooden porch on the side of the facility. 6. The window in the kitchen area had no window screen. 7. The window in the living room area had no window screen. 8. The front storm door screen was ripped and hanging loose from the frame.	1090	2. The lint was cleaned from the stairwell. 3. The water was drained by maintenance. 4. The door was repaired. 5. All the hospital beds were replaced with new ones. 6. The kitchen window now has a screen. 7. The living room window has a screen. 8. The front storm door screen was repaired by maintenance.	3/27/2009 3/28/2009 3/27/2009 3/23/2009 4/16/2009 4/17/2009 3/27/2009
1096	3504.7 HOUSEKEEPING No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area. This Statute is not met as evidenced by: Observation and interview revealed that the GHMRP failed to ensure that caustic agents were not stored in the food preparation and service area. The finding includes: Observation on March 27, 2009 revealed that	1096	A padlock was placed on the cabinets aforementioned.	4/21/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HF003-0163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009
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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016
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I 096	Continued From page 3 cleaning agents (i.e. dishwasher detergent, disinfectant spray, cleanser etc.) were being stored in a unlocked cabinet underneath the kitchen sink.	I 096		
I 136	<p>3505.6 FIRE SAFETY</p> <p>Each QMRP shall maintain records of each simulated fire drill.</p> <p>This Statute is not met as evidenced by: Based on record review revealed that the QMRP failed to ensure fire drills records were monitored and accurately completed for four of the twelve months reviewed.</p> <p>The finding includes:</p> <p>The facility failed to ensure the accurate documentation and record keeping of all fire drills conducted.</p> <p>On March 27, 2009 at approximately 3:15 PM, interview with the Qualified Mental Retardation Professional (QMRP) and review of the fire drill records provided from the period of January 2008 to March 2009 evidenced the following:</p> <ul style="list-style-type: none"> 1st Quarter (January - March) - Unable to determine the date and time of several drills due to incomplete fire drill reports 3rd Quarter- (July - September) - Unable to determine date and time of several drills due to incomplete fire drill reports 4th Quarter - (October - December) - Unable determine date and time of several drills due to incomplete fire drill reports 	I 136	<p>The QMRP and house manager had the staff trained on fire and safety awareness on fire drills and the regulations governing fire safety.</p>	4/16/2009

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I 136 Continued From page 4

Although it appeared that the fire drills may have been held, it was difficult to verify the occurrence due to the missing dates and times on the fire drill reports.

Interview with the Program Director and the QMRP on March 27, 2009 at approximately 4:45 PM, revealed the group home is to implement the fire drill as required by the agency policy. Further interview with the QMRP revealed that the staff were required to conduct a fire drill once per month on each shift. According to the PD the agency has a Quality Assurance (QA) component that monitors the fire drill documentation which should have caught the discrepancies in the documentation of the fire drills. At the time of the survey, there was no evidence that the system of monitoring of the fire drill reports for consistency and accuracy was effective.

I 136

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: Based on observation, interview and record review, GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans for two of the four residents residing in the facility. (Residents #1 and #4).

The findings include:

1. The QMRP failed to ensure Resident #1's

I 180

The QMRP contacted the Speech and Language Pathologist regarding the recommendations indicated 5/1/2009 in her report on 3/27/2009. Client #1 and staff will be participating in signing classes on Mondays and Thursdays at 6pm starting May 4, 2009.

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1180	<p>Continued From page 5</p> <p>Speech and Language expressive language recommendations were implemented as evidenced below:</p> <p>On March 25, 2009 at approximately 5:45 PM, a staff was observed to give Resident #1 several crayons and to verbally prompt her to color a picture. At 5:59 PM, the surveyor asked Resident #1 if she could look at the picture the resident was coloring. Resident #4 then commented to the surveyor, "She can't talk!"</p> <p>Interview with Resident #1's day program instructor on March 27, 2009, revealed that the frequency of the resident's speech had increased, however the volume of the resident's speech continued to be barely above a whisper. The instructor indicated that when verbally prompted, the resident would repeat the alphabets and numbers. Interview with staff at the group home later that day confirmed that the resident did not speak often and that if so, she spoke in a volume "like whispering".</p> <p>On March 27, 2009 at 2:10 PM, the review of a Speech-Language Evaluation dated March 12, 2008, revealed Resident #1 was limited in her expressive language skills. The Speech-Language Pathologist (SLP) noted that she did not witness the resident speaking, however the historical records indicated the resident occasionally whispered, generally when upset. According to the SLP evaluation, staff reported that the resident was learning to do basic signing and staff were also learning basic sign language to improve their communication with the resident. The SLP revealed that "The resident may benefit from speech - language services, including resident and staff education in signing".</p>	1180		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H19103-0163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009	
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20018		
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1180	<p>Continued From page 6</p> <p>The review of recommendations included in the resident's August 1, 2008 Individual Support Plan (ISP) failed to evidence that the interdisciplinary team (IDT) reviewed the Speech and Language recommendations. Review of the Individual Program Plan (IPP) failed to evidence a training objective for communication (sign language). Additionally, review of the in-service training log failed to evidence that Resident #1 or the direct care staff had received training in the area of expressive communication. At the time of the survey, there was no evidence that Resident #1 had received speech and language services and communication training as recommended.</p> <p>2. The QMRP failed to ensure Resident #1's Speech and Language dietary recommendations were implemented as evidenced below.</p> <p>On March 25, 2009 at 6:39 PM, Resident #1 was given a portion of a fresh orange for a snack. The resident was observed to pull a section from the orange. She then quickly placed the orange section in her mouth and began to chew it. After several verbal prompts from the direct care staff, the resident spit the section of orange onto a napkin held by the staff. Meal observation on March 26, 2009 at 7:00 PM, revealed Resident #1 received ground chicken for dinner. Staff indicated that the resident required verbal prompting to chew her food well before swallowing it.</p> <p>Interview with the QMRP on the same day at 2:10 PM, revealed a Speech and Language assessment dated March 12, 2008. According to the QMRP, the (SLP) commented in her report that the Resident tends to chew minimally, then swallow." Further interview with the QMRP</p>	1180	<p>The QMRP reviews all assessments from consulting professionals. The QMRP coordinated with the RN for the home to ensure that all records reflect the recommended dietary regimen need to ensure that no complications. The nutritionist and PCP reports were reviewed to ensure a continuity of care.</p> <p>The QMRP and RN reviewed all required documents to ensure that communication between all consulting professional had been implemented. This information was also shared with the day program. #1's physicians orders reflect a mechanical soft, chopped meat, thin liquids; 1500kcal, NAS, low sodium.</p>	4/20/2009

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I 180	Continued From page 8 4:30 PM. She also indicated that the residents were expected to arrive at the day program no later than from 9:00 AM and depart at 3:00 PM. Interview with the Residential Team Leader (RTL) on March 26, 2009 at 8:55 AM, revealed the group home had its own vehicle. Further interview revealed that the group home have scheduled drivers to transport the residents to their respective day programs and other leisure activities in the community. Interview with the QMRP on the same day at approximately revealed that she does not monitor the resident departure from the group home on a regular basis. Interview with the driver at approximately 2:45 PM, revealed that if the overnight shift does not completed dressing the residents, toileting of the residents and breakfast has not been served, it will push the day program van run back significantly. On March 27, 2009 at 4:10 PM, review of transportation logs maintained by the designated group home drivers revealed the daily departure times were recorded each morning. Further review of the logs for March indicated that the resident were consistently departing after 10:30 when one specified driver was on duty. It should be further noted that the review of day program attendance logs on March 27, 2009 at 9:52 AM, revealed that Residents #1 and #4 arrived at 10:20 AM, or later on at least nine days out of each month for the months of January 2009, February 2009 and March 2009. At the time of the survey, however, there was no evidence that an effective monitoring system had been established and implemented to ensure the residents arrived timely to their day program and were able to participate in the scheduled active	I 180	The house manager met the staff on 4/25/09 about ensuring that individuals are not missing active day treatment due to late arrivals. Disciplinary actions for those who fail to ensure that the individuals have an opportunity to participate in day treatment. The House manager will monitor the log for late departures to the day program.	4/25/2009

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I 180	Continued From page 9 treatment programming.	I 180		
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: Based on interview and review of administrative records, the GHMRP failed to provide evidence of an organizational chart. The finding includes: On March 27, 2009 at approximately 11:45 AM, interview with the QMRP and review of the administrative records failed to provide evidence of an organizational chart. According to the administrator, the organizational chart was included in the agency's policy and procedure manual that was not available for review.	I 187	The Governing Body has attached the organizational chart. The chart identifies the administrative chain of command for agency. Please review attachment for details.	5/1/2009
I 206	3508.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee,	I 206		

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1206	Continued From page 10 prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties for one out of the ten records reviewed. The finding includes: Interview with the Qualified Mental Retardation Professional on March 27, 2009, and review of the GHMRP's personnel records at 2:15 PM revealed that the GHMRP failed to provide evidence that current health certificates were on file for one consultant (MD).	1206	Governing Body applied Clinical Laboratory Certification to test blood glucose level in the facility: 3/30/2009 We are awaiting a response.	
1227	3510.5(d) STAFF TRAINING. Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have on file for review current training in First Aid and CPR for employees for one out of the ten records reviewed. The findings include: Interview with the QMRP on March 27, 2009 at approximately 12:40 PM and the subsequent review of personnel records/training records failed to provide evidence of CPR training for one direct care staff. (S#1)	1227	All staff will receive the mandatory trainings to be in compliance with the policy and procedures.	Ongoing

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I 260	<p>3512.1 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each Residence Director shall maintain current and accurate records and reports as required by this section.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the QMRP failed to ensure that entries into the facility's fire drill reports were dated for four of the twelve months reviewed.</p> <p>The finding includes:</p> <p>The facility failed to ensure the accurate documentation of each fire drills conducted as evidenced below:</p> <p>On March 27, 2009 at approximately 3:15 PM, Interview with the Qualified Mental Retardation Professional (QMRP) and review of the fire drill records provided from the period of January 2008 to March 2009 evidenced the following:</p> <p>1st Quarter (January - March) - Unable to determine the date and time of several drills due to incomplete fire drill reports. 3rd Quarter - (July - September) - Unable to determine date and time of several drills due to incomplete fire drill reports. 4th Quarter - (October - December) - Unable determine date and time of several drills due to incomplete fire drill reports</p> <p>Although it appeared that the fire drills may have been held, it was difficult to verify the occurrence due to the missing dates and times on the fire drill reports.</p>	I 260	<p>The Governing Body had the old and new staff were trained on fire and safety awareness. This is an annual requirement for all the homes.</p> <p>The QMRP will monitor the monthly fire drills to ensure they are being completed as scheduled.</p>	<p>4/16/2009</p> <p>5/1/2009</p>

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I 260	Continued From page 12 Interview with the Program Director and the QMRP on March 27, 2009 at approximately 4:45 PM, revealed the group home is to implement the fire drill as required by the agency policy. Further interview with the QMRP revealed that the staff were required to conduct a fire drill once per month on each shift. According to the PD the agency has a Quality Assurance (QA) component that monitors the fire drill documentation which should have caught the discrepancies in the documentation of the fire drills. At the time of the survey, there was no evidence that the system of monitoring of the fire drill reports for consistency and accuracy was effective.	I 260		
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: Based on observation, interview and record review, the GHMRP failed to ensure professional services included evaluation and treatment service, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. The finding includes: A. The facility failed to ensure that dental treatment and service recommendations were completed as recommended.	I 401		

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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1401	<p>Continued From page 13</p> <p>The facility failed to ensure that dental treatment and service recommendations were completed as recommended.</p> <p>On March 25, 2009 at 5:12 PM, Resident #1 was observed to have protruding upper front teeth and also missing teeth. Interview with the staff revealed the resident was able to chew regular food which had been cut into small pieces.</p> <p>On March 27, 2009 at 1:40 PM, the primary Registered Nurse (RN) was interviewed concerning Resident #1's dental health. The RN acknowledged that the resident had not received comprehensive dental treatments since her admission to the group home on June 27, 2007. Reportedly, Resident #1 had an initial dental evaluation on September 21, 2007.</p> <p>The dental report documented that only one x-ray was taken and described the visual assessment of the resident's mouth. According to the report the resident had, "Generalized carious lesions, several fractured teeth, retained roots, heavy supra gingival calculus, and inflamed gingival tissues. Deep scaling, several extractions and fillings were recommended to be performed using oral or IV sedation".</p> <p>Continued interview with the RN revealed that Resident #1 was scheduled to see a dentist due to experiencing some bleeding of her gums. The RN also revealed that the scheduled April 2008 appointment was not completed and was rescheduled for September 22, 2008. However, there was no documented evidence that this appointment was completed. Continued discussion with the RN on March 27, 2009 at 3:28 PM, revealed the RN informed the surveyor that the resident was evaluated at the emergency</p>	1401	<p>All Individuals will receive scheduled Dental Consultations (Edentulous Individuals: every year and as needed, for those with teeth: every 6 months and as needed. Following each scheduled Dental Consultation, the house RN and the house QMRP will sign the back of of the dental consult indicating acknowledgement that appointment did take place. Nursing, HouseManagers, and QMRPs will be in-serviced on this by May 8, 2009.</p> <p>Client # 1 did receive Dental Consultation on 4/29/09 and is due for next dental follow up on 5/6/09.</p>	5/8/2009 4/29/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009
NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 14 room on February 9, 2009 for another condition. At that time, however, during the assessment it was determined that the resident also had a dental infection. The resident was prescribed anti-biotic by the ER physician to treat the infection and follow up with the dentist was recommended. According to RN, the follow-up dental appointment was scheduled for April 8, 2009. On March 27, 2009 at 1:30 PM, review of Resident #1's Individual Support Plan (ISP) dated August 1, 2008, also revealed a service recommendation to "continue dental services as recommended." At the time of the survey, there was no evidence that Resident #1 had received the recommended dental interventions. B. The facility's nursing staff failed to administer Resident #3's Natural Vegetable Fiber as prescribed as evidenced below: Observation of the medication administration of Resident # 3 on March 26, 2009 at 8:04 AM, revealed the morning medication nurse measured 1 tablespoon of Natural Vegetable Fiber and mixed it with water. The nurse then gave Resident #3 the mixture to drink. The resident consumed the entire amount. Interview with the medication nurse at the same time revealed Natural Vegetable Fiber was prescribed for stools. The review of the medication administration record at 8:35 AM, revealed Metamucil Powder, Generic (Natural Vegetable Fiber), 1 teaspoonful was prescribed to help stool formation. It should be noted that the nurse gave the resident a table spoonful instead of a tea spoon of the mixture. At the time of the survey, there was no evidence	I 401	All nursing and TME will only use medicine cup for measuring teaspoon and tablespoon liquid or powdered medications. In-service with nursing and TME will be done by 5/8/09.	3/27/2009 5/8/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009
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NAME OF PROVIDER OR SUPPLIER ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016
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1401	Continued From page 15 that Resident #3 received the correct amount of the Natural Vegetable Fiber as prescribed by the physician.	1401		