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

PRINTED: 06/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/29/2009
NAME OF PROVIDER OR SUPPLIER: ST JOHN'S COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On April 29, 2009, at approximately 1:38 PM, the State Agency (SA) was notified via telephone message, by the Day Program Case Manager, to report an allegation of abuse that involved Client #1 which allegedly occurred in his group home on April 29, 2009. He reported that a group home staff (no name given) had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. Due to the nature of the incident and information obtained from the administrative review on May 4, 2009, an on-site investigation was initiated on May 29, 2009 by the SA, to verify compliance with federal regulatory requirements. Findings of the investigation were based on observations at the group home and one day program, interviews with Client #1, group home and day program direct care staff, nursing and administrative staff, and review of client and administrative records; including incident reports. As a result of the findings, the SA could not substantiate that Client #1 was physically abused by one or more staff persons. However a determination was made that the facility failed be in compliance with the standard level requirements in Client Protections as evidenced by: A) The facility failed to report the aforementioned alleged abuse as required by the facility's policy and by federal and local regulations. B) The facility failed to notify promptly the client's guardian of an allegation of abuse. C) The facility failed to report the results of all	W 000	The Governing Body seeks to ensure that all incidents surrounding allegations of abuse and neglect are reported in accordance to the policy and procedures in place for situations involving individuals being served. A) The allegation of abuse was reported in accordance to the facilities policy. The governing body policy indicates that all allegations shall be brought to attention of and reported to the Program Director. In this case this was done by the house manager. B) The house manager notified Client #1's grand-mother and was informed that she was already aware.	4/28/09

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

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

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W 000	Continued From page 1 investigations to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.	W 000	C) Client #1's day placement had already reported the incident to the proper authorities. The allegation	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify promptly the client's family member/medical surrogate of an allegation of abuse for one of one client in the investigation. (Client #1) The finding includes: Review of an unusual incident report dated April 29, 2009, on May 27, 2009, at approximately 5:00 PM submitted by the Day Program Case Manager revealed Client #1 had alleged that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. Interview with the Residential Team Leader on May 28, 2009, at approximately 10:55 AM revealed Client #1 had a family member who was his legal medical surrogate. Further interview revealed the facility notified Client #1's family member/medical surrogate of the allegation of abuse.	W 148	was reported to the agency's Incident Management Coordinator (IMC). IMC reported that the was already in the system. An agency report was completed and an investigation was initiated with the staff in question being placed on administrative leave immediately.	4/28/09

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W 148	Continued From page 2 Review of the Department of Developmental Services (DDS) medical surrogate document dated April 9, 2007, on May 28, 2009, at approximately 12:10 PM revealed Client #1 did have a family member who was his legal medical surrogate. There was no documented evidence the facility notified promptly the client's family member/medical surrogate of an allegation of abuse.	W 148	The governing body completed inter-agency report that indicates that Client #1's family was notified of the allegation. The family indicated that they were already notified of the allegation.	
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 implement established procedures of reporting all unusual incidents that impact the clients to the State Agency (SA) for one of one client in the investigation. (Client #1) The finding includes: Review of an unusual incident report dated April 29, 2009, on May 27, 2009, at approximately 5:00 PM submitted by the Day Program Case Manager revealed Client #1 had alleged that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. Interview with the Residential Team Leader on	W 149	The facility implemented its policy on unusual incidents regarding abuse, neglect or abuse of an individual. It was reported immediately to the Program Director, Incident Management Coordinator, QMRP, and his family. Both staff that was on shift at the time of the alleged incident were placed on suspension without pay pending the results of the investigation.	4/28/09

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W 149	Continued From page 3 May 28, 2009, at approximately 10:00 AM revealed the Day Program Case Manager informed her on April 29, 2009, at approximately 3:10 PM of Client #1's allegation of abuse. In an interview with the Residential Team Leader on May 28, 2009, at approximately 11:10 AM it was acknowledged that the facility did not document the allegation of abuse and failed to notify the Department of Health (DOH) of the allegation of abuse reported by Client #1 on April 29, 2009, according to the facility's policy. Interview with Client #1 on May 28, 2009, at approximately 11:50 AM revealed alleged that "a man "(no name given) at his group home, had bent his left arm towards his back , when told that he needed to go to the bathroom at 6 o'clock (date unknown) to wash up for the day program. Further interview revealed Client #1 only reported the allegation of abuse to the Day Program Case Manager. Interview with the Licensed Practical Nurse (LPN #1) on May 28, 2009, at approximately 1:10 PM revealed that on April 29, 2009, at approximately 11:20 AM, Client #1 alleged that "a man" in his group home bent his left arm towards his back, when he would not go to the bathroom to wash up for the day program. Further interview revealed Client #1 was observed to have a small scratch on the inner aspect of his left arm. Interview with the LPN #2 on May 28, 2009, at approximately 1:30 PM revealed that on April 29, 2009, at approximately 10:15 AM, Client #1 stated that he had a scratch after running into a walker and needed treatment. Further interview revealed on that same day at approximately 11:00 AM, Client #1 returned to the nursing station	W 149	The allegation was reported to the agency's Incident Management Coordinator (IMC). IMC reported that the was already in the system. An agency report was completed and an investigation was initiated with the staff in question being placed on administrative leave immediately.	4/28/09

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W 149	Continued From page 4 accompanied by his case manager and alleged that someone in his group home had bent his arm. Interview with the Day Program Case Manager on May 29, 2009, at approximately 1:44 PM revealed that Client #1 reported that "a man" in the group home bent his left hand behind his back when he refused to go into the bathroom to wash up for the day program on April 29, 2009. A telephone message was left at the group home (time unknown) on April 29, 2009, regarding Client #1's allegation of abuse. Further interview revealed the facility's Residential Team Leader called the Day Program Case Manager on April 29, 2009, at approximately 3:05 PM and was informed of Client #1's allegation of abuse. Review of Client #1's Psychological Evaluation Update dated June 2, 2008, on May 28, 2009, at approximately 11:30 AM revealed "he frequently complains and tells falsehoods about the staff, and he sometimes threatens he'll get a staff member fired". Review of an Incident Reporting policy dated October 2008, on June 1, 2009, at approximately 4:50 PM revealed the facility "shall have written documentation of all unusual incidents that impact the person served" (i.e. "instances of alleged or suspected abuse") "incident reports" will serve to notify and inform the administration, applicable state agencies, and provide documentation for subsequent review and investigation of incidents. There was no documented evidence the facility implemented its established procedures of reporting all unusual incidents that impact the	W 149	Client#1 family was notified of the allegation and an incident report was completed. This is a known behavior for Client #1 and it continues to be included in his psychological assessment. This behavior was dropped from his behavior data sheets due to no occurrences in some time. This information was shared with the psychologist.	4/28/09 6/15/09

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W 149	Continued From page 5	W 149		
	clients to the SA.			
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS	W 156		
	The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.			
	This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that investigations into incidences of potential or actual harm were completed within five working days for one of one client in the investigation. (Client #1)		The allegation was reported to the agency's Incident Management Coordinator (IMC). IMC reported that the was already in the system. An agency report was completed and an investigation was initiated with the staff in question being placed on administrative leave immediately. The investigation took longer than expected to ensure the information provided was substantial due to Client #1 history of telling false stories because he is upset with his staff.	4/28/09
	The finding includes:			
	Telephone interview with the facility's Incident Management Coordinator on May 29, 2009, at approximately 11:00 AM revealed that on April 29, 2009, Client #1 had alleged to the Day Program Case Manager that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. Further interview revealed Staff #1 and Staff #2 were immediately placed on administrative leave on April 29, 2009, pending the outcome of the investigation.			
	Review of an investigative report dated April 29, 2009, on June 1, 2009 at approximately 3:35 PM revealed Client #1's allegation of abuse was completed on May 22, 2009; twenty (20) days after the incident was reported.			
	There was no evidence the facility ensured that all			

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W 156	Continued From page 6 allegations of abuse were investigated and completed within five working day.	W 156		
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 interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for one of one client in the investigation. (Client #1) The finding includes: Cross Refer to W 149. The QMRP failed to ensure the implementation of established procedures of reporting all unusual incidents that impact the clients to the State Agency as evidenced by: Review of an unusual incident report dated April 29, 2009, on May 27, 2009, at approximately 5:00 PM submitted by the Day Program Case Manager revealed Client #1 had alleged that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. In an interview with the Residential Team Leader on May 28, 2009, at approximately 11:10 AM it was acknowledged that the facility did not document the allegation of abuse and failed to notify the Department of Health (DOH) of the	W 159	The facility implemented its policy on unusual incidents regarding abuse, neglect or abuse of an individual. It was reported immediately to the Program Director, Incident Management Coordinator, QMRP, and his family. Both staff that was on shift at the time of the alleged incident were placed on suspension without pay pending the results of the investigation. The Staff in the will be trained on the reporting of incidents that occur outside of our agency that involve the individuals the agency serves.	4/28/09 6/25/09

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W 159	Continued From page 7 allegation of abuse reported by Client #1 on April 29, 2009, according to the facility's polity. Review of an Incident Reporting policy dated October 2008, on June 1, 2009, at approximately 4:50 PM revealed the facility "shall have written documentation of all unusual incidents that impact the person served" (i.e. "instances of alleged or suspected abuse") "incident reports" will serve to notify and inform the administration, applicable state agencies, and provide documentation for subsequent review and investigation of incidents. There was no documented evidence the QMRP implemented the facility's established procedures of reporting all unusual incidents that impact the clients to the SA.	W 159	The QMRP was notified of the allegation and process of notifying the required agencies was already in progress. The IMC, Program Director, and family, Answers Please, DOH, and OIG were already notified by the Day Placement. The Incident Management Coord. indicated that the allegation was already in the system. The investigation had already began. The staff in question was pulled from the shift and placed on suspension in accordance with the facility's policy on allegation of abuse, neglect, mistreatment, and exploitation.	4/28/09

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I 000	INITIAL COMMENTS On April 29, 2009, at approximately 1:38 PM, the State Agency (SA) was notified (via telephone) by the Day Program Case Manager, who left a message to report an allegation of abuse that involved Resident #1 which allegedly occurred in his group home on April 29, 2009. On May 4, 2009 at 8:10 AM, the SA contacted the Day Program Case Manager via telephone who stated that on April 29, 2009, Resident #1 reported that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. An onsite investigation was initiated on May 28, 2009, to verify compliance with federal regulatory requirements. The findings of the investigation were based on observations at the group home and one day program, interviews with Resident#1, group home and day program direct care staff, nursing and administrative staff, and review of client and administrative records; including incident reports. As a result of the findings the SA could not substantiate that Resident #1 was physically abused by one or more staff persons. However a determination was made that the facility failed be in compliance with the state requirements as evidenced by: A) The facility failed to report the aforementioned alleged abuse as required by the facility's policy and local regulations. B) The facility failed to notify promptly the resident's family/medical surrogate guardian of an allegation of abuse.	I 000	The Governing Body seeks to ensure that all incidents surrounding allegations of abuse and neglect are reported in accordance to the policy and procedures in place for situations involving individuals being served. A) The allegation of abuse was reported in accordance to the facilities policy. The governing body policy indicates that all allegations shall be brought to attention of and reported to the Program Director. In this case this was done by the house manager. B) The house manager notified Client #1's grand-mother and was informed that she was already aware.	4/28/09

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STATE FORM

SZ9G11

If continuation sheet 1 of 6

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I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on interview the GHMRP failed to ensure that written job descriptions for two of two direct care staff involved in the investigation were available for review. (Staff #1 and Staff #2) The finding includes: Interview with the Residential Team Leader on May 28, 2009 at approximately 12:18 PM revealed that written job descriptions for staff were in the facility's main office. Further interview revealed that the written job descriptions would be provided for review for Staff #1 and Staff #2 by May 29, 2009. There was no documented evidence to ensure written job descriptions had been provided Staff #1 and Staff #2 as of June 2, 2009.	I 202	Staff #1 job description was reviewed 9/4/08 and Staff #2 job description was completed on 6/4/08. The evidence of the completion is attached for review.	9/4/08 6/4/08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by:	I 206	Staff #1 Health certificate was completed on 2/4/2009. Staff #2 physical was completed on 10/9/08.	2/4/09 1/9/08

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I 206	Continued From page 2 Based on interview the GHMRP failed to ensure that annual health certificates/ inventories was obtained for two of two direct care staff involved in the investigation. (Staff #1 and Staff #2) The finding includes: Interview with the Residential Team Leader on May 28, 2009 at approximately 12:18 PM revealed that the health certificates for staff were in the facility's main office. Further interview revealed that the health certificates would be provided for review for Staff #1 and Staff #2 by May 29, 2009. There was no documented evidence to ensure that annual health certificates/ inventories was obtained for Staff #1 and Staff #2 as of June 2, 2009.	I 206	Staff #1 Health certificate was completed on 2/4/2009. Staff #2 health certificate was completed on 10/9/08.	2/4/09 10/9/08
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents, for one of one resident in the investigation. (Resident #1) The finding includes:	I 374	The house manager notified Client #1's grand-mother and was informed that she was already aware.	4/28/09

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I 374	Continued From page 3 Review of an unusual incident report dated April 29, 2009, on May 27, 2009, at approximately 5:00 PM submitted by the Day Program Case Manager revealed Resident #1 had alleged that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. Interview with the House Manager on May 28, 2009, at approximately 10:55 AM revealed Resident #1 had a family member who was his legal medical surrogate. Further interview revealed the facility notified Resident #1's family member/medical surrogate of the allegation of abuse. Review of the Department of Developmental Services (DDS) medical surrogate document dated April 9, 2007, on May 28, 2009, at approximately 12:10 PM revealed Resident #1 did have a family member who was his legal medical surrogate. There was no documented evidence the facility notified promptly the resident's family member/medical surrogate of an allegation of abuse.	I 374	The report was completed by the Day Placement. The QMRP was notified of the allegation and process of notifying the required agencies was already in progress. The IMC, Program Director, and family. Answers Please, DOH, and OIG were already notified by the Day Placement. The Incident Management Coord. indicated that the allegation was already in the system. The investigation had already began. The staff in question was pulled from the shift and placed on suspension in accordance with the facility's policy on allegation of abuse, neglect, mistreatment, and exploitation.	4/29/09
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within	I 379		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0193	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/28/2009
NAME OF PROVIDER OR SUPPLIER: ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 379	Continued From page 4 twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of one resident that resided in the investigation. (Resident #1) The finding includes: Review of an unusual incident report dated April 29, 2009, on May 27, 2009, at approximately 5:00 PM submitted by the Day Program Case Manager revealed Resident #1 had alleged that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. Interview with the Day Program Case Manager on May 29, 2009, at approximately 1:44 PM revealed a telephone massage was left at the facility (time unknown) on April 29, 2009, regarding Resident #1's allegation of abuse. Further interview revealed the facility's House Manager (HM) called the Day Program Case Manager on April 29, 2009, at approximately 3:05 PM and was informed of Resident #1's allegation of abuse. In an interview with the House Manager on May 28, 2009, at approximately 11:10 AM it was acknowledged that the facility did not document the allegation of abuse and failed to notify the	I 379	The QMRP was notified of the allegation and process of notifying the required agencies was already in progress. The IMC, Program Director, and family. Answers Please, DOH, and OIG were already notified by the Day Placement. The Incident Management Coord. indicated that the allegation was already in the system. The investigation had already began. The staff in question was pulled from the shift and placed on suspension in accordance with the facility's policy on allegation of abuse, neglect, mistreatment, and exploitation.	4/28/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0193	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/29/2009
NAME OF PROVIDER OR SUPPLIER: ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 379	Continued From page 5 Department of Health (DOH) of the allegation of abuse reported by Resident #1 on April 29, 2009, according to the facility's polity. Review of an Incident Reporting policy dated October 2008, on June 1, 2009, at approximately 4:50 PM revealed the facility "shall have written documentation of all unusual incidents that impact the person served" (i.e. "instances of alleged or suspected abuse") "Incident reports" will serve to notify and inform the administration, applicable state agencies, and provide documentation for subsequent review and investigation of incidents. There was no documented evidence the facility implemented its established procedures of reporting all unusual incidents that impact the clients to the SA.	I 379	The QMRP was notified of the allegation and process of notifying the required agencies was already in progress. The IMC, Program Director, and family. Answers Please, DOH, and OIG were already notified by the Day Placement. The Incident Management Coord. indicated that the allegation was already in the system. The investigation had already began. The staff in question was pulled from the shift and placed on suspension in accordance with the facility's policy on allegation of abuse, neglect, mistreatment, and exploitation.	4/28/09

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NAME OF PROVIDER OR SUPPLIER: ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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R 000	INITIAL COMMENTS On April 29, 2009, at approximately 1:38 PM, the State Agency (SA) was notified (via telephone) by the Day Program Case Manager, who left a message to report an allegation of abuse that involved Resident #1 which allegedly occurred in his group home on April 29, 2009. On May 4, 2009 at 8:10 AM, the SA contacted the Day Program Case Manager via telephone who stated that on April 29, 2009, Resident #1 reported that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. An onsite investigation was initiated on May 28, 2009, to verify compliance with federal regulatory requirements. The findings of the investigation were based on observations at the group home and one day program, interviews with Resident#1, group home and day program direct care staff, nursing and administrative staff, and review of client and administrative records; including incident reports. As a result of the findings the SA could not substantiate that Resident #1 was physically abused by one or more staff persons. However a determination was made that the facility failed be in compliance with the state requirements as evidenced by: A) The facility failed to report the aforementioned alleged abuse as required by the facility's policy and local regulations. B) The facility failed to notify promptly the resident's family/medical surrogate guardian of an allegation of abuse.	R 000	The Governing Body seeks to ensure that all incidents surrounding allegations of abuse and neglect are reported in accordance to the policy and procedures in place for situations involving individuals being served. A) The allegation of abuse was reported in accordance to the facilities policy. The governing body policy indicates that all allegations shall be brought to attention of and reported to the Program Director. In this case this was done by the house manager. B) The house manager notified Client #1's grand-mother and was informed that she was already aware.	4/28/09

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NAME OF PROVIDER OR SUPPLIER: ST JOHN'S COMMUNITY SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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R 122	Continued From page 1	R 122		
R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview the GHMRP failed to ensure criminal background checks had been obtained before employing 2 out of 2 direct support staff involved in the investigation. (Staff #1 and Staff #2) The finding includes: Interview with the Residential Team Leader on May 28, 2009, at approximately 12:15 PM revealed that the staff criminal background checks were in the facility's main office. Further interview revealed that the criminal background checks would be provided for review for Staff #1 and Staff #2 employed in the facility by May 29, 2009. There was no documented evidence to ensure criminal background checks had been obtained before employing Staff #1 and Staff #2 as of June 2, 2009.	R 122	Staff #1 background check was completed on 3/11/05. Staff #2 background check was completed on 11/29/06. Please review attachments for details.	3/11/05 11/26/06