PRINTED: 02/19/2008
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: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/30/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN		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 Monday, January 28, 2008 at 10:40 AM the Department of Health/ Health Regulation Licensing Administration (DOH/HRA) received an anonymous complaint alleging concerns this Provider's use of Trained Medication Employees (TME'S) to administer clients medications. The complainant alleged the following: (1) The facility's TME's were storing client medication in an unlocked file cabinet; therefore, providing anyone access to the client's medications; (2) The TME's were not documenting medication administered correctly in the Medication Administration Record; (3) The TME's were incorrectly performing finger sticks to check glucose levels of clients who were diabetics. On January 30, 2008 at approximately 2:30 PM the Department of Health initiated an on-site investigation. The findings of this investigation were based on observations, interviews with the facility's direct staff and a TME, and review of habilitation and medical records to include the unusual incident reports.	W 000	All unlicensed personnel have successfully completed the Medication Administration Training Program and are registered with the Board of Nursing as Trained Medication Employee can administer medications to a resident or program partcipant in the MRDD program. 1. All medication are stored in an assigned file cabinet with a combination lock. Only the TMEs know the combination to access the medication. 2. The delegated nurse completed an In-service with the TMEs on how to properly document administered and non-administered medications. 3. There are no diabetics in this home so this citation does not apply to this home. All TMEs were trained on One-Touch glucometer as part of their recertification which required them to complete Units 3 and 4 of Trained Medication Employee Manual.	2/1/08 2/26/08 9/8/07 & 9/9/07
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:	W 104	The Governing Body seeks to ensure that general policy, budget and operating directions are exercised over all its facilities. This is event in all facilities that are owned or operated by the governing body.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sonia Shirwadkar for Precious Myers TITLE: Director (X6) DATE: 2/29/08

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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	09G168		C 01/30/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 Based on interviews with direct care staff, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The findings include:	W 104		
	A. [Cross Reference W365] The governing body failed to have an effective system of monitoring the medical administration records to ensure that the Trained Medication Employees (TME) were documenting information accurately in accordance with the agency's policies and procedures.		A. The system in place by the governing body is as follows: The MARs will be reviewed weekly by the RN and the LPN covering the homes. The LPN or RN will sign off on the back of MAR under the Nurse review section.	2/23/07
	B. [Cross Reference W366] The governing body failed to have an effective system of monitoring the medical administration records to ensure that the Trained Medication Employees (TME) were implementing the facility's medication administrations' policies and procedures as evidenced below:		B. The system in place by the governing body is as follows: The MARs will be reviewed weekly by the RN and the LPN covering the homes. The LPN or RN will sign off on the back of MAR under the Nurse review section.	2/23/07
	Medication Administration Records for the period of August 2007 to January 2008 revealed a series of missed medication for Client #1 and #2 who were prescribed medications and treatments as a part of their habilitation. The Director of Nursing (DON) was interviewed on January 30, 2008, at approximately 3:45 PM and stated that the TME were to implement the agency's policy as follows: 1. When medications were not administered as prescribed, the TME is required to circle the date on the Medication Administration Record (MAR), record their initial inside of the circle, and documented the reason medications were not administered on the back of the MAR.		1. According to the policy and procedures for administering medication, the TME is required to put a circle on the date on MAR and document the reason the medication was not given (i.e. home visit- parents were provided blister pak and will administer the medication).	2/27/08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G166	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/30/2008
NAME OF PROVIDER OR SUPPLIER: ST JOHN		STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015	

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W 104	Continued From page 2 2. All missed medication administrations must immediately be reported to the staff nurse and medical director for instructions for the next administration time. 3. TME'S were to implement policy entitled the "Double Check" system, established to ensure that each client's medication was administered as prescribed by the physician. Review of the Management of Medication, Double Check Policy revealed the following process was to be adhered to as follows: a. A medication trained staff member who is not assigned to administer medication is the checker. b. The checker has successfully completed and received certification in the medication administration. c. Within fifteen-minutes (15) of the prescribed time, the checker will remind the assigned TME staff it is time to prepare to administer the client's medications. d. The checker will then observe the preparation and administration of each client's medication as it is being prepared and administered and document his or her observation. According to the DON this facility has five (5) certified TME's. Reportedly, the staffing schedule reflects the TME assigned to each shift in which medications are administered and the Qualified Mental Retardation Professional is responsible for the TME and direct care staff schedule. Additionally, at the time of the on-site investigation two (2) TME's were on duty.	W 104	2. There were no missed medications in this home. The policy and procedures for missed medicaton is as follows: All TMEs will put a circle on the date the medication was missed and document on the back of the MAR under medication omission/ changes, indicate why it was missed and notify the nurse and physician for instructions. 3. The checker system was designed to provide support to TMEs in the homes. It is also provides additional oversight to ensure that the right person, receives the right medication, right dosage, at the right time, an is documented correctly. The staffing schedule for this home reflects the following: On Sundays- The RTL/house mananger administers the medication in the morning and at noon;in the eveings there is one TME on shift. Mon-RTL administers medication in the morning and noon; in the evening there is a administrator and checker on shift. Tues-RTL administers medication in the morning and noon; in the evening there is a administrator and checker on shift. Wed- an administrator in the morning and a checker and administrator in the evening. Thurs & Fri-administrator in the morning and evening. Sat-administrator in morning and RTL adminsters medication in the evening.	2/26/08 10/06 2/12/08

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W 104	Continued From page 3 There was no evidence that the missed medication were documented as required by the facility's policy and procedures. There was no evidence that the TME "Double Check" system was being implemented in accordance with the agency policy. B. The governing body failed to ensure adequate supervision and oversight of the Trained Medication Employee's. (See W189)	W 104	The governing body seeks to ensure that the agencies policies and procedures are being implemented. This is evident by the implementation of the TME handbook that includes all in-services and observation sheets for the Delegated RN to sign off that the TME assigned to the home is administering the medication properly. The observation will be completed every six months or as needed.	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that entries onto a client's Medication Administration Records were signed and dated for two of two client's investigated. (Client #1 and #2) The findings include: On January 30, 2008 at approximately 3:25 PM, interview with the Director of Nursing and review of the MAR's [including August 2007, September 2007, October 2007, November 2007, December 2007, January, 2008] revealed that MARs were missing date, initials/signatures and reason in which each client's medication was not administered as prescribed. (See W365)	W 114	An inservice was completed with all TMEs on documentation and making sure that the documentation is legilbe, dated, and signed on the MARs. The MARs will be reviewed weekly by the RN and the LPN covering the homes. The LPN or RN will sign off on the back of MAR under the Nurse review section	2/26/08
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		

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W 159	Continued From page 4 This STANDARD is not met as evidenced by: Based on interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The finding includes: The facility's QMRP failed to ensure that the staffing schedule was regularly updated to ensure that the agency's policy and procedure were being implemented by the TME's during medication administration. (See W104)	W 159	The Qualified Mental Retardation Professional ensures the coordination of services and monitors each Individuals active treament regimen. This is evident by ensuring that each Individual is involved a a self -medication program. Their progress in their self medication program is reviewed weekly and documented monthly in their monthly notes. The staff scheduled were reviewed and revised to meet the needs of those persons served. The change in the staffing scheduled was approved on 2/12/2008.	12/30/06 2/12/08
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 observation, interview and record reviews, the facility failed to establish and maintain a systems that ensures that an individuals medication records were maintained for one of the client's residing in the facility. (Client #1 and #2) The findings include: The facility failed to ensure an effective system for documenting Client medication administration as evidence by the following: On January 30, 2008 at approximately 3:30 PM review of the facility's Medication Administration Records (MAR's) revealed the following client's	W 365	All nurses are responsible for maintaining the MARs for the individuals in the home. Training was completed with all the agency nurses on maintaining the individual medication administration records. This is evident by the attached training sign in sheet and agenda. The system in place by the governing body is as follows: The MARs will be reviewed weekly by the RN and the LPN covering the homes. The LPN or RN will sign off on the back of MAR under the Nurse review section.	2/27/08 2/23/08

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

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W 385	Continued From page 5 medications were not administered by the TME's in accordance with the physician orders. 1. Client #1's prescribed medication not administered include: 1/12/08 PM and 1/13/08 dosage of Clozapine 100 mg (AM, noon and PM) for behavior 1/13/08 AM and PM dosage of Benztropine 2 mg for side effects 1/13/08 PM dosage of Clonazepam for side effects 1/13/08 AM Vitamin Supplement 12/10/07 AM dosage of Vitaplex supplement 12/10/07 AM dosage of Clonazepam 2 mg for side effects 12/10/07 AM dosage of Flurocortisone 0.1 mg symptoms of fainting 11/13/07 AM dosage of Benztropine Mes 2 mg for side effects 11/13/07 AM dosage of Fludrocortisone 0.1 mg for allergy 11/21/07 AM dosage of Clonazepam 2 mg for side effects 11/21/07 PM dosage of Clonazepam 2 mg for side effects 11/21/07 PM dosage of Trileptal 300 mg behavior 11/21/07 PM dosage of Diphenhydramine 20 mg for allergy 9/15/07 AM, noon and PM dosage of Clozapine 100 mg for behavior 2. Client #2's prescribed medication not administered include: 12/30/07, 12/25/07, 12/24/07 both the AM and PM dosage of Fluticasone 50 mg NS for allergy 11/1/07, 11/21/07 AM and PM dosage of Fluticasone 50 mg NS for allergy	W 385	1. Client #1 went on a home visit/or outing with his family on the identified dates. Circles were placed in the spaces of those dates. On the back of the MARs under the Omission/Medication changes, the TME on shift should have indicated that the family received the medication in blister paks from the pharmacy. The parents will administer the medication and document it on a copy of the MAR. That would be provided back to the home to be included in his medical record. The delegated nurse completed an in-service with the TMEs on how to properly document administered and non-administered medications. 2. Client #2 went on a home visit with his family on the dates identified. Circles were placed in the spaces of those dates. On the back of the MARs under the Omission/Medication changes, the TME on shift should have indicated that the family received the medication in blister paks from the pharmacy. The parents will administer the medication and document it on a copy of the MAR. That would be provided back to the home to be included in his medical record. The delegated nurse completed an in-service with the TMEs on how to properly document administered and non-administered medications.	2/26/08 2/26/08

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ST JOHN	3012 MILITARY RD, NW WASHINGTON, DC 20015

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W 365	Continued From page 6 10/1/07, 10/28/07, 10/14/07 noon dosage of Ferrous Sulfate iron supplement 10/30/07 AM dosage of Nasonex 50 mg for allergy 10/13/07 AM dosage of Fluticasone 50 mg NS inhaler 9/10/07, 9/14/07, 9/21/07, 9/24/07, 9/28/07 PM application of Ketoconazole Shampoo was not administered. 3. Client #2's prescribed medication not administered include: 9/9/07 and 9/15/07 PM application of Lubrisoft Lot Unscented 473/ML for dry skin 8/10/07 and 8/28/07 AM application of Amlactin 12% Lotion for feet daily. On January 30, 2008 at approximately 3:45 PM, Interview with the Director of Nursing (DON) revealed that the agency's policy is if any medication is not administered, a circle is to be place on the day and initialed by the person not able to administer the client's medication(s). Further interview revealed that a note is to be documented on the back of the MAR. This note usually indicated the purpose the medication was not administered. Review of the medical books failed to evidenced any documented evidence as to the purpose these aforementioned medications were not administered in accordance with the agency policies and the physician's orders.	W 365	3. Client #2 MAR had missing signatures indicating that the mentioned topicals were not administered. The delegated nurse completed an in-service with the TMEs and direct staff on how to properly document administered and non-administered medications.	2/26/08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G188	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/30/2008
NAME OF PROVIDER OR SUPPLIER: ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE: 3012 MILITARY RD, NW WASHINGTON, DC 20015		

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I 000	INITIAL COMMENTS On Monday, January 28, 2008 at 10:40 AM the Department of Health/ Health Regulation Licensing Administration (DOH/HRA) received an anonymous complaint alleging concerns this Provider's use of Trained Medication Employees (TME'S) to administer clients medications. The complainant alleged the following: (1) The facility's TMEs' were storing client medication in an unlocked file cabinet; therefore, providing anyone access to the client's medications; (2) The TMEs' were not documenting medication administered correctly in the Medication Administration Record; (3) The TMEs' were incorrectly performing finger sticks to check glucose levels of clients who were diabetics. On January 30, 2008 at approximately 2:30 PM the Department of Health initiated an on-site investigation. The findings of this investigation were based on observations, interviews with the facility's direct staff and a TME, and review of habilitation and medical records to include the unusual incident reports.	I 000	1. All medication are stored in an assigned file cabinet with a combination lock. Only the TMEs know the combination to access the medication. The Delegated nurse completed an in-service on how to open and dispense medication. 2. The delegated nurse completed an in-service with the TMEs on how to properly document administered and non-administered medications. 3.There are no diabetics in this home so this citation does not apply to this home. All TMEs were trained on One-Touch glucometer as part of their recertification which required them to complete Units 3 and 4 of Trained Medication Employee Manual.	2/1/08 2/23/08 9/8/07 & 9/9/07
I 272	3513.1(c) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (c) Weekly staff schedules, including substitutions;	I 272		

Health Regulation Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
[signature] for Precious Myers Brown
TITLE: AC-CLS Director
(X6) DATE: 2/29/08

STATE FORM 17LU11 If continuation sheet 1 of 3

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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 01/30/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD. NW WASHINGTON, DC 20015		

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I 272	Continued From page 1 This Statute is not met as evidenced by: Based on interview and recorded review the GHMRP failed to have available a weekly staff schedule which detailed the facility's daily staff coverage. The finding includes: Interview with the QMRP on January 30, 2008 at approximately 4:30 PM, revealed that the facility did not have an updated staffing schedule at the time of the on-site investigation. According to the QMRP, she is the person responsible for the monthly staffing schedule. Reportedly the schedule has been amended. Review of the last available staffing schedule available reflected a date of September 2007. Reportedly the staffing schedule also reflects when the TME are scheduled to administer client medications.	I 272	The staff scheduled were reviewed and revised to meet the needs of those persons served. The change in the staffing scheduled was approved on 2/12/2008.	2/12/08
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview, and record review the GHMRP failed to ensure each clients records were kept current. The finding includes: (See Federal Deficiency Citation W114)	I 291	An inservice was completed with all TMEs on documentation and making sure that the documentation is legibe, dated, and signed on the MARs. The MARs will be reviewed weekly by the RN and the LPN covering the homes. The LPN or RN will sign off on the back of MAR under the Nurse review section	2/26/08
I 474	3522.5 MEDICATIONS	I 474		

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I474	Continued From page 2 Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP's nursing staff failed to ensure medication administration records were maintained without documentation error. The finding includes: See Federal Deficiency Report W385	I474	All nurses are responsible for maintaining the MARs for the individuals in the home. Training was completed with all the agency nurses on maintaining the individual medication administration records. This is evident by the attached training sign in sheet and agenda.	2/27/08