

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(X4) ID PREFIX TAG W 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG W 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W189	(X5) COMPLETION DATE 5/14/12
---------------------------------	--	------------------------	---	---------------------------------

W 000 INITIAL COMMENTS

A recertification survey was conducted from April 10, 2012 through April 13, 2012. A sample of two clients was selected from a population of four women with various degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, administrative staff and one client, as well as a review of client and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure that staff received training on clients' feeding protocols, for one of the two clients in the sample. (Client #2)

The finding includes:

On April 10, 2012, at 5:40 p.m., Staff #1 was observed feeding Client #2 her dinner. The meal, which had been processed to a pureed texture, consisted of chicken breast, squash and rotini

W 000

Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
889 North Capitol St., N.E.
Washington, D.C. 20002

W189

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Speech and Language Consultant (SLP) has been notified that the FP may need to be revised to incorporate the head positioning in another wording or to give more specific details on how positions should be accomplished if the individuals diagnosis prevents her from keeping a straight head. As well as the proportion size may need to be re-evaluated due to the irritability of the individuals when 1/2 to 1/4 teaspoon is used. Moreover, the SLP has been notified that DSP's in 24th street need to be retrained on the FP no later than May 24, 2012 on the revised Nutrition Plan which requires specific instructions on feeding protocols that include corrective positioning, corrective feeding proportion and proof and evidence that each DSP working in this home has been trained by the SLP on the current Food Protocol and Nutrition Plan.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Marjul homes will re-review all our individuals books to check food protocols and training documents in order to ensure that all our individuals have current Nutritional Plans and FP that are being followed properly with proper training, this check will be completed no later than 5/24/12.

What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented Identification has been put in place by a Quality Assurance tool that will be done monthly by the QIDDP to ensure that all trainings are updated and in compliance with all protocols including feeding. All QIDDP's & DSP's will be retrained on Food Protocol and Nutrition plans by SLP no later than May 24, 2012.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>V. Shantell</i>	TITLE <i>Program Director</i>	(X6) DATE 5/11/12
---	----------------------------------	----------------------

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days after 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 after the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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

PRINTED: 05/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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
--	---------------	---	----------------------

<p>W 189 Continued From page 1</p> <p>noodles. Facility staff had placed a "feeding protocol" on the dining table in preparation for dinner.</p> <p>1. Client #2, who was seated in a wheelchair, turned her head to the right and kept it in that position for minutes, while the staff fed her. The client ate while her head was turned to the side as well as when it was positioned straight forward.</p> <p>On April 13, 2012, at 3:54 p.m., review of Client #2's Feeding Protocol (FP), dated January 19, 2012, revealed that the speech-language pathologist (SLP) had determined the client's oral motor skills were "inadequate for regular solids." The SLP's recommendations to ensure client safety included the following: "Positioning: chin neutral/ head straight (supported by headrest)." Staff #1, however, had not been observed maintaining the client's head in a straight position while feeding her dinner on April 10, 2012.</p> <p>2. During the dinner meal on April 10, 2012, Staff #1 was observed feeding Client #2 with a coated teaspoon. Each spoonful presented was observed to be 2/3 full to completely full (level) with pureed food. A different staff (Staff #2) was observed feeding Client #2 her lunch on April 12, 2012, beginning at approximately 12:15 p.m. Staff #2 used the client's coated teaspoon. Each spoonful presented was observed to be completely full (either level or slightly heaping) with pureed food.</p> <p>On April 13, 2012, at 3:54 p.m., review of Client #2's FP, January 19, 2012, revealed the SLP recommended "1/2 to 1/3 teaspoon per bite."</p>	<p>W 189</p>
--	--------------

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

PRINTED: 05/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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 189 Continued From page 2
Staff #1 and #2, however, were observed presenting spoonfuls (dinner April 10, 2012 or lunch April 12, 2012, respectively) that were greater in size than the amount recommended in the client's FP.

W 189

[Note: Client #2 did not show any signs of distress during the aforementioned mealtime observations.]

On April 13, 2012, at 2:30 p.m., the qualified intellectual disabilities professional (QIDP) presented the facility's records of staff in-service training. Immediate review of those records revealed that the registered nurse (RN) had provided training on the clients' dietary needs, health plans and FP's on April 4, 2012. The QIDP stated that she had attended the training and she did not recall the RN discussing the amount of food to place on each spoonful. The QIDP also did not find evidence that the SLP had trained staff on the clients' FP's.

W368 what corrective action(s) will be accomplished for those residents found to have been Affected by the deficient practice; Marjul Homes facilities will ensure that all residents receive administered meds in accordance to the Physician Orders (PO.) As well as no resident should be administered any medication that does not have a current P.O

W 368 433.460(k)(1) DRUG ADMINISTRATION

W 368 How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; RN (Boomi) will re-review all PO's to make sure that nursing progress notes are reflecting current information Due to the improper documentation of evening LPN (Patricia) in regards to the Benadryl order, RN has retrained the LPN Patricia on 5/7/12 on verbal orders, telephone orders, making proper entry's and note taking as well as retrieving the actual P.O. that was written by Dr. Bayeh.

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by: Based on interview and review of client records, the facility failed to ensure that clients' medications were administered in accordance with physician's orders, for one of the two clients in the sample. (Client #1)

What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be: RN (Boomi) will be responsible for checking the PO's monthly as well as reviewing the nursing notes as MAR to ensure accuracy.

The finding includes:

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(X4) ID PREFIX TAG W 368	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG W 368	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
---------------------------------	--	----------------------------	---	----------------------

Continued From page 3

On April 11, 2012, at 2:25 p.m., review of Client #1's nurse progress notes revealed that on January 14, 2012, at 6:30 p.m., the evening medication nurse documented having informed the direct of nursing (DON) that the client's right lower lip was swollen. According to the nurse progress note, the DON instructed her to administer Benadryl 50 mg. Immediate review of the client's January 2012 Medication Administration Record (MAR) reflected the administration of Benadryl 50 mg on the evening of January 14, 2012 as well as 25 mg on the morning of January 15, 2012. On January 17, 2012, at 7:25 a.m., a nurse wrote the following progress note: "Writer received a call from <the DON's name> indicating that <client's name> right lower lip was swollen and she got order for Benadryl from <primary care physician's name> which weekend nurse administered..."

On April 11, 2012, beginning at 2:50 p.m., review of Client #1's medical chart failed to show evidence of a physician's order for the administration of Benadryl on January 14, 2012.

On April 13, 2012, at 2:09 p.m., the LPN Coordinator examined Client #1's physicians order sheets and other medical records and confirmed that there was no evidence of a physician's order for Benadryl.

483.460(n)(2) LABORATORY SERVICES

If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.

W 368

W394

What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; Marjul homes has taken the necessary steps to obtain the CLIA (Certificate of Waiver, nurse can continue to administer the finger stick test for blood glucose levels. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; For 24th street home this is the only individuals affected by this issue, however Marjul homes will do a monitoring no later than May 24, 2012 to ensure all other homes have current CLIA certificates. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented; Marjul will install a tickler system on Program Directors Accountability Projects to ensure that the expiration date is installed and will be set to send out a tickler reminder at least 90 days prior to the expiration date. This will give Marjul homes an adequate amount of time to ensure the certificate remains current.

W 394

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002	
(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 394 - Continued From page 4

W 394

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the facility failed to obtain a Certificate of Waiver as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA) before administering finger stick tests for blood sugar glucose levels, for the one client in the facility with diabetes (out of four clients residing in the home). (Client #4)

The finding includes:

On April 10, 2012, at 7:35 a.m., the morning medication nurse (Staff #3) was observed lancing Client #4's finger and testing her blood sugar levels on a glucometer. Review of Client #4's medical record at 9:28 a.m. revealed a physician order (PO) to take blood sugar readings daily via finger stick before breakfast and dinner.

On April 11, 2012, at 12:25 p.m., the facility's licensed practical nurse (LPN) coordinator reported having just spoken with their executive director by telephone. The executive director and the director of nursing recalled having submitted an application with payment for a Certificate of Waiver, as required under the CLIA. To date, however, the agency had not received a response. The LPN coordinator requested contact information for the office responsible for handling CLIA waivers and agreed to ask their executive director for the date of the application and the mailing address to which it had been sent. No additional information was shared before the survey ended on the afternoon of April 13, 2012.

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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 394 : Continued From page 5

W 394

On April 18, 2012 (post-survey), at 11:12 a.m., the qualified intellectual disabilities professional informed this surveyor by telephone that the agency had not kept a copy of the CLIA application and their directors could not recall the date on which they had submitted the application. She further indicated that the facility planned to submit a new application for a Certificate of Waiver.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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
--------------------	--	---------------	---	--------------------

R 000 INITIAL COMMENTS

A licensure survey was conducted from April 10, 2012 through April 13, 2012. A sample of two residents was selected from a population of four women with various degrees of Intellectual disabilities.

The findings of the survey were based on observations in the home and one day program, interviews with direct support staff and one resident, administrative staff and one resident, as well as a review of resident and administrative records, including incident reports.

R 000

R 193 4701.1(d) RECORDKEEPING

Each facility shall maintain, in the personnel record of each employee covered by these rules, the following:

(d) Official documentation of the criminal background check results;

This Statute is not met as evidenced by: Based on interview and review of personnel records, the group home for persons with Intellectual disabilities (GHPID) failed to disclose the results of all criminal background checks, for 2 out of 14 direct support staff. (Staff #3 and #4)

The findings include:

1. On April 12, 2012, at 11:55 a.m., review of the personnel record for Staff #3 indicated that a criminal background check had been performed on August 2, 2011. However, the results of the background check were not available for review in the employee's record.
2. Similarly, at approximately 12:15 p.m., review

R193

What corrective action(s) will be accomplished for those residents found to have been? affected by the deficient practice; The two DSP's identified in this report have been re-check through Marjul homes background system on the dates of August 2, 2011 and November 21, 2011 to show proof that each of these DSP's are in good standing and have clear background checks.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Marjul homes does a Quarterly check on files which identifies any upcoming dates to expire, this gives Marjul home a spread sheet identifying all certificates including Background check that may need to be revised.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented: Marjul homes will continue our Quarterly Quality Assurance internal check to identify any upcoming expiration in certifications such as Background checks.

Regulation & Licensing Administration <i>Vasheer Khalid - a.e.</i> DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Program Director</i>	(X6) DATE <i>5/11/12</i>
---	----------------------------------	-----------------------------

PRINTED: 05/01/2012
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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
--------------------	--	---------------	---	--------------------

R 193 Continued From page 1 R.193

of the personnel record for Staff #4 indicated that a background check had been performed on November 21, 2011. The results of her background check were not available for review.

On April 12, 2012, at 2:00 p.m., the qualified Intellectual disabilities professional (QIDP) indicated that she would ask administrators about the findings/results of the background checks. No additional information was presented before the survey ended the next day at 2:43 p.m.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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
--	---------------	---	--------------------

1 000 INITIAL COMMENTS

A licensure survey was conducted from April 10, 2012 through April 13, 2012. A sample of two residents was selected from a population of four women with various degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and one day program, interviews with direct support staff and one resident, administrative staff and one resident, as well as a review of resident and administrative records, including incident reports.

1206
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All DSP's in the 24th St home are current with Health Certificates as of 5/5/12. Moreover, Marjul Homes will ensure that our health care professionals are in current standards with DOH and DDS regulations, Marjul has requested several times to our Pharmacy Omni Care as well as to our Social Worker Mrs. Thomas, for the current Health Care Certificate. Marjul homes as given all the above names a due date of May 17th to have all current information in the main office. If the information is not given to us by this date, services with Marjul homes will be ended and current Social Worker and Pharmacy will need to be replaced.
How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Currently Marjul homes sends a monthly spread sheet out to all QIDDP's informing them of certificates including health which are soon to expire. This process was put in place to inform QIDDP's of which DSP are soon to be out of compliance in regards to scheduling. Therefore if a DSP does not have the current certificates required by DOH and DDS they will not be able to be placed on schedule.

What measures will be put into place or what systemic changes you will make to
Ensure that the deficient practice does not recur; and
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented
Identification has been put in place by a Quality Assurance Monitoring tool that will be done monthly by the QIDDP to ensure that all Consultants and DSP; s have current health certificates. This tool was implemented before May 30, 2012.

1 206 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:
Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for 1 out of 14 direct support staff and 2 of the 9 consultants. (Staff #5, social worker, pharmacist)

The findings include:

1. On April 12, 2012, beginning at 11:54 a.m., review of the personnel records revealed a physician's health inventory/ certificate for Staff

Regulatory & Licensing Administration DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  ORM	TITLE Program Director	(X6) DATE 5/11/12 If continuation sheet 1 of 8
--	---------------------------	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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
--------------------	--	---------------	---	--------------------

1206 Continued From page 1

#5, dated April 7, 2011. There was no evidence of a more recent health screening.

2. On April 12, 2012, continued review of the personnel records failed to show evidence of a current physician's health inventory/ certificate for the social worker and the pharmacist.

On April 12, 2012, at 2:00 p.m., the qualified intellectual disabilities professional acknowledged that there was no evidence of health inventories performed by a physician for the aforementioned personnel. She stated she would seek additional information from their corporate office. No additional information was presented before the survey ended the following day at 2:43 p.m.

This is a repeat deficiency. See Licensure Deficiency Report dated June 8, 2011.

1229 3510.5(f) STAFF TRAINING

Each training program shall include, but not be limited to, the following:

(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;

This Statute is not met as evidenced by:
Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that staff received effective training on residents' mealtime protocols and reporting requirements regarding incidents that present a significant risk to resident health and safety, for two of the two residents in the sample. (Residents #1 and #2)

1229

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents will have a second look assessment done to re-evaluate the food protocol in order to ensure that this FP is the best fit for each individuals feeding needs. This assessment will take place no later than May 24, 2012.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Marjul homes will re-review all our individuals books to check food protocols and training documents in order to identify and ensure that all our individuals have current Nutritional Plans and FP that are being followed properly with proper training, this check will be completed no later than 5/24/12.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented: Identification has been put in place by a Quality Assurance tool that will be done monthly by the QIDDP to ensure that all trainings are updated and in compliance with all protocols including feeding. All QIDDP's & DSP's will be restrained on Food Protocol and Nutrition plans by SLP no later than May 24, 2012.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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
--------------------	--	---------------	---	--------------------

1 229 Continued From page 2

1 229

The findings include:

1. On April 10, 2012, at 5:40 p.m., Staff #1 was observed feeding Resident #2 her dinner. The meal, which had been processed to a pureed texture, consisted of chicken breast, squash and rotini noodles. Facility staff had placed a Feeding Protocol on the dining table in preparation for dinner.

a. Resident #2, who was seated in a wheelchair, turned her head to the right and kept it in that position for minutes, while the staff fed her. The resident ate while her head was turned to the side as well as when it was positioned straight forward.

On April 13, 2012, at 3:54 p.m., review of Resident #2's Feeding Protocol (FP), dated January 18, 2012, revealed that the speech-language pathologist (SLP) had determined the resident's oral motor skills were "inadequate for regular solids." The SLP's recommendations to ensure resident safety included the following: "Positioning: chin neutral/ head straight (supported by headrest)." Staff #1, however, had not been observed maintaining the resident's head in a straight position while feeding her dinner on April 10, 2012.

b. During the dinner meal on April 10, 2012, Staff #1 was observed feeding Resident #2 with a coated teaspoon. Each spoonful presented was observed to be 2/3 full to completely full (level) with pureed food. A different staff (Staff #2) was observed feeding Resident #2 her lunch on April 12, 2012, beginning at approximately 12:15 p.m. Staff #2 used the resident's coated teaspoon. Each spoonful presented was observed to be

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002	

(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
--------------------	--	---------------	---	--------------------

1229 Continued From page 2

1229

The findings include:

1. On April 10, 2012, at 5:40 p.m., Staff #1 was observed feeding Resident #2 her dinner. The meal, which had been processed to a pureed texture, consisted of chicken breast, squash and rotini noodles. Facility staff had placed a Feeding Protocol on the dining table in preparation for dinner.

a. Resident #2, who was seated in a wheelchair, turned her head to the right and kept it in that position for minutes, while the staff fed her. The resident ate while her head was turned to the side as well as when it was positioned straight forward.

On April 13, 2012, at 3:54 p.m., review of Resident #2's Feeding Protocol (FP), dated January 19, 2012, revealed that the speech-language pathologist (SLP) had determined the resident's oral motor skills were "inadequate for regular solids." The SLP's recommendations to ensure resident safety included the following: "Positioning: chin neutral/ head straight (supported by headrest)." Staff #1, however, had not been observed maintaining the resident's head in a straight position while feeding her dinner on April 10, 2012.

b. During the dinner meal on April 10, 2012, Staff #1 was observed feeding Resident #2 with a coated teaspoon. Each spoonful presented was observed to be 2/3 full to completely full (level) with pureed food. A different staff (Staff #2) was observed feeding Resident #2 her lunch on April 12, 2012, beginning at approximately 12:15 p.m. Staff #2 used the resident's coated teaspoon. Each spoonful presented was observed to be

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002		
(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
1 229	Continued From page 3 completely full (either level or slightly heaping) with pureed food. On April 13, 2012, at 3:54 p.m., review of Resident #2's FP, January 19, 2012, revealed the SLP recommended "1/2 to 1/3 teaspoon per bite." Staff #1 and #2, however were observed presenting spoonfuls (dinner April 10, 2012 or lunch April 12, 2012, respectively) that were greater in size than the amount recommended in the resident's FP. [Note: Resident #2 did not show any signs of distress during the aforementioned mealtime observations.] On April 13, 2012, at 2:30 p.m., the qualified intellectual disabilities professional (QIDP) presented the facility's records of staff in-service training. Immediate review of those records revealed that the registered nurse (RN) had provided training on the residents' dietary needs, health plans and FP's on April 4, 2012. The QIDP stated that she had attended the training and she did not recall the RN discussing the amount of food to place on each spoonful. The QIDP also did not find evidence that the SLP had trained staff on the residents' FP's. 2. [Cross-refer to 1379] On April 10, 2012, interview with the QIDP and review of incident reports, at approximately 9:25 a.m. and 10:25 a.m. respectively, revealed that the GHPID failed to ensure that all incidents that presented a risk to Resident #1's health and well-being were reported immediately and in writing to the Department of Health, Health Regulation and Licensing Administration. Further interview with the QIDP that day, at 3:25 p.m. revealed that she was unaware of the reporting requirements	1 229		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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
--	---------------	---	--------------------

1229 Continued From page 4 stipulated in 22 DCMR § 3519.10.

1229

1379 3519.10 EMERGENCIES

In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.

1379

1379
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Marjul homes will ensure that reporting requirements stated in 3519.5 each GHMRP shall notify the Department of Health, Health Facilities Division on any other unusual incident or event substantially interferes with a resident's health, welfare, living arrangement, well-being or any other way places the resident at risk. Such notification will be made by telephone immediately and shall be followed up by Marjul Homes written notification within twenty four hours of the next working day.
How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Marjul Homes does quarterly Incident Trending and Tracking to identify similar incidents as well as systematic changes and how the incident may have occurred and if this incident could have been avoided.
What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented: QIDDP was retrained re-trained 5/8/12 on the incident reporting protocol to understand that all (GHPID) are responsible for reporting all incidents that take place at the day program. QIDDP is now aware that any incidents that occur with your individuals even if it happens at the day program must be submitted by the QIDDP as this is policy. The QIDDP is responsible for writing the incident, putting the incident in the MCIS system as well as sending this incident to DOH through fax and telephone.

This Statute is not met as evidenced by:
Based on interview and record review, the group home for persons with Intellectual disabilities (GHPID) failed to ensure that all incidents that present a risk to residents' health and well-being were reported immediately and in writing to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the four residents of the GHPID. (Resident #1)

The finding includes:

On April 10, 2012, at approximately 9:25 a.m., the qualified Intellectual disabilities professional (QIDP) stated that Resident #1 had been taken hospital emergency rooms (ER's) on four separate occasions within the past 12 months due to "altered mental status." The QIDP indicated that two of those incidents had occurred while the resident was attending her day program.

Review of unusual incident reports in the facility on April 10, 2012, beginning at 10:21 a.m.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET NE WASHINGTON, DC 20002
--	--

(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
--	---------------	---	--------------------

<p>1379 Continued From page 5</p> <p>confirmed that Resident #1 had been taken to an ER from day program on November 15, 2012 and January 3, 2012. A pre-survey review of incidents reported to the State agency since the previous survey had not shown evidence that the incidents were reported in accordance with this regulation.</p> <p>When the QIDP was interviewed again in the facility on April 10, 2012, at approximately 3:25 p.m., she confirmed that the GHPID had not reported the two aforementioned emergency incidents to DOH/HRLA. She stated that it was her understanding that the day program was responsible for reporting them to DOH/HRLA.</p>	1379		
--	------	--	--