

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G221 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br>04/29/2009 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MARJUL HOMES |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1639 ROXANNA ROAD, NW<br>WASHINGTON, DC 20012   |                      |  |
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| W 000  | <p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from 4/27/09 to 4/29/09. A random sampling of three clients were selected from a population of five individuals with varying degrees of disabilities.</p> <p>This survey was initiated utilizing the fundamental process; however, due to concerns in the areas of active treatment, the process was extended to review the facility's level of compliance in the Conditions of Participation (CoP) for Active Treatment.</p> <p>The findings of this survey were based on observations at the group home and one day program, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.</p> | W 000  | <p><i>Received 5/29/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA<br/>DEPARTMENT OF HEALTH<br/>HEALTH REGULATION ADMINISTRATION<br/>825 NORTH CAPITOL ST., N.E., 2ND FLOOR<br/>WASHINGTON, D.C. 20002</p> |                      |  |
| W 153  | <p><b>483.420(d)(2) STAFF TREATMENT OF CLIENTS</b></p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on staff interview and record review, the facility failed to ensure the timely notification of an injury of unknown origin in accordance with District policies for one of three sampled clients.<br/>[Client #2]</p> <p>The finding includes:</p>   | W 153  |  |                      |  |

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 153  | <p>Continued From page 1</p> <p>The facility failed to ensure that all injuries of unknown origin are reported to the department of health as required by the District of Columbia law (Title 22 Chapter 35; 3519.10) as identified below:</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP), the Licensed Practical Nurse (LPN) Supervisor and record review on 4/28/09 at 2:29 PM, revealed an Unusual Incident Report (UIR) dated 4/26/09, detailed Client #2 was injured and had a bruise on her head. As documented on the UIR, "upon arriving to work, I was informed by the nurse [Client #2] has a bruise on her forehead from a fall that occurred the prior evening."</p> <p>Further interview with the QMRP and the LPN Supervisor revealed neither of the two was able to explain which staff informed the nurse of the injury on the morning of 4/26/2009. In addition, it was not clear if anyone actually witnessed the incident first hand.</p> <p>Review of the nursing progress notes dated 4/26/09 at 7:30 AM, revealed the following entry was made, this "writer was notified by staff that she noted a bruise on the client's forehead while giving her a shower that morning." The progress note did not indicate which staff reported the injury.</p> <p>Further interview with the QMRP revealed he was not aware that the information in the incident report was the result of an unknown third party and as such, it was not reported to the department of health.</p> | W 153  | <p>All staff at the home has been in serviced on incident reporting.</p> <p>This incident has been investigated and a copy of the investigation has been sent to DDS incident management unit.</p> <p>Nursing staff will receive training on documentation and Incident reporting.</p> | <p>5-04-09</p> <p>4-29-09</p> <p>5-31-09</p> |  |
| W 154  | 483.420(d)(3) STAFF TREATMENT OF CLIENTS  | W 154  |  |  |  |

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| W 154  | <p>Continued From page 2</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on staff interview and record review, the facility failed to ensure the investigation of an injury of unknown origin for one of three sampled clients. [Client #2]</p> <p>The finding includes:</p> <p>The facility failed to ensure the investigation of all injuries of unknown origin as identified below:</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP), the Licensed Practical Nurse (LPN) Supervisor and the review of the incident reports on 4/28/09 at 2:29 PM, revealed an Unusual Incident Report (UIR) was filed on 4/26/09 which detailed Client #2 was injured and had a bruise on her head. As documented on the UIR, "upon arriving to work, I was informed by the nurse [Client #2] has a bruise on her forehead from a fall that occurred the prior evening."</p> <p>Review of the nursing progress notes revealed on 4/26/09 at 7:30 AM, the following entry was made, this "writer was notified by staff that she noted a bruise on client 's forehead while giving her a shower that morning."</p> <p>Further interview and record review with the aid of the QMRP and the LPN Supervisor on the same day at approximately 2:40 pm revealed the following discrepancies:</p> <p>1. The staff who notified the nurse of the injury</p> | W 154  |   |                      |  |

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| W 154  | Continued From page 3<br>on the morning 4/26/2009 did not write an incident report and the identity of that staff was unknown at the time of survey.<br><br>2. The nurse who received notice of the injury from the staff on the morning of 4/26/2009 did not write an incident report and she did not identify which staff she received the information from.<br><br>3. The staff who actually wrote the incident report on 4/26/2009 referenced the injury took place on 4/25/09, but there was no nursing note for that date to shed any light on when the injury may have actually taken place.<br><br>4. No staff who worked on 4/25/09 produced an incident report regarding the injury.<br><br>In light of these discrepancies, it was not clear when Client #2 actually sustained her injury. Additionally, it was not clear if there were any staff present at the time of the injury who may have witnessed the incident first hand. | W 154  | 1. All home staff was retrained on reporting incidents.<br><br>2. Nursing staff will receive training on incident reporting<br><br>3. Nursing staff will receive training on documentation<br><br>4. The incident has been investigated by this writer and witness statements from the two prior shifts are included in the investigation | 5-4-09<br><br>5-31-09<br><br>5-31-09<br><br>4-30-09 |
| W 159  | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br><br>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for seven of seven of the clients residing in the facility. [Clients #1, #2, #3, #4, #5, #6 and #7]  | W 159  | There is an inaccuracy on the reporting from this standard being as though, there are only five persons residing in this home.  |   |

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| W 159  | Continued From page 4<br><br>The finding includes:<br><br>1. The QMRP failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). [See W153]<br><br>2. The QMRP failed to ensure the investigation of an injury of unknown origin for one of three sampled clients. [See W154]<br><br>3. The QMRP failed to ensure objectives documented in the Individual Program Plan (IPP) were stated separately, in terms of a single behavioral outcome for two of the three sampled clients. [See W229]<br><br>4. The QMRP failed to ensure that consistent data collection was maintained to accurately assess a client's performance towards the targeted IPP objective for one of the three sampled clients. [See W237]<br><br>5. The QMRP failed to ensure the implementation of a client's money management program was implemented for one of the three sampled clients. [See W249]<br><br>6. The QMRP failed to ensure the accurate and consistent documentation of a client's progress for one of three sampled clients. [See W252]<br><br>7. The QMRP failed to ensure clients were housed in a room equipped with a window to the outside for one of three sampled clients. [See W427] | W 159  | 1. The staff was retrained on incident reporting including reporting all incidents directly to DCHRA office.<br><br>2. Incident was investigated within five days of notification of the incident.<br><br>3. Programs were modified after meeting with persons IDT team<br><br>4. Staff have received in service on programs and documentation. QMRP monitors and document on programs monthly.<br><br>5. QMRP monitors programs monthly<br><br>6. Program are filed monthly to assure documents are not misplaced.<br><br>7. The individual chose this room after moving from her prior residence. She has been selected for the money follows the person program and is a moving to a waiver home. | 5-4-09<br><br>4-29-09<br><br>5-1-09<br><br>5-1-09<br><br>5-1-09<br><br>5-1-09<br><br>8-28-09 |

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| W 159  | Continued From page 5   | W 159  | 8. Staff have been in-serviced on the importance of using all egress points as they continue to implement evacuation drills | 5-1-09               |  |
| W 229  | 8. The QMRP failed to hold evacuation drills under varied conditions utilizing all egress points for all clients residing in the facility. [See W441]<br>483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN<br><br>The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure objectives documented in the Individual Program Plan (IPP) were stated separately, in terms of a single behavioral outcome for two of three sampled clients.<br><br>The findings include:<br><br>The facility failed to ensure that programming objectives were written to address a singular behavioral outcome as identified below:<br><br>1. Observation on the evening of 4/27/09 at approximately 5:55 PM, revealed staff was attempting to communicate with Client #1 during dinner by using hand gestures. The staff made hand gestures as he attempted to communicate with the client in order to determine which drink she preferred to have for dinner. On one other occasion the staff was observed to use hand gestures to ask her if she had finished eating.<br><br>Record review and interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/29/09 at 10:41 AM, revealed Client #1 was currently working on a programmatic | W 229  |   | 6-15-09              |  |

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| W 229  | <p>Continued From page 6</p> <p>objective to improve her communication skills. Review of Client #1's Speech assessment dated 4/23/08 revealed the following communication program was recommended:</p> <p>GOAL: To improve Functional Communication Skills</p> <p>OBJECTIVE: [Client #1] will be able to use sign language at the appropriate time with model prompts on 3 out of 4+ trials for 3 consecutive months. (Vocabulary: hello, name, work, lunch, lotion, finish(ed), get out of wheelchair, etc.)</p> <p>The programmatic objective identified eight words that Client #1 should be taught during the three month implementation period. Review of the data collection sheets did not specify or offer any guidance on which of the eight words was being used /implemented for any given session. According to the data sheet, Client #1's progress was being tracked/documented by the "prompt level" employed by the staff whenever the program was being implemented (ie, verbal prompt, gestural prompt, etc.). At the time of the survey, there was no way to assess the progress of Client #1's participation with each of the vocabulary targeted and identified for this program objective.</p> <p>2. Interview with the facility's QMRP and record review on 4/29/09 at approximately 10:30 AM, revealed Client #2's Individual Service Plan (ISP) which was held on 5/14/08 recommended the following money management goal:</p> <p>GOAL: Training to improve money management skills</p> | W 229  | <p>2. Person # 2 programs modified after her annual meeting goals are written to be measured separately.</p>    | 5-18-09              |  |

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| W 229  | Continued From page 7<br><br>OBJECTIVE 1: [Client #2] will purchase a diet coke with 1 dollar bill with verbal prompts and verbal cues from direct care staff 100% of the opportunities across 12 consecutive months.<br><br>OBJECTIVE 2: [Client #2] will then be given the opportunity to be able to identify the change received back from this purchase.<br><br>The money management program was written with two separate programmatic objectives and was not written to address a single behavioral measure.<br><br>The facility failed to ensure that all written programs addressed a single behavioral outcome.   | W 229  |   |                      |  |
| W 237  | 483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN<br><br>Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that consistent data collection was maintained to accurately assess a client's performance towards the targeted IPP objective for one of the three sampled clients. [Client #3]<br><br>The finding includes:<br><br>The facility failed to maintain an accurate accounting of a client's programmatic record to ensure a proper assessment could be made on | W 237  |   |                      |  |

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| W 237  | Continued From page 8<br>their level of progress as identified below:<br><br>Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/29/09 at 12:08 PM, revealed the programmatic data prior to 4/2009 for all the clients were filed separately and not in their habilitation records. Review of Client #3's habilitation records on the same day at approximately 12:15 PM, revealed the facility failed to ensure consistent data collection as identified below:<br><br>Client #3 's current Individual Support Plan dated 4/25/08 recommended that a program to " Increase Safety Skills " be implemented. The programmatic plan was as follows:<br><br>GOAL: to have [Client #3] learn safety skills while out in the community.<br><br>OBJECTIVE: [Client #3] will learn and be able to identify when it is safe to cross the crosswalk, by pushing the pedestrian button 80% of the time for 12 consecutive months. [Frequency Mon-Wed] | W 237  | Person # 3 along with all individuals records are documented for progress, accuracy and filed at the end of the month. In the person individual files.<br><br>Staff received training on program documentation | 5-10-09<br><br>5-4-09 |  |
| W 249  | 483.440(d)(1) PROGRAM IMPLEMENTATION<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the  | W 249  |  |                       |  |

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| W 249  | <p>Continued From page 9</p> <p>objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on staff interview and record review, the facility failed to ensure the implementation of a client's money management program for one of the three sampled clients. [Client #2]</p> <p>The findings include:</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) and record review on 4/29/09 at approximately 10:30 AM, revealed Client #2's Individual Service Plan (ISP) dated 5/14/08 recommended the following money management goal:</p> <p>GOAL: Training to improve money management skills</p> <p>OBJECTIVE 1: [Client #2] will purchase a diet coke with 1 dollar bill with verbal prompts and verbal cues from direct care staff 100% of the opportunities across 12 consecutive months.</p> <p>OBJECTIVE 2: [Client #2] will then be given the opportunity to be able to identify the change received back from this purchase.</p> <p>The money management program was inclusive of two separate programmatic objectives. There was no evidence at the time of survey that the second objective written to aid Client #1 in "identifying change" was implemented. There was no data for the "identify change" component in Client #2's file to review. Further interview with</p> | W 249  | <p>Client program documentation has been separated per team to measure making a purchase and receiving change as separate program goals</p> | 5-18-09                                      |

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| W 249  | Continued From page 10<br>the QMRP on 4/28/09 at approximately 10:40 AM, also revealed the "indentify change" component of the money management program was overlooked and that he was not aware of the programmatic recommendation.   | W 249  |   |                      |  |
| W 252  | 483.440(e)(1) PROGRAM DOCUMENTATION<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview and record review the facility failed to accurately and consistently document the client's progress in achieving a programmatic objective for two of three sampled clients. [Clients #2 and #3]<br><br>The findings include:<br><br>1. Observation on the evening of 4/27/09 at approximately 4:15 PM revealed staff escorted Client #2 up the stairs to the bathroom and again back down the stairs and into the rear sun room. Staff was also observed taking an active part in aiding Client #2 up and down the single step leading from the rear sun room into the living room.<br><br>Record review on 4/28/09 at approximately 3:00 PM revealed Client #2's Physical Therapy assessment dated 4/23/08 recommended the following programmatic plan:<br><br>GOAL: to improve her physical fitness. | W 252  |   |                      |  |

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| W 252  | <p>Continued From page 11</p> <p><b>OBJECTIVE:</b> [Client #2] will go up and down a flight of stairs 2/2 trials every hour at 100% of the trials 5 times a week for 6 months.</p> <p>Review of the data collection sheets for this physical fitness program revealed only the months of 3/09 and 4/09 was available for review. Interview with the Qualified Mental Retardation Professional (QMRP) on 4/29/09 at approximately 11:30 AM, revealed the missing data collection sheets dating back to 4/2008 were either missing or misfiled.</p> <p>There was no evidence presented or on file at the time of survey to substantiate that the data for Client #2's physical fitness program was being accurately and consistently documented to ensure a measureable assessment of her performance could be conducted.</p> <p>2. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/29/2009 at 12:08 PM revealed the programmatic data prior to 4/20/09 for all the clients were filed separately and not in their habilitation records. Review of Client #3's habilitation records on the same day at approximately 12:15 PM, revealed the facility failed to ensure consistent data collection as identified below:</p> <p>Client #3's current Individual Support Plan dated 4/25/08 recommended that a program to "Increase Safety Skills" be implemented. The programmatic plan was as follows:</p> <p><b>GOAL:</b> to have [Client #3] learn safety skills while out in the community.</p> | W 252  | <p>Staff received training on documentation all programs.</p> <p>Individual program files are monitored and filed monthly.</p> | 5-18-09              |  |

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| W 252  | Continued From page 12<br>OBJECTIVE: [Client #3] will learn and be able to identify when it is safe to cross the crosswalk, by pushing the pedestrian button 80% of the time for 12 consecutive months. [Frequency Mon-Wed]<br><br>Review of the data collection sheets on 4/28/09 at approximately 12:20 PM, revealed there was no program data on file for the months of 10/2008, 11/2008, and 12/2008. The QMRP rechecked the archived files and was not able to find the missing data sheets. The QMRP further added that he would have to review the filing system for the programmatic records and address the problem.<br><br>There was no evidence presented or on file at the time of survey to substantiate that Client #3's "safety skills" program was being accurately and consistently documented to ensure a measureable assessment of her performance could be conducted. | W 252  | Community safety program was modified to a community inclusion program by IDT team.                             |  |
| W 365  | 483.460(j)(4) DRUG REGIMEN REVIEW<br><br>An individual medication administration record must be maintained for each client.<br><br>This STANDARD is not met as evidenced by: Based on interview with the facility's Licensed Practical Nurse (LPN) and record review, the facility failed to ensure the consistent documentation of all administered medications for one of the three sampled clients. [Client #3]<br><br>The finding includes:<br><br>The facility failed to enact an effective system to ensure the documentation of all administered medications as presented below.   | W 365  |   |  |

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| W 365  | Continued From page 13<br><br>Interview with the facility's supervisory LPN and record review on 4/28/2009 at approximately 1:30 PM revealed Client #3's medication regimen included "Prednisolone Acetate 1% sol ... instill in right eye QID until follow-up in two weeks". Review of Client #3's 4/2009 Medication Administration Record presented the following discrepancies:<br><br>1. 12:00 PM dosage was not recorded on 4/25/09, 4/26/09<br><br>2. 6:00 PM dosage was not recorded on 4/27/09<br><br>3. 12:00 AM dosage was not recorded on 4/25/09, 4/26/09, and 4/27/09.<br><br>In addition, the supervising LPN indicated she interviewed the medication nurse and was informed, the Prednisolone was not administered on 4/27/2009 at 12:00 PM, but was at 5:00 PM. This error indicates the 12:00 PM dosage was also not recorded on 4/27/09. | W 365  | Medication nurse received counseling pertaining to documentation on 5-1-09 follow up in service is scheduled with all nurses | 5-31-09              |  |
| W 427  | 483.470(e)(1)(i) HEATING AND VENTILATION<br><br>Each client bedroom in the facility must have at least one window to the outside.<br><br>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure clients were housed in a room equipped with a window to the outside for one of three sampled clients. [Client #5]<br><br>The finding includes:<br><br>The facility failed to ensure clients are housed in  | W 427  |  |                      |  |

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| W 427  | Continued From page 14<br>rooms that are equipped with an exterior window as presented below:<br><br>Observation on 4/27/2009 at 5:30 PM, revealed Client #5's bedroom was located in a small room on the second floor. Her bedroom has no windows and two entrances/exit points; an exterior door to the outside and an interior door leading into the main hallway on the second floor.<br><br>Interview with the QMRP on the same day/time verified Client #5 was housed in this bedroom. The QMRP further revealed he was not aware a client could not be housed in a room without a window.   | W 427  | Individual has been selected to participate in the DC waiver program through the money follows the person program. This person has privacy issues also and is not a candidate to share a room DDS Service Coordinator along with QMRP will attempt to expedite person move | 8-28-09                                      |
| W 441  | 483.470(i)(1) EVACUATION DRILLS<br><br>The facility must hold evacuation drills under varied conditions.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to hold evacuation drills under varied conditions utilizing all egress points for all clients residing in the facility. [Clients #1, #2, #3, #4, #5]<br><br>The finding includes:<br><br>The facility failed to ensure all egress points were being utilized during fire drills as presented below:<br><br>Interview with the Qualified Mental Retardation Professional (QMRP) and record review on 4/29/2009 at approximately 3:00 PM, revealed the facility failed to ensure all egress points was being used during fire drills. Over the three month period a fire drill records reviewed covering included the months of 1/2009, 2/2009, 3/2009, | W 441  |  |  |

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| W 441  | <p>Continued From page 15</p> <p>the "side door" leading from the kitchen was used once. The front door was used for every other fire drill held. In addition, the second floor egress (located in Client #5 's bedroom) was not recorded as being used at all for the time period reviewed.</p> <p>Interview with the facility's House Manager (HM) and QMRP on 4/29/2009 at approximately 3:15 PM, revealed none of the clients have ever been taken out the facility through the exit door on the second floor and/or out of the sliding glass door in the "rear" of the facility. According to the HM, the sliding glass doors are not used because it is hard to slide open. Further inspection revealed the sliding glass door was indeed difficult to slide open. After the door was inspected, the HM indicated the sliding glass door was going to be replaced and the QMRP concurred with that statement.</p> <p>Note: Despite Client #5 being housed in the same room as the exit door for the second floor, neither the client nor any of her house mates were allowed to use that point of egress during fire drills. [Reference W427]</p> | W 441  | Different egress points will be used when doing monthly evacuation drills                                       | 519-09               |  |

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| 1 000  | INITIAL COMMENTS<br><br>A re-licensure survey was conducted from 4/27/09 to 4/29/09. A random sampling of three residents was selected from a population of five individuals with varying degrees of disabilities.<br><br>The findings of this survey were based on observations at the group home and one day program, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.  | 1 000  |   |  |
| 1 082  | 3503.10 BEDROOMS AND BATHROOMS<br><br>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure all bathrooms were equipped with paper towels and cup dispensers to accommodate the needs of all residents residing in the facility. [Residents #1, #2, #3, #4, and #5]<br><br>The finding includes:<br><br>Observation and interview with the facility's House Manager during the environmental inspection on 4/27/2009 at approximately 5:30 PM revealed, the bathroom on the main floor and the second floor hallway were not equipped with either a cup dispenser or paper towels. | 1 082  | Paper towels and cup dispenser are in the bathroom indicated  | 4-28-09                                      |

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TITLE

(X6) DATE

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

STATE FORM

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If continuation sheet 1 of 10



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| 1090   | Continued From page 2<br>the chandelier in the kitchen were inoperable.<br><br>4. The bulb in the front foyer was inoperable.<br><br>5. The gutters around the home were overflowed with debris (leaves, small branches, etc.).<br><br>6. The back yard and the grounds on the east side of the home were cluttered with old furniture and building equipment (planks of wood, tubing, etc.).  | 1090   | 3. Repaired<br><br>4. Repaired<br><br>5. Completed<br><br>6. Completed  | 4-28-09<br><br>4-28-09<br><br>4-28-09<br><br>4-28-09 |
| 1092   | 3504.3 HOUSEKEEPING<br><br>Each GHMRP shall be free of insects, rodents and vermin.<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure a bug free environment for five of five residents residing in the facility.<br>[Residents #1, #2, #3, #4, and #5]<br><br>The finding includes:<br><br>During the environmental inspection on 4/27/2009 at approximately 5:55pm, a wasp's nest was observed on the exterior vent leading to the kitchen. Additionally, a second wasp's nest was found along the side of the door leading from the basement out to the back yard.<br><br>Interview with the GHMRP's house manager and QMRP on the same day at approximately 5:57pm, revealed the nests should not be there and they would be removed immediately. | 1092   | Completed   | 4-27-09  |

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| I 183  | Continued From page 3  | I 183  |   |  |
| I 183  | 3508.4 ADMINISTRATIVE SUPPORT<br><br>Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning for five of five of the residents residing in the facility. [Residents #1, #2, #3, #4, and #5]<br><br>The findings include:<br><br>1. The QMRP failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). [See Federal Deficiency Report Citation W153 and Licensure Citation 3519.10]<br><br>2. The QMRP failed to ensure the implementation of a resident's money management program for one of the three sampled residents. [See Federal Deficiency Report Citation W249 and Licensure Citation 3521.3] | I 183  | 1. Staff in-serviced on incident reporting including reporting to all regulating agencies.<br><br>2. Program was modified to measure goals separately | 5-4-09<br><br>5-18-09                        |
| I 375  | 3519.6 EMERGENCIES<br><br>Each GHMRP shall document each emergency and enter the follow-up actions into the resident's permanent record, which shall be made available for review by authorized individuals.   | I 375  |   |  |

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| 1375 | <p>Continued From page 4</p> <p>This Statute is not met as evidenced by:<br/>Based on staff interview and record review, the facility failed to ensure the investigation of an injury of unknown origin for one of three sampled clients. [Resident #2]</p> <p>The finding includes:</p> <p>The facility failed to ensure the investigation of all injuries of unknown origin as identified below:</p> <p>Interview with the facility's QMRP and LPN Supervisor and the review of the facility's incident reports on 4/28/09 at 2:29 PM, revealed an Unusual Incident Report (UIR) was filed on 4/26/09 which detailed resident #2 was injured and had a bruise on her head. As documented on the UIR, "upon arriving to work, I was informed by the nurse [resident #2] has a bruise on her forehead from a fall that occurred the prior evening."</p> <p>Review of the nursing progress notes revealed on 4/26/09 at 7:30 AM, the following entry was made, this "writer was notified by staff that she noted a bruise on resident 's forehead while giving her a shower that morning. "</p> <p>Further interview and record review with the aid of the QMRP and the LPN Supervisor on the same day at approximately 2:40 pm revealed the following discrepancies:</p> <ol style="list-style-type: none"> <li>1. The staff who notified the nurse of the injury on the morning 4/26/2009 did not write an incident report and the identity of that staff was unknown at the time of survey.</li> <li>2. The nurse who received the report from the staff on the morning of 4/26/2009 did not write an</li> </ol> | 1375 | <p>This investigation was completed</p> <p>1. staff has been in-serviced on reporting incidents</p> | <p>4-29-09</p> <p>5-4-09</p> |
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| 1422   | Continued From page 8<br><br>Further interview with the QMRP on 4/29/09 at approximately 10:40 AM also revealed the "identifying change" component of the money management program was overlooked and that he was not aware of the programmatic recommendation.  | 1422   |  |  |
| 1474   | 3522.5 MEDICATIONS<br><br>Each GHMRP shall maintain an individual medication administration record for each resident.<br><br>This Statute is not met as evidenced by:<br>Based on interview with the facility's Licensed Practical Nurse (LPN) and record review, the facility failed to ensure the consistent documentation of all administered medications for one of the three sampled residents. [Resident #3]<br><br>The finding includes:<br><br>The facility failed to enact an effective system to ensure the documentation of all administered medications as presented below.<br><br>Interview with the facility's supervisory LPN and record review on 4/28/2009 at approximately 1:30 PM revealed Resident #3's medication regimen included "Prednisolone Acetate 1% sol ... instill in right eye QID until follow-up in two weeks".<br>Review of Resident #3's 4/2009 Medication Administration Record presented the following discrepancies:<br><br>1. 12:00 PM dosage was not recorded on 4/25/09, 4/26/09<br><br>2. 6:00 PM dosage was not recorded on 4/27/09 | 1474   | Medication nurse received counseling pertaining to documentation on 5-1-09 follow up in service is scheduled with all nurses | 5-31-09                                      |

Health Regulation Administration

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|--|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MARJUL HOMES |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1639 ROXANNA ROAD, NW<br>WASHINGTON, DC 20012 |   |  |
| (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                           |
| 1474   | Continued From page 9<br><br>3. 12:00 AM dosage was not recorded on 4/25/09, 4/26/09, and 4/27/09.<br><br>In addition, the supervising LPN indicated she interviewed the medication nurse and was informed, the Prednisolone was not administered on 4/27/2009 at 12:00 PM, but was 5:00 PM. This error indicates the 12:00 PM dosage was also not recorded on 4/27/09. | 1474   |   |  |

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| 1375   | Continued From page 5<br>Incident report and she did not identify which staff she received the information from.<br><br>3. The staff who actually wrote the report on 4/26/2009 referenced the injury took place on 4/25/09, but there was no nursing note for that date to shed any light on when the injury may have taken place.<br><br>4. No staff who worked on 4/25/09 produced an incident report regarding the injury.<br><br>In light of these discrepancies, it was not clear when Resident #2 actually sustained her injury. Additionally, it was not clear if there were any staff present at the time of the injury who may have witnessed the incident first hand.  | 1375   | 2. Medication nurse received in-service on incident reporting<br><br>3. Nurses receive in service on documentation<br><br>4. staff has been in-serviced on reporting incidents | 5-31-09<br><br>5-31-09<br><br>5-4-09         |
| 1379   | 3519.10 EMERGENCIES<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure the timely notification of an injury of unknown origin in accordance with District policies for one of three sampled clients. [Resident #2] | 1379   |  |  |

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| I 379  | <p>Continued From page 6</p> <p>The finding includes:</p> <p>The facility failed to ensure that all injuries of unknown origin are reported to the Department of Health as required by the District of Columbia law (Title 22 Chapter 35; 3519.10) as identified below:</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP), the Licensed Practical Nurse (LPN) Supervisor and record review on 4/28/09 at 2:29 PM, revealed an Unusual Incident Report (UIR) dated 4/26/09, detailed Resident #2 was injured and had a bruise on her head. As documented on the UIR, "upon arriving to work, I was informed by the nurse [Resident #2] has a bruise on her forehead from a fall that occurred the prior evening."</p> <p>Further interview with the QMRP and the LPN Supervisor neither was not able to explain which staff informed the nurse of the injury on the morning of 4/26/2009. In addition, it was not clear if anyone actually witnessed the incident first hand.</p> <p>Review of the nursing progress notes dated 4/26/09 at 7:30 AM, revealed the following entry was made, this "writer was notified by staff that she noted a bruise the on client's forehead while giving her a shower that morning." The progress note did not indicate which staff completed the incident reported for the injury.</p> <p>Further interview with the QMRP revealed he was not made aware that the information in the incident report was the result of an unknown third party and as such, it was not reported to the department of health.</p> | I 379  | <p>Staff received in service on reporting incidents this training also included who to inform and what reporting agency to report incidents. This included the reporting to DCHRA all incidents within 24hrs</p> | 5-4-09                                       |

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| I 422   | Continued From page 7  | I 422  |   |   |
| I 422   | <p><b>3521.3 HABILITATION AND TRAINING</b></p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by:<br/>Based on observation, staff interview and record review, the facility failed to ensure the implementation of a resident's money management program for one of the three sampled residents. [Resident #2]</p> <p>The findings include:</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) and record review on 4/29/09 at approximately 10:30 AM revealed Resident #2's 5/14/08 Individual Service Plan (ISP) recommended the following money management goal:</p> <p><b>GOAL:</b> Training to improve money management skills</p> <p><b>OBJECTIVE 1:</b> [Client #2] will purchase a diet coke with 1 dollar bill with verbal prompts and verbal cues from direct care staff 100% of the opportunities across 12 consecutive months.</p> <p><b>OBJECTIVE 2:</b> [Client #2] will then be given the opportunity to be able to identify the change received back from this purchase.</p> <p>The money management program was inclusive of two separate programmatic objectives. There was no evidence at the time of survey that the second objective written to aid Resident #2 in "identifying change" was implemented.</p> | I 422  | <p>Person # 2 money management goal has been modified to measure making a purchase and counting change as separate goals.</p> | 5-18-09   |