

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

PRINTED: 03/02/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2010
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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 6634 EASTERN AVENUE, NW WASHINGTON, DC 20012
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(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
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W 000	INITIAL COMMENTS A recertification survey was conducted from January 25, 2010 through January 28, 2010. A sample of two clients was selected from a population of four women with varying degrees of intellectual disabilities. In addition, a focused review was conducted of another (third) client's mealtime adaptive equipment needs and adaptive living skills assessment. This survey was initiated utilizing the fundamental process; however, due to concerns in the areas of active treatment, the process was extended on January 28, 2010, at 11:40 a.m., to review the facility's level of compliance in the Condition of Participation (CoP) for Active Treatment.	W 000	Received 3/28/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 124	463.420(a)(2) PROTECTION OF CLIENTS RIGHTS The findings of the survey were based on observations, interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports. The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure legal guardians and surrogate decision-makers were informed of the risks and benefits of restrictive programs and supports.	W 124	QMRP/Nurse will ensure that all parents/guardians and healthcare decision makers are informed of risks and benefits of all restrictive procedures to include psychotropic medications as they are ordered by the physician. Evidence of this will be maintained in the individual's medical/clinical records. QMRP/Nurse will ensure that documented evidence are maintained in individual records of benefits and risks for all restrictive measures being explained to parents/guardians and healthcare decision makers via quarterly reviews of charts, to be conducted by QMRP/Director of Operations. QMRP/Director of Operations will document in individual record when review is completed on a quarterly basis.	3/1/10

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kydia G. Gorman</i>	TITLE Director of Operations	(X6) DATE 3.17.10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	<p>Continued From page 1</p> <p>including psychotropic medications, for one of the two clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>On January 25, 2010, at approximately 8:25 a.m., Client #2 was administered Gabapentin (Neurontin) 600 mg, Clonazepam (Klonopin) 1 mg and Chlorpromazine HCL (Thorazine) 200 mg. At approximately 11:50 a.m., the qualified mental retardation professional (QMRP) indicated that Client #2's psychotropic medications were incorporated in her behavior support plan (BSP). She further stated that the client's mother was her designated surrogate health care decision-maker.</p> <p>On January 26, 2010, at 9:53 a.m., review of Client #2's Psychological Assessment, dated September 1, 2009, revealed that the client was not competent to make health care decisions. Her Individual Support Plan (ISP), dated October 15, 2009, confirmed that her mother was the designated health care decision-maker. Further review of Client #2's record on January 28, 2010, beginning at 9:03 a.m. failed to show evidence that the mother had been fully informed of the client's mental health status and the risks and benefits associated with the use of Gabapentin. Her mother had not signed the attendance sheet for her ISP meeting and there was no written consent form for the use of Gabapentin observed in her record.</p> <p>On January 28, 2010, at 9:17 a.m., the QMRP confirmed that the mother had not attended the October 15, 2009, ISP meeting. The QMRP indicated that the consulting psychologist had reviewed Client #2's medication regimen and BSP with the mother in years past. Moments later, the</p>	W 124		

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W 124	Continued From page 2 QMRP acknowledged that the facility had not documented said review(s) in the client's record. There was no evidence that the risks and benefits associated with all restrictive programs and supports, including psychotropic medications, were fully explained to Client #2's mother.	W 124		
W 125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to encourage individual clients to exercise their rights as clients of the facility, including filing complaints and due process, for one of the two clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>On January 26, 2010, at 1:05 p.m., review of an internal investigation report dated January 29, 2009, revealed that on January 24, 2009, at 8:05 p.m., staff discovered that Client #2 had left the facility without informing anyone. The investigative findings indicated that at 8:05 a.m. earlier that day, Client #2 had asked staff to call the police to report that money was missing from her room. Staff on that (8:00 a.m. - 4:00 p.m.) shift reportedly calmed her down. Following a shift change, the client asked the evening staff (4:00 p.m. - 12:00 a.m.) to call the police because her money was missing. The evening staff</p>	W 125	<p>QMRP has been in-serviced on conducting thorough, expedient investigations of all incidents whereby the individual's health, safety, and welfare have been compromised or any rights violation has occurred.</p> <p>Investigations include theft of funds (Client #2's funds were returned to her by provider administrator). QMRP will ensure that all individuals are able to exercise their rights and will encourage them to do so via training on their rights and who to report any violation of their rights to, at least bi-annually, and as needed. Documented evidence of individual training will be maintained in the individual's record and such trainings will occur every six months during ISP & semi-annual reviews (more often when the need arises). During quarterly review of individual records, QMRP/Director of Operations will ensure this is being done consistently and document evidence of such review.</p>	3/1/10

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W 125	<p>Continued From page 3</p> <p>reportedly calmed her down. She then left the facility alone, without telling anyone, and staff initiated the incident reporting process.</p> <p>Continued review of the investigation report revealed that after the client was brought home from the police station, facility staff had examined the client's personal funds and found that \$2.71 (out of \$10 cash) could not be accounted for. They determined that the missing money was "a contributing factor to <client's name> leaving the house ..." The investigation report reflected interviews with the evening shift; however, there was no evidence that staff on the morning shift had been interviewed. In addition, there was no evidence that the issue of Client #2's missing money had been resolved.</p> <p>On January 26, 2010, at 1:50 p.m., interview with the QMRP (who had conducted the investigation) revealed that she did not recall interviewing staff who were on duty at 8:05 a.m., when the client first reported that money was missing. The QMRP acknowledged that she did not know how staff had responded to the client's complaint. She stated that she had focused the investigation on the evening "elopement." She confirmed that staff had only contacted the house manager after the client was discovered missing from the facility that evening. When asked, the QMRP said the morning staff should have notified the house manager of Client #2's request for police assistance, and should have prepared an incident report regarding the missing funds. The QMRP indicated that she could not recall whether the missing \$2.71 had been further investigated and/or if the money was ever found or reimbursed.</p>	W 125			

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W 125	Continued From page 4	W 125		
W 130	There was no evidence that Client #2's due process rights had been ensured. 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that the clients' right to privacy during medication administration was protected, for one of the four clients residing in the facility. (Client #1) The finding includes: During the morning medication pass on January 25, 2010, at 8:40 a.m., the nurse brought Client #1's medications upstairs to the living room instead of having the client come to the basement. She administered Client #1's medications to her, while Clients #2 and #4 stood to her side. Client #3 and several staff also watched the process from a few feet away.	W 130	LPN Coordinator has counseled/re-in serviced Medication Pass Nurses on providing individuals with privacy during medication administration. LPN Coordinator/QMRP will ensure that privacy policy is consistently being implemented via a checklist for Medication Nurses which will indicate that privacy be given for all individuals when administering medications.	3/1/10
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop and/or ensure that staff consistently implemented policies developed to protect client health and safety, for four of the four	W 149		

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W 149	<p>Continued From page 5</p> <p>residents of the facility. (Clients #1, #2, #3 and #4)</p> <p>1. Cross-refer to W125. Based on interview and record review, facility staff failed to report timely a January 24, 2009, allegation by Client #2 that some of her money was missing from her bedroom. Progress notes in the client's record indicated that she first reported the missing money to morning staff, at 8:05 a.m. The client repeated her allegation later, after the 4:00 p.m. staff arrived for the evening shift. However, her allegation that money was taken from her bedroom was not reported until later. It only became an issue after the facility began investigating Client #2's departure from the home that evening without informing staff. On January 26, 2010, at approximately 1:55 p.m., the QMRP stated that the allegation of missing funds (the client had asked to call the police) should have been reported immediately to the house manager and an incident report generated, in accordance with facility policies. There was no evidence, however, that an incident report (specific to the allegation of missing money) had been completed by staff, or that the client's complaint of theft was reported to the administrator timely.</p> <p>2. Cross-refer to W153.1. On January 25, 2010, staff failed to prepare an incident report after they witnessed peer on peer abuse, in accordance with the incident management policy.</p> <p>3. Cross-refer to W369.2. On January 26, 2010, Clients #1, #2, #3 and #4 received their morning medications anywhere from 80 - 115 minutes later than the 7:00 a.m. designated administration time. On January 26, 2010, at approximately 8:25 a.m., interview with the house manager and</p>	W 149	<ol style="list-style-type: none"> 1. See W125: Staff in-serviced on Abuse, Neglect, Mistreatment Policy and Incident Management Policy to include timely reporting of incidents and Client Rights. (Funds returned to Client #2) 2. See W153.1: Incident report was generated for individual to individual abuse observed on January 25, 2010. All staff trained on incident reporting policy to include timely reporting and making immediate notification to supervisor and provider administrator. 3. See W369.2: Late Medication Administration Policy implemented. Nursing staff trained on policy to include documenting arrival times (nurses will utilize time-clock that provides electronic signature of arrival to facility); informing MD/RN Supervisor of late medication pass; and writing incident report for medication error. LPN Coordinator will conduct reviews of Time Reports issued to management on a bi-weekly basis to ensure Medication Nurses are utilizing the time-clock system and administering medications on time. 	<p>2/4/10 1/28/10</p>

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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES				STREET ADDRESS, CITY, STATE, ZIP CODE 6834 EASTERN AVENUE, NW WASHINGTON, DC 20012			
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W 149	Continued From page 6 LPN Coordinator revealed that nurses were expected to administer medications within the two-hour period of 8:00 a.m. - 8:00 a.m. However, further interview revealed that nurses were not required to document their arrival times. The house manager and LPN Coordinator could not locate an applicable written policy. They further acknowledged that there was no system in place for determining whether there were similar medication administration timing errors and/or the frequency of said errors.	W 149					
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. This STANDARD is not met as evidenced by: Based on observation, interview and review of incident reports and investigations, the facility failed to ensure that all allegations of abuse or neglect (medical) and injuries of unknown origin were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA), for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. On January 25, 2010, at 8:55 a.m., Client #1 hit Client #2 on her left arm while they were seated next to one another on the living room sofa. A direct support staff was passing by at the time.	W 153	1. Incident report was generated for individual to individual abuse observed on January 25, 2010. All staff trained on incident reporting policy to include timely reporting and making immediate notification to supervisor and provider administrator.	1/28/10			

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W 153	<p>Continued From page 7</p> <p>The staff instructed Client #1 to keep her hands to herself. She then examined Client #2's arm (minor reddish hue) and then escorted Client #1 to her bedroom. On January 28, 2010, at 11:52 a.m., review of the facility's incident management policy revealed a definition of physical abuse that includes "physical contact with, or handling of, an individual with more force than reasonable necessary ... slapping, hitting ..." At 11:59, the qualified mental retardation professional (QMRP) stated that she and the designated administrator were previously unaware that Client #2 had been hit by her peer. She further indicated that the staff who observed the incident should have completed an incident report.</p> <p>2. Cross-refer to W369.2. On January 25, 2010, Clients #1, #2, #3 and #4 received their morning medications anywhere from 80 - 115 minutes later than the 7:00 a.m. designated administration time. This timing error was brought to the attention of the LPN Coordinator and the house manager on the next morning (January 26, 2010). On January 28, 2010, at 11:52 a.m., review of the facility's incident management policy revealed that medication errors, including administering medications at the wrong time, should be reported on an incident report. At 11:58 a.m., the QMRP stated that there was no incident report generated for the January 25, 2010 medication (timing) error.</p> <p>3. Cross-refer to W154. According to an incident report, staff discovered a scratch on the right side of Client #1's face on July 15, 2009. The scratch was approximately 1 1/2 inches in length and no cause of the injury was indicated. Further review of the incident report, and its corresponding investigation report, failed to show evidence that</p>	W 153	<p>2. See W369.2: Late Medication Administration Policy implemented. Nursing staff trained on policy to include documenting arrival times (nurses will utilize time-clock that provides electronic signature of arrival to facility); informing MD/RN Supervisor of late medication pass; and writing incident report for medication error.</p> <p>3. See W154: QMRP in-serviced/trained on thoroughly investigating incidents to include interviewing all potential witnesses to the incident (in particular for incidents where individual sustains injury of unknown origin) to ensure individual protection from harm and prevention of potential for incident recurrence. QMRPs/Investigators will report all incidents to Provider Administrator and HRLA immediately upon notification of an incident occurring per MarJul Homes, Inc. Incident management Policy. Verbal notification will be made to Administrator and HRLA by QMRP/Investigator immediately with written report to follow within 24 hours.</p>	2/1/10 3/1/10

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W 153	Continued From page 8 the facility's designated administrator had been notified. On January 25, 2010, at approximately 12:30 p.m., the QMRP acknowledged that immediate notification of their designated administrator could not be verified.	W 153			
W 154	489.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries of unknown origin, for one of the four clients residing in the facility. (Client #1) The findings include: According to an incident report, staff discovered a scratch on the right side of Client #1's face on July 15, 2009, at 8:60 a.m. The scratch was approximately 1 ½ inches in length. Client #1 was non-verbal. The incident report did not indicate a cause of the injury. On January 25, 2010, at approximately 10:59 a.m., review of the corresponding investigation report revealed no indication that staff or other clients (all three of whom were verbal) were interviewed as part of the investigation. The investigation report did, however, indicate that the scratch had been deemed self-inflicted. The qualified mental retardation professional (QMRP), who conducted the investigation, was interviewed later that day, beginning at 12:10 p.m. She stated that the facility's policy required that all injuries of unknown origin must be investigated.	W 154	QMRP in-serviced/trained on thoroughly investigating incidents to include interviewing all potential witnesses to the incident (in particular for incidents where individual sustains injury of unknown origin) to ensure individual protection from harm and prevention of potential for incident recurrence.	3/1/10	

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W 154	Continued From page 9 At 12:23 p.m., she confirmed that she had not conducted interviews, saying that it was "because of where it was ... it looked self-inflicted ... her nails were long ... just seemed logical." When asked if the client was known to scratch herself, she replied "I think that was the first time."	W 154			
W 190	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure training to enable each staff to effectively demonstrate competency toward the specific developmental needs of one of two clients in the sample. (Client #1) The findings include: Facility staff failed to encourage Client #1 to perform routine activities of daily living to the extent of her assessed abilities, as follows: 1. On January 25, 2010, at 7:18 a.m., a direct support staff person (S13) held a cup of milk to Client #1's lips while the client ate her breakfast. The cup was double handled. At the time, the client was holding a spoon with a built-up handle with her left hand and was feeding herself independently. At approximately 7:20 a.m., S13 again held the cup of milk to the client's lips and she drank more. However, at approximately 7:23 a.m., Client #1 was observed holding a double handled cup in her right hand. She drank coffee from the double handled cup independently.	W 190	1-3: QMRP will ensure that all staff are trained on each Individual Program Plan (IPP) to include goals and objectives and encouraging individuals to participate independently in all areas of training/ADL skills. Staff training to include each individual's right to participate in ADLs independently when they are able to do so.	3/1/10	

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W 190	<p>Continued From page 10</p> <p>2. After Client #1 finished her breakfast on January 25, 2010, S13 carried the client's plate and table setting to the kitchen and placed them in the sink. At the same time, Client #1 walked to the living room and sat down on the sofa. Interview with the client's day program staff the next day, at 11:08 a.m., revealed that the client routinely carried her dirty lunch plates to a sink and washed them herself.</p> <p>3. On January 25, 2010, at 8:43 a.m., the medication nurse was observed using a regular metal teaspoon to administer Client #1's medications. She had crushed the medications and mixed them with apple sauce. The nurse held the spoon as she fed the client the mixture. Earlier that morning, at 7:18 a.m., the client had been observed feeding herself breakfast independently, using a built-up handled spoon. At 9:04 a.m., interview with the medication nurse and the LPN Coordinator revealed that they both thought Client #1 would likely participate with the medication administration pass, using her specialized spoon. The nurses further indicated that, prior to that date, the client had not been asked to spoon the medications herself.</p> <p>On January 27, 2010, beginning at 4:02 p.m., review of staff in-service training records revealed no evidence that S13, who worked the overnight shift (12:00 a.m. - 8:00 a.m.) had received training on Client #1's training and support needs.</p> <p>On January 28, 2010, at approximately 10:17 a.m., review of Client #1's individual support plan (ISP), dated March 8, 2009, confirmed that the client could feed herself with a built-up handled spoon and drink independently from a</p>	W 190		

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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES				STREET ADDRESS, CITY, STATE, ZIP CODE 6634 EASTERN AVENUE, NW WASHINGTON, DC 20012			
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W 190	Continued From page 11 doubled-handed cup. When interviewed at 11:45 a.m., the qualified mental retardation professional could not verify that S13 had received in-service training on Client #1's habilitation and support needs. Staff S13 reportedly began working in the facility in March 2009.	W 190					
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to re-evaluate clients' behavior management needs (specifically, repeated removals and reapplication of shoes and socks), for one of the two clients in the sample. (Client #1) The finding includes: On January 25, 2010, at 6:41 a.m., Client #1 was observed seated on the living room sofa. At the time, she was not engaged in a meaningful activity. She removed her shoes and socks then put them back on (without prompting from staff). Moments later, she repeated the behavior. One of her peers (Client #2), who was in the living room at the time, stated that Client #1 removed her shoes and socks frequently. At 7:01 a.m., Client #1 removed her shoes and socks again. At 7:12 a.m., she was observed seated on the sofa with both of her shoes and socks removed. At 7:45 a.m., she was observed alone in her bedroom. She was barefoot and looking in her dresser drawer. A moment later, she put on a pair of socks and shoes and left her bedroom.	W 214	QMRP will ensure that Psychologist reviews all BSPs (to include Client #1; addressing removing shoes through BSP and adding that as target behavior) to review all behavioral needs and ensure these needs are being addressed in the BSP. Staff to be re-trained on BSP revisions and documenting behaviors to ensure QMRP/Psychologist aware of all potential behavioral management needs.	3/1/10			

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W 214	<p>Continued From page 12</p> <p>Her attention was focused almost exclusively on her shoes and socks from 6:41 a.m. until she was called to the breakfast table at 7:12 a.m.</p> <p>Similar observations were made later that afternoon. At 4:10 p.m., Client #1 was observed seated next to her assigned 1:1 staff at the dining room table. The client fumbled with her shoes and socks for approximately two minutes before actually removing them, while seated. She put them back on immediately. At 4:30 p.m., the client got up from the table, walked through the facility with her 1:1 staff then sat back down at the dining room table and promptly removed her shoes and socks. She put them back on a moment later. The client ignored her 1:1 staff's verbal prompting to engage in table top activities. At 4:57 p.m., the client had her shoes and socks off while seated in her bedroom. At 4:59 p.m., her 1:1 staff asked her to put them back on; the client did so after she returned to the dining room table. For the next 22 minutes, Client #1 continually focused her attention on her shoes and socks, while largely ignoring her 1:1 staff's suggestions of various activities at the table. Her 1:1 staff indicated that this was not unusual behavior for Client #1.</p> <p>On January 27, 2010, beginning at 3:32 p.m., review of Client #1's behavior support plan (BSP), dated February 1, 2009, revealed that it did not address her repeatedly taking off her shoes and socks. At approximately 4:35 p.m., interview with the qualified mental retardation professional (QMRP) revealed that in the past, the client's BSP had addressed disrobing, including her shoes and socks. The QMRP said the client "stopped doing that pretty much ... the occurrences dropped ... She doesn't do it that much anymore." She</p>	W 214		

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W 214	Continued From page 13 further indicated that staff were not expected to document the shoe/sock removal behavior and the psychologist would probably request baseline data collection if this or other past behaviors re-emerged. There was no evidence that the facility reassessed Client #1's shoe and sock-removal behavior.	W 214			
W 223	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include social development. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to evaluate clients' sexuality needs, for two of the four clients residing in the facility. (Clients #2 and #4) The findings include: On January 25, 2010, at approximately 3:30 p.m., Client #2 stated that she had a "boyfriend" who attends the same day program. A direct support staff person seated with her confirmed the statement. When asked what they enjoyed doing together, Client #2 stated that although she would like to go out with him, they had not yet had a first date. The staff person indicated that the facility was in the preliminary planning stage. Client #4 (not in the sample), who was seated next to Client #2 at the time, stated that she too had a "boyfriend." Client #2's records were reviewed on January 28, 2010, beginning at 9:37 a.m. There was no evidence that she had received a sexuality assessment and/or that her interdisciplinary team had discussed her interest in dating. On January	W 223	QMRP has revised Client #2's Comprehensive Functional Assessment and updated it to reflect her pleasure in being in and having a relationship. Further Client #2's interest in having a relationship will be communicated to clinicians at IDT Meeting to review need for sexuality training to ensure she is educated on all her options related to having a relationship. Review of all individuals' functional assessment will be conducted to ensure all areas of need are addressed comprehensively and training goals are provided for these needs.	3/1/10	

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W 223	<p>Continued From page 14</p> <p>28, 2010, at approximately 1:05 p.m., interview with the qualified mental retardation professional and the LPN Coordinator confirmed that to date, Client #2 had not received a sexuality assessment. [Note: They also indicated that Client #4's sexuality needs had not been assessed.]</p> <p>It should be noted that Client #2 was observed receiving Cryselle 0.3-0.03 mg, one tablet, on January 26, 2010, at 8:22 a.m. The nurse stated that the medication was prescribed for birth control. It should be further noted that her Annual Physical/Medical Evaluation, dated October 13, 2009, indicated that she was "not sexually active."</p>	W 223		
W 224	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to evaluate clients' independent living skills (specifically, using eating utensils), for one of the four clients residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>On January 26, 2010, at approximately 6:00 p.m., a direct support staff person cut Client #4's turkey cutlet into bite size pieces before presenting it to the client. A short time later, staff used a knife to cut the client's canned peaches into bite size pieces. At 6:18 p.m., interview with the qualified mental retardation professional (QMRP) revealed</p>	W 224	<p>QMRP will ensure Nutritionist and/or SLP review the needs of each individual related to use of adaptive eating equipment and food textures (for Client #4, reviewing her need for bite-sized food texture) and make revisions if recommended.</p>	3/10/10

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W 224	<p>Continued From page 15</p> <p>that Client #4's foods were cut bite size because a former nutritionist had recommended it in years past. The QMRP referred to it as "a carryover" precaution to address fast eating pace. The client, however, had not been observed eating quickly at either breakfast or at dinner that day.</p> <p>Client #4's nutrition records were reviewed the next morning, beginning at 9:10 a.m. Her annual Nutrition Assessment, dated December 1, 2009, indicated that she "tolerates her food cut into bite sized pieces." The assessment did not, however, refer to any concerns regarding eating pace, or otherwise indicate the rationale for the specialized dietary texture. Client #4's Individual Support Plan (ISP), dated January 14, 2009, indicated that she was an "independent self-feeder and chews and swallows her food adequately. She is on ... bite size <sic> pieces diet ... does not require a dining plan, physical or nutritional management."</p> <p>On January 27, 2010, at 1:42 p.m., interview with the QMRP and LPN Coordinator revealed that Client #4's interdisciplinary team had met on January 14, 2010 to review and update her annual plan. The issue of bite size texture reportedly had not been discussed by the team. When asked if the client's ability to use a knife had been assessed, they replied "no." They both acknowledged that her eating pace was no longer a concern and upon further discussion, they both indicated that the client might be willing and able to learn how to cut her own foods with a knife.</p>	W 224		
W 251	<p>483.440(d)(3) PROGRAM IMPLEMENTATION</p> <p>Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with</p>	W 251		

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W 251	<p>Continued From page 16</p> <p>the client, including professional, paraprofessional and nonprofessional staff.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all staff provided needed interventions or reinforced acquired skills in accordance with the individual support plan (ISP), for one of the two clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>1. On January 25, 2010, at 6:41 a.m., there were two direct support staff persons on duty. Client #1 was observed seated on the living room sofa, not engaged in a meaningful activity. Client #2 sat nearby. One staff was preparing breakfast in the kitchen while the other staff (S13) was assisting clients elsewhere in the facility. For the next 14 minutes (until 6:55 a.m.), neither staff spoke with Client #1 or engaged her in formal or informal active treatment activities. The client repeatedly removed her shoes and socks then put them back on while seated on the sofa.</p> <p>2. At 6:55 a.m., Client #1 hit Client #2 on her left arm while they were seated on the living room sofa. The direct support staff (S13) who had been assisting other clients in their bedrooms moments earlier was walking through the living room at that time. When S13 observed the incident, she instructed Client #1 to keep her hands to herself. She then examined Client #2's arm (minor reddish hue) and then escorted Client #1 to her bedroom. S13 interacted with Client #1 for six minutes.</p>	W 251	<p>1. QMRP will ensure that each individual's staffing needs are met to ensure adequate active treatment is provided for individuals. (Client #1 has been assigned 1:1 staff person.)</p> <p>2. QMRP will ensure adequate staffing is in place for all individuals to include 1:1 staffing where assigned to ensure staff support for protection from harm and engaging/exhibiting target behaviors. (Client #1 has 1:1 staff for designated hours to prevent her from hitting herself or others.)</p>	<p>2/1/10</p> <p>2/1/10</p>	

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W 251	<p>Continued From page 17</p> <p>3. At 7:01 a.m., the staff person brought Client #1 back to the living room sofa and then left the room. The client sat on the sofa from 7:01 a.m. - 7:12 a.m., not engaged in formal or informal active treatment activities and without staff interaction.</p> <p>4. Cross-refer to W190. During breakfast, between 7:12 a.m. - 7:24 a.m., S13 failed to encourage Client #1 to independently use her double handed cup as prescribed. Instead, the staff person held the cup of milk to the client's mouth for her to drink. The staff also carried the client's dirty tableware to the kitchen sink instead of encouraging the client to take them herself, as other staff had done at other times during the day.</p> <p>5. For 28 minutes that followed breakfast (7:24 a.m. - 7:52 a.m.), Client #1 wandered about the facility without staff interaction and not engaged in formal or informal active treatment activities.</p> <p>6. Later that morning, at approximately 11:57 a.m., the qualified mental retardation professional (QMRP) stated that Client #1 was to receive one-to-one staff support during awake hours. The QMRP said that although the team had prescribed one-to-one support for 16 hours daily, a staff person would provide one-to-one support if the client woke up early or wished to stay up late. Staff on the overnight shift, however, had not been observed providing one-to-one support. Client #1 received one-to-one attention after 7:52 a.m., with the arrival of her 8:00 a.m. - 4:00 p.m. staff.</p> <p>7. On January 27, 2010, beginning at 3:32 p.m., review of Client #1's behavior support plan (BSP),</p>	W 251	<p>3. QMRP will ensure 1:1 staffing in place (for Client #1) to provide continuous active treatment and engagement inappropriate activity.</p> <p>4. QMRP will ensure that all staff are trained on all Individual program Plans: to include goals and objectives, BSP, and other clinical needs met by staff support.</p> <p>5. QMRP will ensure all staffing needs are met (Client #1 provided 1:1 staff person) for engagement in continuous active treatment.</p> <p>6. QMRP will ensure adequate staffing is provided (Client #1 has 1:1 staff assigned for 16 hours daily) to ensure proper supervision of individuals is attained as indicated/recommended by IDT.</p>	<p>2/1/10</p> <p>2/1/10</p> <p>2/1/10</p> <p>2/1/10</p>
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W 251 Continued From page 18
dated February 1, 2009, revealed that staff were to keep the client engaged in activities, provide verbal praise to the client every 10-15 minutes for good behavior and to keep her focused on what she has done well. "Under stimulation" and "boredom" were among the listed antecedents for physically aggressive behavior.

8. On January 27, 2010, beginning at 4:02 p.m., review of staff in-service training records failed to show evidence that staff on the overnight shift (12:00 a.m. - 8:00 a.m.) had received training on Client #1's BSP and other habilitation and support needs. This was acknowledged by the QMRP at approximately 4:30 p.m. On the next day (January 28, 2010), at approximately 12:20 p.m., the QMRP could not verify that S13 had received in-service training on Client #1's one-to-one protocol. Staff S13 reportedly began working in the facility in March 2009.

9. On January 28, 2010, at approximately 10:17 a.m., review of Client #1's individual support plan (ISP), dated March 6, 2009, confirmed that the client was to receive one-to-one staffing. The ISP did not specify the number of hours of one-to-one support and did not prescribe in writing that one-to-one support during awake hours, as described by the QMRP.

There was no evidence that staff on the overnight shift had been instructed to provide Client #1 the supports and services prescribed in her ISP and BSP.

W 251

- 7. QMRP will ensure all staffing needs are met (Client #1 provided 1:1 staff person) for engagement in continuous active treatment.
- 8. QMRP has ensured that overnight staff were trained in Individual Program Plan to include BSP for all individuals supported with a formal Behavior Support Plan in the facility.
- 9. QMRP will ensure the ISP specifies the amount of hours (Client #1) individual receives 1:1 staffing as recommended by the IDT.

1/28/10
3
2/1/10

3/1/10

W 252 483.440(e)(1) PROGRAM DOCUMENTATION
Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable

W 252

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W 252	<p>Continued From page 19 terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, facility staff failed to document all behavior data in accordance with the behavior support plan (BSP), for one of the two clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>On January 25, 2010, at 6:55 a.m., Client #1 hit Client #2 on her left arm while they were seated next to one another on the living room sofa. A direct support staff (S13) was passing by at the time. The staff instructed Client #1 to keep her hands to herself. She then examined Client #2's arm (minor reddish hue) and then escorted Client #1 to her bedroom.</p> <p>On January 27, 2010, at 3:29 p.m., review of Client #1's behavior data sheets revealed that S13 had not documented the incident of physical aggression that she witnessed on January 25, 2010, at 6:55 a.m. Subsequent review of the client's behavior support plan (BSP), dated February 1, 2009, revealed that staff were instructed to document each incident of targeted maladaptive behaviors on the designated behavior data collection sheets. At 3:56 p.m., further review of Client #1's behavior data sheets revealed that staff on the overnight shift (12:00 a.m. - 8:00 a.m.) had not been documenting incidents (or the absence) of targeted behaviors. Staff on the other two shifts had either documented behaviors or written "No behavior."</p>	W 252	<p>QMRP in-serviced staff on documentation of Individual Program Plan (IPP) to include Behavior Support Plan (BSP) and ABC Data Chart; Incident Management Policy and active treatment program goals. QMRP will ensure all behavior data is completed in a timely manner and that staff are trained in documenting behaviors.</p>	3/1/10

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W 252	Continued From page 20 It should be noted that on January 27, 2010, beginning at 4:02 p.m., review of staff in-service training records revealed no evidence that staff on the overnight shift had received training on Client #1's BSP and/or data collection. This was later acknowledged by the QMRP, at approximately 4:30 p.m. The QMRP also confirmed that behavior data should be documented on "all shifts."	W 252			
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered without error, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The findings include: The morning medication administration pass was observed on January 25, 2010, beginning at 8:20 a.m. The following errors were observed: 1. At 8:22 a.m., Client #2 began punching her medications out from their blister packs, under the supervision of the medication nurse. She then took the medications and left the area. The process lasted approximately 4 minutes. The nurse completed the medication administration pass shortly before 9:00 a.m. and left the facility at 9:04 a.m. At 9:25 a.m., review of Client #2's January 2010 physician's orders revealed an order for "Nasonex Scent-Free 50 mcg Nasal	W 369	1. LPN Coordinator trained Medication Pass Nurses on ensuring all individuals receive all medications and treatments as indicated/ordered by physician.	2/1/10	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2010
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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 6634 EASTERN AVENUE, NW WASHINGTON, DC 20012
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W 369	<p>Continued From page 21</p> <p>Spray, 1 squirt in each nostril every day." Client #2 was not observed receiving Nasonex spray that morning.</p> <p>It should be noted that the medication nurse initialed Client #2's medication administration record that morning, as if she had administered the Nasonex spray that morning.</p> <p>2. On January 25, 2010, a nurse administered client medications between 8:20 a.m. - 8:55 a.m. Subsequent review of the clients' medical records revealed that 7:00 a.m. was the designated administration time for all four clients. Receiving medications 80 - 115 minutes beyond the designated time represented a timing error. The LPN Coordinator and the house manager were interviewed the next morning, beginning at 8:23 a.m. The LPN Coordinator stated that the morning nurse could have called her or the house manager (who is also an LPN) on the day before, to alert them to her delayed arrival; however, the medication nurse had not done so. They were unable to locate a written medication administration policy available for review in the facility. The LPN Coordinator and the house manager further indicated that the medication nurse had administered medications that morning (January 26, 2010) between 7:00 a.m. - 7:30 a.m. The medication nurse, however, had not recorded an arrival and/or departure time; therefore, this could not be verified. The LPN Coordinator and the house manager acknowledged that nurses were not required to document their arrival times or otherwise document the exact time that medications were administered. They also acknowledged that they had not previously determined whether medication administration passes were occurring within the 2-hour allotted</p>	W-369	<p>2. Late Medication Administration Policy implemented. Nursing staff trained on policy to include documenting arrival times (nurses will utilize time-clock that provides electronic signature of arrival to facility); informing MD/RN Supervisor of late medication pass; and writing incident report for medication error. LPN Coordinator will conduct reviews of Time Reports issued to management on a bi-weekly basis to ensure Medication Nurses are utilizing the time-clock system and administering medications on time.</p>	2/1/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2010
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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 8634 EASTERN AVENUE, NW WASHINGTON, DC 20012
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W 369	Continued From page 22 time frame.	W 369		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2010
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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 6634 EASTERN AVENUE, NW WASHINGTON, DC 20012
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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from January 25, 2010 through January 28, 2010. A sample of two residents was selected from a population of four women with varying degrees of intellectual disabilities. A third resident was selected for a focused review of her mealtime adaptive equipment needs and adaptive living skills assessment.</p> <p>The findings of the survey were based on observations, interviews with residents and staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.</p>	1 000		
1 082	<p>3503.10 BEDROOMS AND BATHROOMS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to equip all bathrooms used by residents with paper cups.</p> <p>The finding includes:</p> <p>1. On January 25, 2010, at 7:35 a.m., there was no paper cup dispenser, no paper cups and no paper towels available in the restroom located in the basement. On January 26, 2010, at 1:45 p.m., a roll of paper towels was available at the basement sink; however, there still were no paper cups and no cup dispenser. On January 28, 2010, at 1:00 p.m., the qualified mental</p>	1 082	<ol style="list-style-type: none"> 1. Director of Operations/QA will ensure paper cup dispenser, paper cups, and paper towels are in place in the basement bathroom. 2. a & b) Director of Operations/QA will ensure paper towel holder, paper cups, and dispenser are placed in upstairs bathroom. 	<p style="text-align: right;">2/1/10</p> <p style="text-align: right;">2/1/10</p>

<p>Health Regulation Administration</p> <p><i>[Signature]</i> Director of Operations</p> <p>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE</p>	<p style="text-align: right;">(X6) DATE</p> <p style="text-align: right; font-size: 24pt;">3.17.10</p>
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Health Regulation Administration

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1082	Continued From page 1 retardation professional acknowledged that paper cups were unavallable at the bathroom located in the basement. 2. An environmental inspection of the GHMRP was conducted on January 27 2010, at approximately 4:45 p.m. The inspection revealed the following: a. A paper towel holder was missing from the wall in the upstairs bathroom and there were no paper towels available. b. There was no cup dispenser observed in the upstairs bathroom and there were no paper cups available. These observations were acknowledged by the house manager at that time. This is a repeat deficiency. <hr/> Previously, the licensure deficiency report dated October 16, 2008, included the following: "The environmental inspection on October 16, 2008, at 11:15 a.m. revealed the facility failed to ensure that all bathrooms were equipped with a cup dispenser, paper towels and soap as required by this section."	1082		
1080	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable	1080		

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1090	Continued From page 2 odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and was free of accumulations of dirt, rubbish, and objectionable odors. The findings include: An environmental inspection of the GHMRP was conducted on January 27 2010, at approximately 4:45 p.m. The inspection revealed the following: 1. A paper towel holder was missing from the wall in the upstairs bathroom. 2. A paper towel holder on the wall in the first floor bathroom was broken. 3. There was no toilet tissue holder in the first floor bathroom. 4. The kitchen counter top was chipped. 5. There were cracks in the ceiling in the laundry room. 6. The toilet was not secured in the bathroom located in the basement. 7. Stains from water damage were observed on the basement ceiling, in front of the bathroom. These observations were acknowledged by the house manager at that time.	1090	1. Director of Operations/QA will ensure paper towel holder is placed in upstairs bathroom. 2. Director of Operations/QA will ensure paper towel holder is fixed in first floor bathroom. 3. Director of Operations/QA will ensure toilet tissue holder is placed in first floor bathroom. 4. Director of Operations/QA will ensure kitchen counter top (chip) is repaired. 5. Director of Operations/QA will ensure cracks in ceiling in laundry room are repaired. 6. Director of Operations/QA will ensure toilet is repaired in basement bathroom 7. Director of Operations/QA will ensure stains on the ceiling from water damage is repaired in basement bathroom. Director of Operations will ensure housekeeping and facility maintenance issues are addressed in a timely manner via monthly service site visits and weekly checklists to be completed by residence staff/house supervisor and submitted to DOO on a weekly basis. Residence staff will also conduct daily walk-throughs and report any needs or repairs to supervisor immediately.	2/1/10 2/1/10 2/1/10 2/1/10 2/1/10 2/1/10

Health Regulation Administration

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I 160	Continued From page 3	I 160		
I 160	<p>3507.1 POLICIES AND PROCEDURES</p> <p>Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member.</p> <p>This Statute is not met as evidenced by: Based on interview, the GHMRP failed to have a written policies and procedures manual on site and available for review by staff on the first day of survey.</p> <p>The finding includes:</p> <p>On January 25, 2009, at approximately 12:10 p.m., the qualified mental retardation professional (QMRP) stated that there was no policies and procedures manual available for review on site.</p>	I 160		
I 160	<p>3508.5(c) ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall have an organization chart that shows the following:</p> <p>(c) The categories and numbers of supportive and direct care staff, and...</p> <p>This Statute is not met as evidenced by: Based on review of the organizational chart that was presented, the GHMRP failed to ensure that the organizational chart showed the numbers of supportive staff.</p> <p>The finding includes:</p> <p>On January 25, 2010, at 3:50 p.m., review of the facility's Organizational Chart (not dated) revealed that it did not reflect the use of</p>	I 166	<p>(c) Director of Operations will ensure that the agency's organizational chart is revised to include all clinical staff (the 4 Medication Pass Nurses will be added to organizational chart).</p>	2/1/10

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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 6834 EASTERN AVENUE, NW WASHINGTON, DC 20012		
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I 186	Continued From page 4 medication nurses. On January 28, 2010, at approximately 9:07 a.m., the LPN Coordinator and the qualified mental retardation professional (QMRP) examined the Organizational Chart and acknowledged that it failed to include the four medication nurses assigned to the facility.	I 186		
I 187	3508.5(d) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: Based on review of the organizational chart and interview with the LPN Nurse Coordinator, the GHMRP failed to provide an organizational chart depicting the actual lines of authority. The finding includes: Review of the Organizational Chart on January 26, 2010, at 8:51 a.m., revealed a line drawn from the LPN Nurse Coordinator to the Director of Program Operations (DPO), suggesting that she reported directly to the DPO. However, when the LPN Nurse Coordinator was interviewed 9:05 a.m., she stated that her immediate supervisor was the consultant RN. After examining the Organizational Chart, the LPN Coordinator and the qualified mental retardation professional (QMRP) acknowledged that it did not reflect the current lines of authority (chain of command) within the nursing department.	I 187	(d) Director of Operations will ensure organizational chart is revised to reflect correct chain of command regarding nursing personnel and their reporting lines of supervision.	2/1/10
I 206	3508.6 PERSONNEL POLICIES Each employee, prior to employment and	I 206		

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I 206	<p>Continued From page 5</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for 1 out of 16 employees, 2 out of 4 licensed practical nurses (LPNs), and 9 out of 13 professional consultants.</p> <p>The findings include:</p> <p>On January 25, 2010, at approximately 12:15 p.m., the qualified mental retardation professional (QMRP) agreed to make available for review, the personnel records for all employees and consultants, including evidence of current health inventories/certificates. On January 27, 2010, beginning at 3:15 p.m., review of personnel records revealed no evidence of current health certificates for the following:</p> <ul style="list-style-type: none"> - 1 of the 14 direct support staff (S10); - the house manager; - the QMRP; - 2 LPNs; and, 	I 206	<p>Director of Operations will ensure physician's certification (health certificates) are on file for all employees; LPNs and Consultants for review and updated annually per QA review by Human Resources and Director of Operations which will be conducted monthly and as the need arises to review personnel files and training records; written evidence will be maintained at the Administrative Office of the provider.</p>	3/10/10

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I 208	Continued From page 6 - the consulting nutritionist, pharmacist, physical therapist, psychologist, psychiatrist, registered nurse, social worker, and speech pathologist. At 4:00 p.m., the QMRP confirmed the missing health certificates were not available. No additional information was presented before the survey ended the following afternoon. This is a repeat deficiency. Previously, the licensure deficiency report dated May 7, 2008, included the following: "The State regulatory agency conducted a review of personnel records on May 7, 2008, at which time there was no evidence that ten direct care staff (Staff #2, #4, #6, #9, #10, #11 #12, #14, #15, #16 and #18) and the qualified mental retardation professional had a current health certificate."	I 206		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have on file for review current training in cardiopulmonary resuscitation (CPR)	I 227	(d) Director of Operations will ensure all employees, including nurses and consulting RN are certified in CPR/First Aid. 1. Director of Operations will ensure all employees are certified in CPR. 2. Director of Operations will ensure all employees are certified in First Aid. 3. Director of Operations will ensure all nurses (and consultant nurse) are certified in CPR.	3/10/10

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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 6634 EASTERN AVENUE, NW WASHINGTON, DC 20012		
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I 227	Continued From page 7 and first aid for 3 out of 16 employees, 3 out of 4 licensed practical nurses (LPNs) and the registered nurse consultant. The findings include: On January 25, 2010, at approximately 12:15 p.m., the qualified mental retardation professional (QMRP) agreed to make available for review, the personnel records for all employees and consultants, including evidence of current CPR certifications and first aid training. On January 27, 2010, beginning at 3:15 p.m., review of personnel records and staff training records revealed the following: 1. There was no evidence that the QMRP, direct support staff S9 and S13, had current CPR certifications; 2. There was no evidence that the house manager, QMRP and direct support staff S4, S9 and S13 had received current training in first aid; and, 3. There was no evidence of current CPR certifications for 3 LPNs and the registered nurse. At approximately 4:30 p.m., the QMRP confirmed the aforementioned documentation was not available. No additional information was presented before the survey ended the following afternoon.	I 227	QA review by Human Resources and Director of Operations which will be conducted monthly and as the need arises to review personnel files and training records; written evidence will be maintained at the Administrative Office of the provider. Only employees who are CPR/FA and in compliance with other required trainings and certifications will be eligible to maintain an active schedule with the provider.	2/10/10
I 229	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	I 229		

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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 0634 EASTERN AVENUE, NW WASHINGTON, DC 20012
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1229	<p>Continued From page 8</p> <p>residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee was provided with training on residents' sexuality and behavior support needs, for two of the four residents in the facility. (Residents #2 and #4)</p> <p>The findings include:</p> <p>1. Cross-refer to I401.3. On January 25, 2010, at approximately 3:30 p.m., Residents #2 and #4 mentioned having "boyfriends" at their day programs. Review of staff in-service training records on January 27, 2010, beginning at 4:02 p.m., revealed no evidence that facility staff had received sexuality-related training. On January 28, 2010, at approximately 1:05 p.m., the qualified mental retardation professional (QMRP) and the LPN Coordinator confirmed that, to date, there had been no sexuality-related training offered for staff.</p> <p>2. There was no evidence that staff on the overnight shift had received training on Resident #1's behavior support plan (BSP), as follows:</p> <p>On January 25, 2010, at 8:41 a.m., there were two direct support staff persons on duty. Resident #1 was observed seated on the living room sofa, not engaged in a meaningful activity. Resident #2 sat nearby. One staff was preparing breakfast in the kitchen while the other staff (S13) was assisting residents elsewhere in the facility. For the next 14 minutes (until 8:55 a.m.), neither staff spoke with Resident #1 or engaged her in</p>	1229	<p>(f) Director of Operations will ensure sexuality training is given to all staff supporting individuals in the facility.</p> <ol style="list-style-type: none"> 1. Director of Operations will ensure staff supporting individuals in the facility receive training in human sexuality. 2. Director of Operations will ensure BSP training is provided to all staff supporting individuals in the facility. <p>Director of Operation will conduct monthly service site visits/reviews as well as quarterly QA reviews to ensure compliance with regulatory guidelines and that all issues in the facility are addressed in a timely manner.</p>	<p>2/10/10</p> <p>3/10/10</p>

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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 6634 EASTERN AVENUE, NW WASHINGTON, DC 20012		
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I 229	Continued From page 9 formal or informal active treatment activities. The resident repeatedly removed her shoes and socks then put them back on while seated on the sofa. At 6:55 a.m., Resident #1 hit Resident #2 on her left arm while they were seated on the living room sofa. The direct support staff (S13) who had been assisting other residents in their bedrooms moments earlier was walking through the living room at that time. When S13 observed the incident, she instructed Resident #1 to keep her hands to herself. She then examined Resident #2's arm (minor reddish hue) and then escorted Resident #1 to her bedroom. S13 interacted with Resident #1 for six minutes. At 7:01 a.m., the staff person brought Resident #1 back to the living room sofa and then left the room. The resident sat on the sofa from 7:01 a.m. - 7:12 a.m., not engaged in formal or informal active treatment activities and without staff interaction. After breakfast, Resident #1 wandered about the facility for 28 minutes (7:24 a.m. - 7:52 a.m.) without staff interaction and not engaged in formal or informal active treatment activities. Later that morning, at approximately 11:57 a.m., the QMRP stated that Resident #1 was to receive one-to-one staff support during awake hours. The QMRP said that although the team had prescribed one-to-one support for 16 hours daily, a staff person would provide one-to-one support if the resident woke up early or wished to stay up late. Staff on the overnight shift, however, had not been observed providing one-to-one support. Resident #1 received one-to-one attention after 7:52 a.m., with the arrival of her 8:00 a.m. - 4:00 p.m. staff.	I 229		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2010
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1 229	Continued From page 10 On January 27, 2010, beginning at 3:32 p.m., review of Resident #1's behavior support plan (BSP), dated February 1, 2009, revealed that staff were to keep the resident engaged in activities, provide verbal praise to the resident every 10-15 minutes for good behavior and to keep her focused on what she has done well. "Under stimulation" and "boredom" were among the listed antecedents for physically aggressive behavior. On January 27, 2010, beginning at 4:02 p.m., review of staff in-service training records failed to show evidence that staff on the overnight shift (12:00 a.m. - 8:00 a.m.) had received training on Resident #1's BSP and other habilitation and support needs. This was acknowledged by the QMRP at approximately 4:30 p.m. On the next day (January 28, 2010), at approximately 12:20 p.m., the QMRP could not verify that S13 had received in-service training on Resident #1's one-to-one protocol. Staff S13 reportedly began working in the facility in March 2009. This is a repeat deficiency. Previously, the licensure deficiency report dated May 7, 2008, included the following: "Interview and the review of the in service training records on May 7, 2008, the GHMRP failed to provide training on nutrition, sexuality, and behavior management."	1 229		
1 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	1 401		

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1401	<p>Continued From page 11</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to evaluate residents' adaptive living skills, behavior support needs and sexuality needs, for three of the four residents in the facility. (Residents #1, #2 and #4)</p> <p>The findings include:</p> <p>1. On January 25, 2010, at approximately 6:00 p.m., a direct support staff person cut Resident #4's turkey cutlet into bite size pieces before presenting it to the resident. A short time later, staff used a knife to cut the resident's canned peaches into bite size pieces. At 6:18 p.m., interview with the qualified mental retardation professional (QMRP) revealed that Resident #4's foods were cut bite size after a former nutritionist recommended it. However, she said it was "a carryover" precaution to address fast eating pace. The resident had not been observed eating quickly at either breakfast or dinner that day. The QMRP indicated that the resident's eating pace had not been reassessed.</p> <p>Resident #4's nutrition records were reviewed the next morning, beginning at 9:10 a.m. Her annual Nutrition Assessment, dated December 1, 2009, indicated that she "tolerates her food cut into bite sized pieces." The assessment did not, however, suggest any concern with eating pace, or otherwise indicate the rationale for the specialized dietary texture. Resident #4's</p>	1401	<p>1. QMRP will ensure Nutritionist and/or SLP review the needs of each individual related to use of adaptive eating equipment and food textures (for Client #4, reviewing her need for bite-sized food texture) and make revisions if recommended.</p>	3/10/10

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1401	<p>Continued From page 12</p> <p>Individual Support Plan (ISP), dated January 14, 2009, indicated that she was an "independent self-feeder and chews and swallows her food adequately. She is on ... bite side <sic> pieces diet ... does not require a dining plan, physical or nutritional management."</p> <p>On January 27, 2010, at 1:42 p.m., interview with the QMRP and LPN Coordinator revealed that Resident #4's interdisciplinary team had met on January 14, 2010 to review and update her annual plan. When asked if the resident's ability to use a knife had been assessed, they replied "no." They both acknowledged that her eating pace was no longer a concern and upon further discussion, they both indicated that the resident might be willing and able to learn how to cut her own foods with a knife.</p> <p>2. On January 26, 2010, at 6:41 a.m., Resident #1 was observed seated on the living room sofa. At the time, she was not engaged in a meaningful activity. She removed her shoes and socks then put them back on (without prompting from staff). Moments later, she repeated the behavior. One of her peers (Resident #2), who was in the living room at the time, indicated that Resident #1 removed her shoes and socks frequently. At 7:01 a.m., Resident #1 removed her shoes and socks again. At 7:12 a.m., she was observed seated on the sofa with both of her shoes and socks removed. At 7:45 a.m., she was observed alone in her bedroom. She was barefoot and looking through a dresser drawer full of undergarments. A moment later, she put on a pair of socks and shoes and left her bedroom. Her attention was focused almost exclusively on her shoes and socks from 6:41 a.m. until she was called to the breakfast table at 7:12 a.m.</p>	1401	<p>2. QMRP will ensure that Psychologist reviews the BSP (for Client #1) to review all of her behavioral needs and to address removing shoes through BSP and adding that as target behavior.</p>	3/1/10

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1401	<p>Continued From page 13</p> <p>Similar observations were made in the afternoon later that day. At 4:10 p.m., Resident #1 was observed seated next to her assigned 1:1 staff at the dining room table. The resident fumbled with her shoes and socks for approximately two minutes before actually removing them, while seated. She put them back on immediately. At 4:30 p.m., the resident got up from the table, walked through the facility with her 1:1 staff then sat back down at the dining room table and promptly removed her shoes and socks. She put them back on a moment later. The resident ignored her 1:1 staff's verbal prompting to engage in table top activities. At 4:57 p.m., the resident had her shoes and socks off while seated in her bedroom. At 4:59 p.m., her 1:1 staff asked her to put them back on; the resident did so after she returned to the dining room table. For the next 22 minutes, Resident #1 continually focused her attention on her shoes and socks, while largely ignoring her 1:1 staff's suggestions of various activities at the table. Her 1:1 staff indicated that this was not unusual behavior for Resident #1.</p> <p>On January 27, 2010, beginning at 3:32 p.m., review of Resident #1's behavior support plan (BSP), dated February 1, 2009, revealed that it did not address her repeatedly taking off her shoes and socks. At approximately 4:35 p.m., interview with the QMRP revealed that in the past, the resident's BSPs had addressed disrobing, including her shoes and socks. The QMRP said the resident "stopped doing that pretty much ... the occurrences dropped ... She doesn't do it that much anymore." She further indicated that staff were not expected to document the shoe/sock removal behavior and the psychologist would probably request baseline data collection if this or other past behaviors</p>	1401		

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I 401	<p>Continued From page 14</p> <p>re-emerged. There was no evidence that the facility reassessed Resident #1's shoe and sock-removal behavior.</p> <p>3. On January 25, 2010, at approximately 3:30 p.m., Resident #2 stated that she had a "boyfriend" who attends the same day program. A direct support staff person seated with her confirmed the statement. When asked what they enjoyed doing together, Resident #2 stated that although she would like to go out with him, they had not yet had a their first date. The staff person indicated that the facility was in the preliminary planning stage. Resident #4 (not in the sample), who was seated next to Resident #2 at the time, also stated that she had a "boyfriend."</p> <p>Resident #2's records were reviewed on January 26, 2010, beginning at 9:37 a.m. There was no evidence that she had received a sexuality assessment and/or that her interdisciplinary team had discussed her interest in dating. On January 28, 2010, at approximately 1:05 p.m., interview with the QMRP and the LPN Coordinator confirmed that to date, Resident #2 had not received a sexuality assessment. [Note: They also indicated that Resident #4's sexuality needs had not been assessed.]</p> <p>It should be noted that Resident #2 was observed receiving Cryselle 0.3-0.03 mg, one tablet, on January 28, 2010, at 8:22 a.m. The nurse stated that the medication was prescribed for birth control. It should be further noted that her Annual Physical/Medical Evaluation, dated October 13, 2009, indicated that she was "not sexually active."</p>	I 401	<p>3. QMRP has revised Client #2's Comprehensive Functional Assessment and updated it to reflect her pleasure in being in and having a relationship. Further Client #2's interest in having a relationship will be communicated to clinicians at IDT Meeting to review need for sexuality training to ensure she is educated on all her options related to having a relationship.</p> <p>QA Review will be conducted quarterly by Director of Operations/QMRP to ensure all clinical issues and training areas are addressed in a timely manner and that professional services are comprehensively evaluated, implemented and consistently meeting the needs of all individuals in the facility.</p>	3/1/10
I 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure</p>	I 500		

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/28/2010
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1500	<p>Continued From page 15</p> <p>that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for four of the four residents of the facility. (Residents #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>1. Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure that Resident #2's legal guardian and/or surrogate decision-maker was informed of the risks and benefits of restrictive programs and supports, including psychotropic medications, as follows:</p> <p>On January 25, 2010, at approximately 8:25 a.m., Resident #2 was administered Gabapentin (Neurontin) 800 mg, Clonazepam (Klonopin) 1 mg and Chlorpromazine HCL (Thorazine) 200 mg. At approximately 11:50 a.m., the qualified mental retardation professional (QMRP) indicated that Resident #2's psychotropic medications were incorporated in her behavior support plan (BSP). She further stated that the resident's mother was her designated surrogate health care decision-maker.</p> <p>On January 26, 2010, at 9:53 a.m., review of</p>	1500	<p>1. QMRP/Nurse will ensure that all parents/guardians and healthcare decision makers are informed of risks and benefits of all restrictive procedures to include psychotropic medications as they are ordered by the physician. Evidence of this will be maintained in the individual's medical/clinical records.</p>	3/1/10

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I 500	<p>Continued From page 16</p> <p>Resident #2's Psychological Assessment, dated September 1, 2009, revealed that the resident was not competent to make health care decisions. Her individual Support Plan (ISP), dated October 15, 2009, confirmed that her mother was the designated health care decision-maker. Further review of Resident #2's record on January 28, 2010, beginning at 9:03 a.m. failed to show evidence that the mother had been fully informed of the resident's mental health status and the risks and benefits associated with the use of Gabapentin. Her mother had not signed the attendance sheet for her ISP meeting and there was no written consent form for the use of Gabapentin observed in her record.</p> <p>On January 28, 2010, at 9:17 a.m., the QMRP confirmed that the mother had not attended the October 15, 2009 ISP meeting. The QMRP indicated that the consulting psychologist had reviewed Resident #2's medication regimen and BSP with the mother in years past. Moments later, the QMRP acknowledged that the facility had not documented said review(s) in the resident's record. There was no evidence that the risks and benefits associated with all restrictive programs and supports, including psychotropic medications, were fully explained to Resident #2's mother.</p> <p>2. Based on interview and record review, the facility failed to encourage individual Resident #2 to exercise her rights as a resident of the facility, including filing complaints and due process, as follows:</p> <p>On January 26, 2010, at 1:05 p.m., review of an internal investigation report dated January 29, 2009, revealed that on January 24, 2009, at 8:06 p.m., staff discovered that Resident #2 had left</p>	I 500	<p>2. QMRP has been in-serviced on conducting thorough, expedient investigations of all incidents whereby the individual's health, safety, and welfare have been in compromised or any rights violation has occurred. Investigations include theft of funds (Client #2's funds were returned to her by provider administrator).</p>	3/1/10

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I 500	<p>Continued From page 17</p> <p>the facility without informing anyone. The investigative findings indicated that at 8:05 a.m. earlier that day, Resident #2 had asked staff to call the police to report that money was missing from her room. Staff on that (8:00 a.m. - 4:00 p.m.) shift reportedly calmed her down. Following a shift change, the resident asked the evening staff (4:00 p.m. - 12:00 a.m.) to call the police because her money was missing. The evening staff reportedly calmed her down. She then left the facility alone, without telling anyone, and staff initiated the incident reporting process.</p> <p>Continued review of the investigation report revealed that after the resident was brought home from the police station, facility staff had examined the resident's personal funds and found that \$2.71 (out of \$10 cash) could not be accounted for. They determined that the missing money was "a contributing factor to <resident's name> leaving the house ..." The investigation report reflected interviews with the evening shift; however, there was no evidence that staff on the morning shift had been interviewed. In addition, there was no evidence that the issue of Resident #2's missing money had been resolved.</p> <p>On January 26, 2010, at 1:50 p.m., interview with the QMRP (who had conducted the investigation) revealed that she did not recall interviewing staff who were on duty at 8:05 a.m., when the resident first reported that money was missing. The QMRP acknowledged that she did not know how staff had responded to the resident's complaint. She stated that she had focused the investigation on the evening "elopement." She confirmed that staff had only contacted the house manager after the resident was discovered missing from the facility that evening. When asked, the QMRP said the morning staff should have notified the</p>	I 500		

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I 500	<p>Continued From page 18</p> <p>house manager of Resident #2's request for police assistance, and should have prepared an incident report regarding the missing funds. The QMRP indicated that she could not recall whether the missing \$2.71 had been further investigated and/or if the money was ever found or reimbursed.</p> <p>There was no evidence that Resident #2's due process rights had been ensured.</p> <p>3. Based on observation, the facility failed to ensure Resident #1's right to privacy during medication administration, as follows:</p> <p>During the morning medication pass on January 25, 2010, at 8:40 a.m., the nurse brought Resident #1's medications upstairs to the living room instead of having the resident come to the basement. She administered Resident #1's medications to her, while Residents #2 and #4 stood to her side. Resident #3 and several staff also watched the process from a few feet away.</p> <p>4. Based on observation, interview and record review, the facility failed to ensure that residents received their medications without error, for four of the four residents residing in the facility (Residents #1, #2, #3 and #4), as follows:</p> <p>a. The morning medication administration pass was observed on January 25, 2010, beginning at 8:20 a.m. At 8:22 a.m., Resident #2 began punching her medications out from their blister packs, under the supervision of the medication nurse. She then took the medications and left the area. The process lasted approximately 4 minutes. The nurse completed the medication administration pass shortly before 9:00 a.m. and left the facility at 9:04 a.m. At 9:25 a.m., review</p>	I 500	<p>3. LPN Coordinator has counseled/re-inserviced Medication Pass Nurses on providing individuals with privacy during medication administration.</p> <p>4. a) LPN Coordinator trained Medication Pass Nurses on ensuring all individuals receive all medications and treatments as indicated/ordered by physician. b) Late Medication Administration Policy implemented. Nursing staff trained on policy to include documenting arrival times (nurses will utilize time-clock that provides electronic signature of arrival to facility); informing MD/RN Supervisor of late medication pass; and writing incident report for medication error.</p>	2/1/10 2/1/10

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I 500	<p>Continued From page 19</p> <p>of Resident #2's January 2010 physician's orders revealed an order for "Nasonex Scent-Free 50 mcg Nasal Spray, 1 squirt in each nostril every day." Resident #2 was not observed receiving Nasonex spray that morning.</p> <p>It should be noted that the medication nurse initialed Resident #2's medication administration record that morning, as if she had administered the Nasonex spray that morning.</p> <p>b. On January 25, 2010, a nurse administered resident medications between 8:20 a.m. - 8:55 a.m. Subsequent review of the residents' medical records revealed that 7:00 a.m. was the designated administration time for all four residents. Receiving medications 80 - 115 minutes beyond the designated time represented a timing error. The LPN Coordinator and the house manager were interviewed the next morning, beginning at 8:23 a.m. The LPN Coordinator stated that the morning nurse could have called her or the house manager (who is also an LPN) on the day before, to alert them to her delayed arrival; however, the medication nurse had not done so. They were unable to locate a written medication administration policy available for review in the facility. The LPN Coordinator and the house manager further indicated that the medication nurse had administered medications that morning (January 26, 2010) between 7:00 a.m. - 7:30 a.m. The medication nurse, however, had not recorded an arrival and/or departure time; therefore, this could not be verified. The LPN Coordinator and the house manager acknowledged that nurses were not required to document their arrival times or otherwise document the exact time that medications were administered. They also acknowledged that they had not previously</p>	I 500	<p>LPN Coordinator will conduct reviews of Time Reports issued to management on a bi-weekly basis to ensure Medication Nurses are utilizing the time-clock system and administering medications on time.</p>	2/1/10

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I 500	Continued From page 20 determined whether medication administration passes were occurring within the 2-hour allotted time frame.	I 500		

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(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
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R 000: INITIAL COMMENTS

A licensure survey was conducted from January 25, 2010 through January 28, 2010. A sample of two residents was selected from a population of four women with varying degrees of intellectual disabilities. A third resident was selected for a focused review of her mealtime adaptive equipment needs and adaptive living skills assessment.

The findings of the survey were based on observations, interviews with residents and staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.

R 122 4701.2 BACKGROUND CHECK REQUIREMENT

Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person.

This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person, for 1 out of 14 direct support staff employed. (S14)

The finding includes:

On January 26, 2010, at approximately 12:15 p.m., the qualified mental retardation professional agreed to make available for review, the personnel records for all employees and consultants, including evidence of criminal

Director of Operations and Human Resources will ensure that all employees have criminal background checks on file for review in personnel records and that documentation is available for verification that background checks have been obtained. Periodic reviews of personnel records will be conducted to ensure protocol is implemented effectively.

3/10/10

Health Regulation Administration <i>Rafael Galan, Director of Operations</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Director of Operations	(X6) DATE 3.17.10
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2010
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R 122	Continued From page 1 background checks for all staff employed in the facility. Review of the personnel records on January 27, 2010, beginning at 3:15 p.m., revealed no documentation available to verify that a background check had been obtained prior to employment for one direct support staff, S14. No additional information was provided before the survey ended the following afternoon.	R 122		