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

PRINTED: 07/09/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G145		06/12/2009

NAME OF PROVIDER OR SUPPLIER: MARJUL HOMES

STREET ADDRESS, CITY, STATE, ZIP CODE: 4010 ARKANSAS AVENUE, NW, 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) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from June 10, 2009 through June 12, 2009. 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. A random sampling of three clients was selected from a population of six male clients with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.		Received 7/23/09 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	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS 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 clients, family members or guardians were informed of their risks and benefits of their medication, for two of the three clients included in the sample. (Clients #2 and #3) The findings include:	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7-23-09

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	Continued From page 1 1. The facility failed to ensure that informed consent was obtained from Client #2's guardian prior to the administration of his psychotropic medications. Interview with the Qualified Mental Retardation Professional (QMRP) on June 10, 2009, at 4:30 PM, during the entrance conference indicated Client #2 receives psychotropic medications to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. Observation of the evening medication administration on June 10, 2009 at 6:20 PM, revealed Client #2 was administered Clonidine HCL 0.2 mg, Paxil 30 mg and Risperdal 0.5 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behaviors. Review of Client #2's current physician orders dated June 2009, on June 11, 2009 at 9:10 AM revealed that the client was also prescribed Clonidine HCL 0.2 mg and Risperdal in the morning to address his maladaptive behaviors. The QMRP's statement was verified on June 11, 2009, at 2:41 PM through review of Client #2's current psychological assessment dated February 15, 2009. According to the assessment, Client #2 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or financial matters". Further interview with the QMRP during the survey, revealed that the client	W 124	1. Person # 2 management team is obtaining consent form with notarized signature for use of psychotropic medication	7-31-09

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W 124	Continued From page 2 had several family members who were involved in his habilitation planning and decision making process. Record verification on June 11, 2009 3:43 PM revealed that Client #2's guardian had given informed consent for the use of Risperdal 0.05 mg (only or less) and Paxil 30 mg (only or less) dated October 17, 2006. However there was no consent signed for the client's current prescribed psychotropic medications. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication. 2. The facility failed to ensure that informed consent was obtained from Client #3's guardian prior to the administration of his psychotropic medications. Observation of the morning medication administration on June 10, 2009 at 6:04 PM, revealed Client #3 was administered Lithium Carbonate ER 600 mg, Revia 100 mg and Thorazine HCL 200 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behaviors. Review of Client #3's current physician orders dated June 2009, on June 12, 2009 at 9:57 AM, revealed that the client was also prescribed the aforementioned medication and Cogentin 0.5 mg, in the morning to address his maladaptive behaviors. Interview with the Qualified Mental	W 124	2. Person # 3 management team is obtaining signed consent form. The current medications will be listed and the consent will be dated and authorized by a notary public.	7-31-09

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W 124	Continued From page 3 Retardation Professional (QMRP) on June 10, 2009, at 4:30 PM confirmed the client received the aforementioned medications to address his behaviors. During the entrance conference on June 10, 2009, at 4:30 PM, an interview was conducted with the QMRP that revealed Client #3 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on June 12, 2009, at 11:56 AM through review of Client #3's current psychological assessment dated June 20, 2008. According to the assessment, Client #3 "is not able to make independent decisions concerning his residential or day placements. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He lacks the judgment and insight required to make decisions independently." Further interview with the QMRP during the survey, revealed that the client had a court appointed guardian. Record review of Client #3's medical record on June 12, 2009 at 1:00 PM revealed that the client's guardian had given informed consent dated August 29, 2009, for Thorazine 200 mg BID. Additional review revealed that the guardian signed a consent dated September 11, 2007. The consent was for Prozac 20 mg, Lithium Carbonate ER 300 mg, Risperdal 5 mg. It should be noted that the signed consents were not the client's current prescribed psychotropic medications. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized	W 124		

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W 124	Continued From page 4 representative prior to the administration of the psychotropic medication.	W 124		
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to teach clients to manage their own financial affairs, for one of the three in the sample. (Client #2) The finding includes: During observations at Client #2's day program on June 11, 2009, at 12:00 PM, an interview was conducted with Client #2's day program staff. The day program staff revealed that the client received a stipend of $5.00 per day, if his attendance is greater than 20 days for the entire month. Interview with the Program Director/Qualified Mental Retardation Professional (QMRP) on June 11, 2009 at approximately 3:00 PM revealed that Client #2 gives his check to the House Supervisor or QMRP. The client's check was then taken to the corporate office and deposited into the client's personal account by the Chief Executive Officer (CEO). Record review on June 12, 2009, at 3:30 PM, revealed that Client #2 had a comprehensive money management assessment dated	W 126		

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W 126	Continued From page 5 November 2007 that outlined his current skills and specific needs in this area. The assessment reflected that the client was unable to identify coins and bills and state their values, make deposits or complete withdrawals. According to staff interviews conducted on June 11, 2009, at approximately 4:00 PM, the client required assistance to make purchases in the community. There was no formal program developed to encourage Client #2 to engage in management of his finances to his greatest extent possible.	W 126	Person #2 QMRP updated his money management assessment and developed a money management program to teach community banking skills.	7-20-09
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients personal funds for two of three clients in the sample. (Clients #1 and #2) The findings include: Review of the financial records on June 11, 2009, at approximately 10:15 AM revealed there was no accurate account of how the Client #1 and #2 ' s funds were being received and disbursed. a. Review of Client #1's financial records revealed that there were no bank statements from September 2008 through December 2008. Interview with the Chief Executive Officer (CEO)	W 140	a. Person #1 Bank Statements and receipts are kept in each individual financial record book with receipts indicating purchases	7-15-09

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W 140	Continued From page 6 on June 12, 2009 at approximately 9:30 AM, revealed that the records were disarrayed because there had been three changes in the administrative staff within the last year. b. Review of Client #2's financial records (bank statement) revealed a balance of $1,170.29 in September 2008. The next statement that was in May 2009, showed a balance of $5.29 in the client's account. There were no receipts in the client's file to show how and when the money had been spent. Interview with the CEO on June 12, 2009, at approximately 10:00 AM revealed that the records were disarrayed because there had been three changes in the administrative staff within the last year.	W 140	b. Person # 2 bank statements and receipts are kept in his financial record with receipts to indicate purchases.	on-going
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate, integrate and monitor services, for four the six clients residing in the facility. (Clients #1, #2, #3 and #6) The findings include: 1. The QMRP failed to report the results of all investigations to the administrator within five working days of the incident for Client's #6 and	W 159	Incident management will follow DDS & HRA policy for reporting and investigating incidents. All reported to the Administrator As they occur and management team reviews incidents along with administrator weekly.	On going

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W 159	Continued From page 7 #2. Review of the facility's incidents reports and investigation reports on June 10, 2009, beginning at 5:30 PM revealed the following incidents: a. On February 28, 2009, staff observed Client #6's left hand was swollen around nail area. The medication nurse assessed the client's finger and it appeared to be infected. The client was sent to the emergency room and was admitted with a diagnosis of paronychia. b. On November 7, 2009, staff discovered that Client #2 had pulled off his big toe nail. Interview with the QMRP on June 10, 2009 at approximately 7:00 PM indicated that the Chief Executive Officer (CEO) was notified at the QMRP's weekly meeting. The notes of the QMRP's weekly meetings, dated from May 2009 through June 2009 did not evidence that the CEO had been informed of the results of the aforementioned investigations. Continued review of the facility's incidents failed to provide evidence that the administrator was notified of the results of all investigations within five working days. 2. The QMRP failed to coordinate and integrate services to ensure Client #1 frequent non-compliance/refusals were aggressively addressed by the interdisciplinary team. Interview with the Psychologist on June 12, 2009 at approximately 4:15 PM by telephone revealed that the client had seen her several times for behavioral counseling. She acknowledged that additional and regular counseling sessions would be beneficial to encourage the client to be more	W 159	2. QMRP and Psychologist will develop a reward program to help encourage person #1 to participate in his therapy sessions	7-23-09

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W 159	Continued From page 8 cooperative. According to the Psychologist, the client had not attended the sessions on a regular basis due to his refusals. The Psychologist stated that she updated the client's behavior support plan after the October 14, 2008 incident, which resulted in the client transfer to the emergency room due to his refusal to take his medication for several days. The Psychologist acknowledged that she participated in the PMRs held monthly which were designed to monitor the client's behavioral progress. The BSP was updated on October 23, 2008. The review of the client's Annual Psychological Assessment dated May 5, 2008 on June 12, 2009 at 3:15 PM revealed the recommendation that the client participate in individual counseling sessions. According to the assessment, individual therapy may help the client to feel less threatened, more secure, and that he was accepted and liked by others. The psychological assessment recommendation included , "Evaluate the degree of a possible depressed mood. Provide psychological consultation." Record review June 12, 2009 at 3:30 PM revealed a psychotherapy session dated July 26, 2008. According to this psychotherapy note, the client agreed to future planned psychotherapy sessions. The record also reflected a counseling session in February 2009. Interview with the psychologist revealed that the client had seen her for counseling twice, however, more recently was slightly more agreeable to counseling. Record review revealed the client also failed to go for his June 2009 counseling session. At the time of the survey,there was no evidence the client was participating in regular psychological counseling	W 159		

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W 159	Continued From page 9 sessions as recommended. [See also W214] 3. The QMRP failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) included a data collection system directly related to the outcome of the objective for Client's #1 and #3. [See W237] 4. The QMRP failed to coordinate services to ensure the individual program plan (IPP) included training to address the dental hygiene need of Client's #2 and #3. [See W242] 5. The QMRP failed to coordinate services to ensure the behavior support plans of Client's #1 and #3 were effectively implemented . [See W249] 6. The QMRP failed to coordinate services to ensure accurate documentation of progress on the individual program plan (IPP) objectives was maintained for Client #1. [See W252]	W 159	3. QMRP will meet will write goals that are related to individuals ISP goals. 4. Person #2 & 3 will have program goals added o include dental hygiene 5. Staff will receive training on BSP for all person who have BSP"s residing at this facility 6. Staff will be in serviced on documenting individual's programs	8-1-09 8-1-09 7-30-09 7-23-09
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each employee was provided initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently for two of three clients in the sample. (Clients #1 and #3)	W 189		

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W 189	Continued From page 10 The findings include: 1. The facility failed to ensure staff were trained to implement Client #1's objectives recommended in his individual program plan. [See W249] 2. The facility failed to ensure staff were provided training on the clients' nutritional needs and modified diets. Meal observation on June 10, 2009 at 6:25 PM revealed a meal which included roasted turkey wings, sweet potatoes, steamed cabbage, and fruit cocktail. At 6:35 PM, Client #1 sat at the table and began to eat. He was observe to throw his turkey wing into the trash can at 6:40 AM. Staff was not observed to offer him anything else to eat, in place of the turkey wing. The review of the physician's orders dated June 1, 2009 on June 11, 2009 at 12:29 PM, revealed the client was prescribed an 1800 calorie weight reduction, Low Sodium, High Fiber Diet. On June 11, 2009, at 11:05 AM, the review of Client #1's individual support plan (ISP) dated July 28, 2009 revealed they did not have a food preference list, had a good appetite and generally ate most foods. Further review of the ISP however revealed that training should be provided by the nutritionist to all direct care staff quarterly or as needed. Interview with the interim QMRP on June 12, 2009 at 10:38 AM revealed there was no documented staff training by the nutritionist on the clients' therapeutic diets. Further record review revealed that at the time of the survey, there was no evidence the nutritionist had provided the recommended training to direct care staff.	W 189	1. Staff will be retrained on Behavior Support Programs. 2. Training by Nutritionist that addresses persons diet and alternative meals	7-30-09 7-31-09

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W 189	Continued From page 11	W 189		
	3. The facility failed to ensure staff were effectively trained to document progress on the individual programs plan (IPP) objectives in measurable terms. Interview with the house manager on June 11, 2009 at 10:45 AM, indicated that staff had been trained on how to document on the clients' IPP training objectives. Record review on June 12, 2009 at 10:17 AM revealed an agenda and signature sheet dated December 1, 2008, which was titled " How to Run and Document the Behavior Support Plans" for each of the six clients residing in the facility. The review of the data collection revealed data had not been documented as needed to accurately monitor the progress of Clients #1 and #3. [See W252]		3. Staff will be re-trained on program documentation	7-30-09
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the individual program plan (IPP) stated a specific objective that addressed an identified training need (improved compliance with treatment regimen) for one of three clients in the sample. (Client #1) The finding includes: On June 10, 2009 at 6:30 PM, interview with the	W 227		

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W 227	Continued From page 12 Qualified Mental Retardation Professional (QMRP) revealed Client #1 had a history of refusals, which interfered significantly with his active treatment and his health management. The review of Client #1's Individual Support Plan (ISP) dated July 28, 2008 confirmed this history and the continuing concern of refusals in various aspects of his life. However, the Interdisciplinary Team (IDT) failed to design a plan to address the client's non-compliance as evidenced by the following: A. The review of Client #1's records on June 11, 2009 revealed he refused to consistently participate in his active treatment programs as evidenced below: - Goal: To improve his self-Medication skills. [Client] will take his medication daily (AM and PM as directed by his doctor with one verbal prompt under supervision of a licensed nurse...). The objective was to be implemented daily. On June 10, 2009 at 6:27 PM, the nurse was observed to call Client #1 several times to take his medications, however he did not come to the medication station. From 6:40 PM to 6:50 PM, the client was observed in the dining room eating his evening meal. At 7:00 PM, while in his bedroom, Client #1 accepted his prescribed medications from the nurse. Interview with the medication nurse on June 10, 2009 at 6:29 PM confirmed that the client refused to come to the medication closet located in the office to receive his prescribed medications. Further interview with the medication nurse revealed the client participated in his medication administration only to a limited extent, due to his	W 227	1. Person # 1 QMRP will develop program along Psychologist that adds a reward for person # 1 participation in his self medication.	7-30-09

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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
W 227	Continued From page 13 poor vision, and non-compliance at times for taking his medications. - Goal: To improve his personal hygiene. [Client] will take a shower twice per week on two days of his choice independently for six consecutive months by 2/09. Interview with the QMRP on June 10, 2009 at 6:45 PM revealed that Client #1 did not like to take baths and had not made progress in the objective. According to interview with staff on June 11, 2009 at 4:10 PM, they informed Client #1 when it was time to take his shower. Continued staff interview revealed, if the client refused to take a bath, they asked the client to tell staff if he took a bath later, so that it could be documented. The review of the Client #1's ISP dated July 28, 2008 revealed, the client continued to refuse taking a daily bath. According to the ISP however, the client agreed to take a shower on two days a week of his choice. On June 12, 2009 at 12:30 PM, the QMRP's Monthly Status Report for March 2009 and April 2009 documented that the client took three (3) showers during each of the two months. According to the data collection form, the client should take a shower twice a week (eight times a month). The review of program data for May 2009 revealed that the client had taken three showers during the month and that the last shower was on May 18, 2009. Program data for June 2009 revealed that the client had refused all showers during the month. On June 12, 2009 at 12:30 PM, the review of a sheet of paper in the notebook kept by the client indicated that he took a shower on May 6, May	W 227	2. Person # 1 QMRP will develop program along Psychologist that adds a reward for person # 1 participation in his ADL skills	

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	09G145		06/12/2009

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W 227	Continued From page 14 18, June 2, and June 10, 2009. It should be noted that this information was contradictory to the data collection. The review of a staff note written on the June 2009 IPP revealed "Tried to encourage the client to take shower on Monday and Friday, but he refused. He does it his way. Whenever he gets ready to shower, that's when he will shower." - Goal: To improve his money management skills. [Client] will make change (with one verbal prompt) for $20.00 using $1, $5, $10 bills in different denominations for six consecutive months by February 2009. The objective was to be implemented two times a week (on Tuesdays and Thursdays). Review of the QMRP's Monthly Status for April 2009 revealed the client refused the task to participate in the money management program when offered thirteen (13) times during the month. Record review on June 12, 2009 revealed the training should be implemented on Tuesdays and Thursdays. According to the data collection records for May 2009, data was collected for 2 of the 8 days the objective was scheduled to be implemented. Interview and record review at the time of the survey revealed no data was available for June 2009. - Goal: To enhance his physical fitness skills. Three days per week, [Client] will go for a walk in his neighborhood with one verbal prompt for six consecutive months by February 2009. Interview with staff on June 11, 2009 at 4:20 PM revealed Client #1 refused to go on the scheduled walks identified in his IPP training objective. Record review revealed the program was scheduled to be implemented on Mondays,	W 227	3. Person # 1 QMRP will develop program along Psychologist that adds a reward for person # 1 participation in his money management skill improvement 4. Person # 1 QMRP will develop program along Psychologist that adds a reward for person # 1 participation in physical fitness program	

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W 227	Continued From page 15 Wednesdays and Fridays. Program data revealed the following information concerning this objective: - 2/09: Walked 3 days; refused on 7 days offered - 3/09: Walked on 3 days; refused on 10 days offered - 4/09: Walked on 1 day; refused on 12 days offered - 5/09: Walked on 3 days; refused 6 of 13 days offered - 6/09: Refused on 3 of 5 days offered; on 2 of the 5 days scheduled, there was no documentation to determine if the client was given an opportunity to walk. At the time of the survey, there was no evidence that the IDT had addressed the client's persistent refusal to participate in his program objectives. There was no evidence the facility had ensured continuous and aggressive active treatment to improve Client 1's level of functioning in his environment. B. It should be further noted that Client #1 failed to permit or participate in needed appointments. According to Client #1's medical record he had failed to allow the following recommended appointments/procedures to be completed as evidenced below: (1) A colonoscopy initially scheduled to be done on April 23, 2007 still had not been completed. (See W322) (2) An ophthalmology evaluation had been scheduled for December 11, 2008 in accordance with the specialist recommendation in 2007. (See W323)	W 227	B. A reward based program will be developed to help person 1 participate/receive medical services.	7-30-09

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W 227	Continued From page 16 Interview with the Designated Licensed Practical Nurse (DLPN) on June 12, 2009 at 2:20 PM revealed the client's annual ophthalmology had been scheduled for December 11, 2008, however after arriving at the clinic, the client refused to be examined by the practitioner. Further interview with the DLPN on June 12, 2009 revealed the client's ophthalmology had not been rescheduled. The nurse indicated that due to the client's refusal to go on more than three appointments in a month, it had been difficult to ensure that each of the client's needed assessments and follow-up appointments were completed. C. The facility failed to identify a program to address Client #1's refusals. Record review on June 11, 2009 at 2:34 PM revealed Client #1 had a Psychiatric Assessment dated February 26 2009. The Psychiatric Assessment identified Client #1's Axis I diagnosis of Intermittent Explosive Disorder and Bipolar Disorder. The record also included an Axis IV diagnosis of Occupational Disorder. However, the interdisciplinary team failed to design a plan to address the client's non-compliance/refusal. On June 12, 2009 at 3:30 PM, the review of Client #1's Annual Psychological Assessment dated May 8, 2009 revealed it identified the following goals to address targeted behaviors: (1) Explosive episode will decrease to 0 a month for nine consecutive months. (2) Psychotic Ideations will decrease to zero a month for nine consecutive months. According to the psychological assessment psychotic Ideations are statements made that have no basis in reality, that refer to the past; or that make no sense in	W 227		

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W 227	Continued From page 17 the current setting; refusing medications. Interview with the DLPN on June 11, 2009 at 3:29 PM revealed that the client was monitored monthly by the Psychiatrist during the Psychotropic Medication Reviews. According to the DLPN, the meetings were also attended by the Psychologist, the DLPN, the QMRP and the client. According to the May 2009 PMR Meeting report, the client had one behavioral episode in May 2009, and was clinically stable. The team recommended that the client continue his BSP and continue therapy. At the time of the survey, however, there was no evidence that the IPP included a specific objective to address Client #1's refusal to participate in his IPP objectives, other than for refusal of medication.	W 227	C. QMRP &Psychologist will collaborate on a reward system to help person 1 participate in programming	7-30-09
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN 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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) included a data collection system directly related to the outcome of the objective, for one of the three clients included in the sample. (Client #3) The finding includes:	W 237		

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W 237	Continued From page 18 The facility failed to document the type of data collection necessary to be able to assess the progress toward the desired outcome, for Client #3. a. On June 10, 2009 from at 5:15 PM until 5:25 PM, Client #3 was observed sitting at the dining room table participating in arts/craft activities. Interview with the client indicated, "I am coloring a happy wolf." Interview with the direct care staff at 7:45 PM revealed that the client will participate in coloring activities. Review of Client #3's Social Work assessment dated May 6, 2008 on June 12, 2009 at 12:52 PM revealed a recommendation to improve the creative/leisure skills. According to the client's IPP dated July 25, 2008 at 11:56 AM, revealed a program objective which stated, "Three times per week, [the client] will participate in an arts and craft activity for ten minutes with verbal assistance for six consecutive month." According to the data sheets, staff documented the level of assistance needed to perform the exercises. The data sheet did not reflect the number of minutes completed. It could not be determined how this objective was being measured for progress. Interview with the Interim QMRP on June 12, 2009, at approximately 1:30 PM acknowledged that the current data collection system did not provide accurate measurement on the client's progress. b. Review of Client #3's IPP dated July 25, 2008 at 11:56 AM revealed an objective which stated, "[the client] will participate in a series of exercise activities and maintain the activities for at least 30 minutes with verbal prompts as needed for six	W 237	Person # 3 data collection sheets have been modified to include length of time person participated in program.	7-12-09

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W 237	Continued From page 19 consecutive months." According to the data sheets, staff documented the level of assistance needed to perform the exercises. The data sheet did not reflect the number of minutes completed. It could not be determined how this objective was being measured for progress. Interview with the Interim QMRP on June 12, 2009, at approximately 1:30 PM acknowledged that the current data collection system did not provide accurate measurement on the client's progress. 3. During medication administration on June 10, 2009 at 6:10 PM, the medication nurse handed Client #3 his locked medication box and key. The client opened the box, independently. The medication nurse asked the client what was the name of the medication and the date. The client required verbal prompts to stated with the medications with the exception of one (Thorazine). Interview with the medication nurse, after the medication pass indicated that the client is doing well with medication administration participation. Review of Client #3's IPP dated July 25, 2009 on June 12, 2009 at 11:56 AM revealed an objective which stated, "[the client] will learn the purpose of each identified pill with one verbal prompts from a licensed nurse daily for six consecutive months." Review of the data sheet revealed the following steps: - indicated time for medication; - sanitize hands; -retrieve medication box; - unlock box with key from nurse; - identify AM/PM medications	W 237	b. Person # 3 data collection sheets have been modified to include length of time person participated in program 3. Medication Nurses will receive training on person # 3 medication program	

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W 237	Continued From page 20 - read out medication by name; - punch out medication into cup; - empty medication into mouth; - drink 8 ounces of water; - return unused medication to locked box; - lock box and return to cabinet; and - complete and return medication administration record sheet. There was no evidence that the aforementioned steps asked the client to name the purpose of each identified pill.	W 237		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for two of the three clients included in the sample. (Clients #2 and #3) The findings include: 1. On June 10, 2009, at 5:30 PM, Client #2 was observed with dentures in his mouth. Interview with the client at 5:45 PM indicated that he cleaned his dentures. Interview with the direct care staff on June 11, 2009 at approximately 9:30	W 242		

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W 242	Continued From page 21 AM confirmed the statement of Client #2 and the direct care staff. Review of the Client #2's dental consultation dated December 16, 2008 on June 11, 2009 at 10:40 AM, revealed the client was evaluated for dentures. On March 11, 2009, Client #2's partial dentures were fitted and "everything was fine", according to the dental consultation report. Continued review of #2's record on June 11, 2009, at 2:28 PM revealed his Individual Program Plan (IPP) dated March 13, 2009. Review of the IPP failed to provide evidence of a training program to address the client's dental hygiene needs to ensure the maintenance of his remaining teeth. 2. On June 10, 2009, at 5:30 PM, Client #3 was observed missing teeth. Interview with the Licensed Practical Nurse (LPN) Coordinator on June 12, 2009 at approximately 10:47 AM revealed the client refused to wear his dentures. Review of Client #3's medical record on June 12, 2009, at 11:00 AM revealed a dental consultation dated December 10, 2008. The dentist recommended that the client "needs better brushing supervision." Continued review of the Client #3's records on June 12, 2009 at 11:56 AM revealed his IPP dated July 25, 2008. Review of the IPP failed to provide evidence of a training program to address the client's poor oral hygiene.	W 242	1. Tooth brushing and denture care program will be added to person # 2 daily formal programming schedule 2. Tooth brushing and denture care program will be added to person # 3 daily formal programming schedule	7-21-09
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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	W 249		

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W 249	Continued From page 22 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to implement client's Behavior Support Plan (BSP), for one of the three clients included in the sample. (Client #3) The findings include: The facility failed to implement Client # 3's BSP as written. During evening observation on June 10, 2009, at 6:28 PM, Client #3 was observed slapping the right side of his face and his hand. At 6:32 PM, the client was observed slapping the right side of his face and head. At 6:34 PM, the client was punching his chest . At 6:39 PM, the client was observed slapping the right side of his face, eight times. Staff was observed in the room during the aforementioned behaviors, however failed to intervene. Interview with the direct care staff indicated that the client has a BSP to address his behavior of self-injurious behaviors. Interview with the Interim Qualified Mental Retardation Professional (QMRP) on June 11, 2009 at approximately 10:00 AM revealed that all staff received training on Client #3's BSP on December 1, 2008. Review of Client #3's BSP dated June 20, 2008 on June 12, 2009 at 12:15 PM revealed, the client	W 249	Staff in-service on BSP for person # 3 scheduled for 7-30-09	7-30-09

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W 249	Continued From page 23	W 249		
	had maladaptive behaviors of self-injurious behaviors, physical aggression, property destruction, inappropriate verbalization, and agitation. Further review of the BSP revealed the following consequences to target behaviors: a. Verbally direct the client to stop the behavior; b. Redirect the client immediately to an alternative activity; c. Encourage him to extend his hand to staff by asking and holding out. Say, "hands down, lease, not hitting, please", let's walk together. d. Provide praise as he calms himself; and e. When behaviors occurs, staff should document behaviors on ABC charts. There was no evidence that the facility implemented Client #3's BSP as instructed.			
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop an active treatment schedule that outlined the current active treatment programs, for one of the three clients in the sample. (Client #1) The finding includes:	W 250		

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W 250	Continued From page 24	W 250		
	The facility failed to ensure an alternative activity schedule was provided for Client #1 as evidenced below: (Cross refer W227) Interview with staff on June 11, 2009 at 9:10 AM revealed that Client # 1 did not have a written activity schedule. Further interview with the staff revealed attempts were being made to engage the client in his formal individual program objectives; however, he often refused to participate in them. Record review on June 11, 2009 beginning at 11:37 AM, revealed an activity schedule included in Client #1's Individual Support Plan(ISP), dated July 28, 2008. The activity schedule had not been revised after the client stopped attending a day program in July 2008. The review of the July 28, 2008 activity schedule revealed that Client #1 should be at the day program from 9:00 AM to 4:00 PM. The review of the Annual Psychological Assessment dated May 5, 2008 on June 11, 2009 at 1:49 PM revealed a recommendation to "Develop a personal activity schedule and plan for daily active engagement. Activities should not be absent because he does not attend day program." At the time of the survey, there was no evidence a current activity schedule had been developed as recommended.		Person # 1 has a daily activity program. QMRP will collaborate with psychologist in effort to increase person #1 participation programming including day program participation	on-going
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 terms.	W 252		

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W 252	Continued From page 25 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate documentation of progress on the Individual Program Plan (IPP) objectives, for two the three clients included in the sample. (Clients #1 and #3) The findings include: 1. Interview with staff on June 11, 2009 at 5:15 PM revealed that Client #1 participated in training to improve his money management skills. According to staff, the client was learning to count change needed to go along with the bills when he made purchases. Further interview with the staff revealed the days the program should be implemented were circled on the data collection form, however sometimes the client refused to participate in the training on those days. Record review later that day revealed a training objective which stated "[Client] will make change for ten ($10.00) using ones, five dollar bill and different coin combinations with one verbal prompt for six (6) consecutive months by May 2009. The circled days on the data collection form revealed the training should be implemented twice a week, on Tuesdays and Thursdays. The program data form reflected no data was collected on two of the eight days days the program was scheduled to be implemented. At the time of the survey, there was no evidence data needed to monitor Client #1's progress in the objective had been consistently maintained. 2. Interview with staff on June 11, 2009 4:15 PM revealed Client #1 had a goal to improve his physical fitness by walking. According to staff, the	W 252	Staff received training on program documentation. This training will be reinforced with additional training on 7-30-09	7-2-09

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W 252	Continued From page 26 days the program should be implemented were circled on the data collection form. Staff indicated however, that the client often refused to participate in the training on those days (Mondays, Wednesdays, Fridays). Staff revealed, however, that the client does walk if he is on an outing with his housemates. Record review on June 11, 2009 at 4:35 PM confirmed a goal to enhance Client #1's physical fitness skills. According to the program objective, "Three days per week, [Client] will go for a walk in his neighborhood with one verbal prompt for six consecutive months. The distance the client was expected to walk was from 1/4 mile up to greater than one mile. The program data form revealed the client's refusal to walk on 3 of the five schedule days. No data was collected on other two of the five days days the program was scheduled to be implemented in June 2009, At the time of the survey, there was no evidence that Client #1's neighborhood walks had been documented in measurable terms. 3. The facility failed to document behavior data in accordance with Client 3's Behavior Support Plan (BSP). During evening observation on June 10, 2009, at 6:28 PM, Client #3 was observed slapping the right side of his face and his hand. At 6:32 PM, the client was observed slapping the right side of his face and head. At 6:34 PM, the client was punching his chest . At 6:39 PM, the client was observed slapping the right side of his face, eight times. During the aforementioned behaviors, staff was observed in the room. Interview with the direct care staff indicated that the client has a BSP to address his behavior of self-injurious	W 252	Program data sheet has been change to document distance person #1 walked and staff has been in serviced on program documentation	7-2-09

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	09G145		06/12/2009

NAME OF PROVIDER OR SUPPLIER: MARJUL HOMES

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W 252	Continued From page 27 behaviors. On June 12, 2009 at approximately 12:30 PM, review of Client #3's BSP dated June 20, 2009, confirmed that one of his targeted behaviors was self-injurious behaviors. The BSP further revealed Client #3's behaviors should be recorded accurately and consistently on data collection sheets. Review of the ABC behavior data collection sheets on June 11, 2009, at approximately 3:00 PM, however, revealed that staff did not document the client's self-injurious behaviors that were displayed on June 10, 2009. At approximately 3:20 PM, the Designated Licensed Practical Nurse (DLPN) acknowledged that staff had not documented the self-injurious behaviors as required. 3. The review of Client #1's Individual Support Plan dated July 28, 2008 revealed the IDT recommended a goal "to improve his personal hygiene". Instructions for program implementation revealed, the "[Client] will take a shower twice per week on two days of his choice independently. Staff was to document the when the client took a shower. Interview with the QMRP on June 10, 2009 at 6:45 PM revealed that Client #1 did not like to take baths and had not made progress in the objective. According to staff on June 11, 2009 at 4:10 PM, they informed Client #1 when it was time to take his shower. Continued staff interview revealed, if the client refused to take a bath, they asked the client to tell staff if he took a bath later, so that it could be documented. Interview with the DLPN and the residential director on June 11, 2009 at 2:30 PM revealed the client documents his own programs.	W 252	Staff received training on program documentation. This training will be reinforced with additional training on 7-30-09	7-2-09

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W 252	Continued From page 28 On June 12, 2009 at 12:30 PM, the review of a sheet of paper in the notebook kept by the client indicated that he took a shower on May 6, May 18, June 2, and June 10, 2009. It should be noted that this information was contradictory to the data collection. The review of a staff note written on the June 2009 IPP revealed "Tried to encourage the client to take shower on Monday and Friday, but he refused. He does it his way. Whenever he gets ready to shower, that's when he will shower." At the time of the survey, there was no evidence a system had been developed to accurately monitor the client's progress in the objective designed to improve his personal hygiene. [See also W227]	W 252	Staff received training on program documentation. This training will be reinforced with additional training on 7-30-09	7-2-09
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for two of the three clients included in the sample. (Clients #2 and #3) The findings include: [Cross-refer to W124] 1. The facility failed to ensure that written informed consent was obtained from Client #2's guardian prior to the administration of his psychotropic medications.	W 263		

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W 263	Continued From page 29 Interview with the Qualified Mental Retardation Professional (QMRP) on June 10, 2009, at 4:30 PM, during the entrance conference indicated Client #2 receives psychotropic medications to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. Observation of the evening medication administration on June 10, 2009 at 6:20 PM, revealed Client #2 was administered Clonidine HCL 0.2 mg, Paxil 30 mg and Risperdal 0.5 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behaviors. Further interview was conducted with the QMRP revealed that the client did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on June 11, 2009, at 2:28 PM through review of Client #2's psychological assessment dated February 20, 2009. According to the assessment, Client #2 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or financial matters. He can not execute a durable power of attorney." Continued interview with the QMRP, revealed that Client #2 had several family members who were involved in his decision making and habilitation planning. Further review of Client #2's record on June 11, 2009, at 3:00 PM revealed that the client, in	W 263	Person # 2 management team is obtaining signed consent form. The current medications will be listed and the consent will be dated and authorized by a notary public.	7-31-09

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W 263	Continued From page 30 addition to taking psychotropic medications, also had a Behavior Support Plan dated February 15, 2009, to address his behaviors of explosive episodes and mood instability related to depression. At the time of the survey however, the facility failed to provide written evidence that consent was obtained for the use of the psychotropic medication and Behavior Support Plan (BSP) that were designed/conducted to reduce Client #2's behaviors. Record verification on June 11, 2009 3:43 PM revealed that Client #2's guardian had given informed consent for the use of Risperdal 0.05 mg (only or less) and Paxil 30 mg (only or less) dated October 17, 2006. However there was no consent signed for the client's current prescribed psychotropic medications. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication. 2. Observation of the morning medication administration on June 10, 2009 at 6:04 PM, revealed Client #3 was administered Lithium Carbonate ER 600 mg, Revia 100 mg and Thorazine HCL 200 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behaviors. During the entrance conference on June 10, 2009, at 4:30 PM, an interview was conducted with the QMRP revealed that the client did not have the capacity to give informed consent for the	W 263		

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W 263	Continued From page 31 use of medications and habilitation services. The QMRP's statement was verified on June 12, 2009, at 11:56 AM through review of Client #3's psychological assessment dated June 20, 2008. According to the assessment, Client #3 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to profound mental retardation. He can not execute a durable power of attorney." Continued interview with the QMRP, revealed that Client #3 had a court appointed guardian. Further review of Client #3's record on June 12, 2009, at 12:10 PM revealed that the client, in addition to taking psychotropic medications, also had a Behavior Support Plan dated June 20, 2008, to address his behaviors of physical aggression, self injurious behaviors, property destruction, inappropriate verbalizations and agitation. According to the signed consent forms revealed that the client's guardian had given informed consent dated August 29, 2009, for Thorazine 200 mg BID. Additional review revealed that the guardian signed a consent dated September 11, 2007. The consent was for Prozac 20 mg, Lithium Carbonate ER 300 mg, Risperdal 5 mg. It should be noted that the signed consents were not the client's current prescribed psychotropic medications. At the time of the survey however, the facility failed to provide evidence that consent was obtained for the use of the psychotropic medications as prescribed that was designed/conducted to reduce Client #3's	W 263	Person # 3 management team is obtaining signed consent form. The current medications will be listed and the consent will be dated and authorized by a notary public.	7-31-09

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W 263	Continued From page 32 behaviors.	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure preventive health services for one of the three clients in the sample. (Client #1) The findings include: The facility failed to implement measures to ensure that Client #1 received a recommended colonoscopy as evidenced below: Interview with the DLPN on June 11, 2009 at approximately 3:15 PM revealed Client #1 refused to go on some of his appointments and that they had to be rescheduled. The nurse indicated that this was largely due to the client not wanting to leave the facility more than once a week. Further interview with the DLPN revealed that the colonoscopy recommended for the client in 2007 had not been completed. Record review revealed the colonoscopy was recommended by the primary care physician due to Client #1's weight loss in 2007. The review of a nursing assessment dated August 18, 2007 revealed the colonoscopy was scheduled for April 23, 2007, however the client refused to go on the appointment. Interview with the DLPN revealed preoperative studies were done for the colonoscopy on	W 322		

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W 322	Continued From page 33 October 12, 2008 for the procedure on October 15, 2008. Further interview with the QMRP revealed the client refused to go on the appointment on that date, stating that he wanted to eat and that the promised painting of his bedroom had not been completed. The DLPN indicated the colonoscopy was then scheduled for November 15, 2008, however the client refused to be prepared for the procedure. At the time of the survey, there was no evidence that Client #1's colonoscopy had been completed as recommended.	W 322	Person #1 IDT team is working on a reward system to increase his participation in medical appointments	On-going
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide an annual eye evaluation for one of the three clients in the sample. (Client #1). The finding includes: The facility failed to ensure Client #1 received a recommended vision examination as evidenced below: a. Observation of Client #1 on June 10, 2009 at 5:50 PM revealed he was wearing thick glasses as he sat in his bedroom watching television. At 6:27 PM, the nurse called the client several times to take his medications, however he did not come to the medication room. From 6:40 PM to 6:50 PM, the client was observed eating his dinner with his face close to the plate.	W 323		

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W 323	Continued From page 34 The client was observed to accept the medications in the cup from the nurse, when she took them to his bedroom at 7:00 PM. Interview with the medication nurse on June 10, 2009 at 6:25 PM revealed that Client #1 had a physician's order to self medicate under nursing supervision. Further interview with the medication nurse revealed the client had a program objective to take his medication with one verbal prompt. The medication nurse acknowledged that the client sometimes refused to come to the office to get his medications. According to the medication nurse, the client was only able to participate in his medication administration to a limited extent, due to his poor vision, and non-compliance at time for taking his medications. Record review on June 11, 2009 at 10:30 AM revealed a physician's order dated June 1, 2009 which stated "Client may self-medicate under supervision of nurse." b. Interview with the Designated Licensed Practical Nurse (DLPN)on June 12, 2009 at 2:20 PM revealed the client's annual ophthalmology evaluation had been scheduled for December 11, 2008. According to the DLPN, after arriving at the clinic, the client refused to be examined by the practitioner. Further interview with the nurse revealed the client's ophthalmology appointment had not been rescheduled. On June 11, 2009 at 3:12 PM the designated nurse revealed that the client wants to limit his appointments to three times a month. Further interview with the nurse revealed that the client considers each time that he leaves the facility as an appointment.	W 323	Medical assessment will be complete to assess Person#1 ability to self medicate. b. Person #1 IDT team is working on a reward system to increase his participation in medical appointments	7-22-09 on-going

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W 323	Continued From page 35	W 323		
	Record review on June 11, 2009 at AM revealed the client's diagnoses included "Bilateral Partial Vision Loss compatible with legal blindness, Bipolar Disorder and Intermittent Explosive Disorder". The review of the annual individual support plan dated July 28, 2008, revealed a recommendation for an annual eye evaluation. Further record review revealed Client #1's last Ophthalmology evaluation was completed on December 10, 2007. The specialist recommended "Needs glasses at all times; follow-up in one year." At the time of the survey, there was no evidence Client #1 had received the annual ophthalmology assessment as recommended to monitor the status of his vision.			
W 331	483.460(c) NURSING SERVICES	W 331		
	The facility must provide clients with nursing services in accordance with their needs.			
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of two of the six clients residing in the facility. (Clients #1 and #5)			
	The findings include:			
	1. [Cross Refer to W393] The facility failed to ensure an effective system for glucose monitoring for Client #5.		Only nursing will monitor and document individuals glucose level	6-12-09
	a. Observation of the medication administration on June 10, 2009 at 6:04 PM, revealed Client #5 received Metformin 1000 mg, 1 tab. Interview with the Licensed Practical Nurse (the medication nurse) administering the medication			

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W 331	Continued From page 36 revealed that Client #5 had a diagnosis of Type II Diabetes Mellitus and that the purpose of the medication was to control his blood glucose level. Interview with the designated Designated (DLPN) on June 11, 2009 at 10:25 AM revealed that the direct care staff monitor Client #5's blood sugar before he eats in the morning and prior to his eating a snack when he returns from his day program. According to the DLPN, this prevents the client from having to wait for his food. The DLPN indicated that she trained all staff on how to administer the fingerstick to check the client's blood sugar using the glucometer. According to the DLPN, staff should document the results of each fingerstick in the client's record and sign the Glucose Monitoring Sheet. The DLPN acknowledged that the results of the fingersticks should be monitored by the nurse. The review of the Glucose Monitoring Sheet revealed direct care staff failed to monitor and/or document Client #5's glucose on some days as evidenced below: - April 3, 2009 - PM - April 5, 2009 - AM - April 23, 2009 - PM - April 27, 2009 - AM - May 1, 2009 - AM and PM - May 5, 2009 - AM - May 30, 2009 -AM - June 1, 2009 - AM - June 5, 2009 - AM Further review of the Glucose Monitoring Sheets revealed the individuals performing the tests on May 11, 2009 (AM/PM) and May 15, 2009 (PM) failed to sign the form. Additionally, review of the	W 331		

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W 331	Continued From page 37 April, May and June 2009 forms revealed that staff performing the testing in the AM initialed the form instead of signing them as required. At the time of the survey, there was no evidence the documentation of Client #5's glucose monitoring (fingersticks) had been closely monitored by the nurse to ensure that it was performed and documented as required. b. Interview with the DLPN on June 11, 2009 at approximately 10:05 AM revealed she trained all staff on how to administer the fingerstick to check the client's blood sugar using the glucometer. Subsequent review of training records at that time revealed this training was included in the training on "Signs and Symptoms of Illness" on December 1, 2008. Further interview with the DLPN revealed she instructed staff on the procedures that were outlined in the literature provided with the glucometer. At the time of the survey, the was no evidence that the facility's nursing policy outlined procedures for using the glucometer. 2. [Cross refer to W323] The facility failed to ensure that Client #1's recommended annual vision examination was rescheduled after he was non-compliant during the scheduled appointment as evidenced below: Observation of Client #1 on June 10, 2009 at 5:50 PM revealed he was wearing thick glasses as he sat in his bedroom watching television. Interview with the Designated Licensed Practical Nurse (DLPN) on June 12, 2009 at 2:20 PM revealed the client's annual ophthalmology evaluation had been scheduled for December 11, 2008, however after arriving at the clinic, the client refused to be examined by the practitioner. Interview with the	W 331	Person #1 Ophthalmology appointment scheduled	8- 17-09

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W 331	Continued From page 38 DLPN and the record review on June 12, 2009 revealed that at the time of the survey, there was no evidence that Client #1 ophthalmology evaluation had been rescheduled to determine the current status of his vision.	W 331		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for clients in the facility whose blood glucose was being tested by facility staff, for one of the six clients in the facility. (Client #5) The finding includes: Observation of the medication administration on June 10, 2009 at 6:04 PM, revealed Client #5 received Metformin 1000 mg, 1 tab. Interview with the Licensed Practical Nurse (LPN) administering the medication revealed that Client #5 had a diagnosis of Type II Diabetes Mellitus and that the purpose of the medication was to control his blood glucose level. On June 11, 2009, at approximately 11:00 AM, during the environmental inspection, a red container of used glucose blood testing needles were observed in an unlocked cabinet. Interview with the House Supervisor at 11:30 AM revealed that Client #5 received finger sticks (fasting) prior to his breakfast and dinner.	W 393		

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W 393	Continued From page 39 Review of Client #5's physician's orders (POs) for the period from August 2008 through June 2009, indicated that the client had an order for in-home finger sticks (fasting), twice daily (before meals). Interview with the Lead Supervisor on June 11, 2009. at approximately 4:30 PM indicated that she performed finger sticks on the client prior to his afternoon snack, upon return from day program. The Licensed Practical Nurse (LPN) Coordinator confirmed that the direct care staff were performing finger sticks on Client #5. Interview with the Chief Executive Officer (CEO) on June 11, 2009. at approximately 9:00 AM revealed that the provider did not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA) to perform laboratory services, such as glucose monitoring in the facility.	W 393	Provider is currently securing certifying nurses to comply with CLIA requirement	8-17-09

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012

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R 000	INITIAL COMMENTS A relicensure survey was conducted from June 10, 2009 through June 12, 2009. 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. A random sampling of three clients was selected from a population of six male clients with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the checks, for one (1) out of eight (8) personnel. The finding includes:	R 125		

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R 125	Continued From page 1 Review of the personnel files on June 12, 2009 revealed the GHMRP failed to provide evidence of criminal background checks on file for one direct care staff.	R 125	Staff will provide background information by 7-31-09 or be removed from shift until required documentation is received.	7-31-09

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I 000	INITIAL COMMENTS A relicensure survey was conducted from June 10, 2009 through June 12, 2009. 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. A random sampling of three clients was selected from a population of six male clients with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	I 000		
I 090	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 odors. This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to maintain the facility in a clean and attractive manner. The findings include: An environmental inspection was conducted on June 11, 2009 at approximately 9:45 AM revealed the following: 1. There was a hole in the living room wall; 2. The window blind in the first floor dinning room	I 090	1. Repaired 2. Blind replaced	7-20-09 7-20-09

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

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I 090	Continued From page 1	I 090		
	was torn; 3. There was a broken bed slat on one of the resident's bed; 4. The second floor bathroom had a broken towel rack; 5. Neither the second floor bathroom or the first floor bathroom had cup dispensers; 6. There was a broken window pane in the second floor rear bedroom; 7. Three of the five dining chairs were extremely dirty; 8. There was a torn venetian blind in the first floor family room. 9. On June 11, 2009, at approximately 11:00 AM, during the environmental inspection, a red container of used glucose blood testing needles were observed in an unlocked cabinet. There was no evidence the facility's nursing services had ensure that the glucose testing needles were stored in a locked environment. 10. Interview with the DLPN on June 11, 2009 at approximately 10:05 AM revealed she trained all staff on how to administer the fingerstick to check the client's blood sugar using the glucometer. Subsequent review of training records at that time revealed this training was included in the training on "Signs and Symptoms of Illness" on December 1, 2008. Further interview with the DLPN revealed she instructed staff on the procedures that were outlined in the literature provided with the glucometer. At the time of the survey, the was no evidence that the facility's nursing policy outlined procedures for using the glucometer. Interview with the House Supervisor on June 11, 2009, at approximately 11:30 AM confirmed the above identified concerns which were observed during the environmental walk-through.		3. Slat replaced 4. towel rack replaced 5. dispenser installed 6. pane replaced 7. Chairs cleaned 8. blind replaced 9. Glucose material locked in nursing station 10. see response to W 393	6-30-09 7-20-09 7-2-09 7-15-09 6- 21-09 7-20-09 6-12-09

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I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure each poison and caustic agent was stored in a locked cabinet /area and out of the direct of the residents. The finding includes: On June 11, 2009 at approximately 10:00 AM, the door leading to the basement was observed to be unlocked. Further observations while in the basement revealed caustic agents and cleaning supplies were also observed to be stored in an unsecured area. Interview with the House Supervisor acknowledged that the chemicals were not stored in an unsecured area. There was no evidence these items were kept in a secured location to ensure the residents' safety and well being.	I 095	Caustic items placed in secure place	6-11-09
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to provide residents with at least seven changes of clothing, for one of the three residents included in the sample. (Resident #1)	I 108		

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I 108	Continued From page 3 The finding includes: An environmental inspection was conducted on June 11, 2009, at approximately 10:00 AM. The inspection revealed that Resident #1 had three pairs of pants in his dresser drawer. In an interview with the House Supervisor revealed Resident #1 had been offered additional clothing, but had refused to accept and wear them. Further interview with the home staff confirmed the findings.	I 108	Person #1 IDT team is working on a reward system to increase his compliance to programs	on-going
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure a system had been implemented to maintain a complete accounting of the personal funds for two of three residents in the sample. (Residents #1 and #2)) The findings include: Review of the financial records on June 11, 2009, at approximately 10:15 AM revealed there was no accurate account of how the Resident #1 and #2's funds were being received and disbursed. a. Review of Resident #1's financial records revealed that there were no bank statements from September 2008 through December 2008. Interview with the Chief Executive Officer (CEO) on June 12, 2009 at approximately 9:30 AM revealed that the records were disarrayed because there had been three changes in the administrative staff within the last year.	I 189	See Response to W126 & W 140	

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I 189	Continued From page 4 b. Review of Resident #2's financial records (bank statement) revealed a balance of $1,170.29 in September 2008. The next statement that was in May 2009, showed a balance of $5.29 in the resident's account. There were no receipts in the resident's file to show how and when the money had been spent. Interview with the CEO on June 12, 2009, at approximately 10:00 AM revealed that the records were disarrayed because there had been three changes in the administrative staff within the last year. Review of the financial records on June 11, 2009, at approximately 10:15 AM revealed there was no accurate accounting of how Resident #1's and #2's funds were being received and disbursed. c. Review of Resident #1 financial record revealed that there were no bank statements from September 2008 thru December 2008. Interview with the Chief Executive Officer (CEO) on June 12, 2009 at approximately 9:30 AM revealed that the records were disarrayed because there had been three changes in the administrative staff within the last year. d. Review of Resident #2 financial record revealed that there was a bank statement for $1,170.29 in September 2008 and the next statement that was for May 2009, showed a balance of $5.29 in the resident's account. There were no receipts in the resident's file to show how and when the money had been spent. Interview with the CEO on June 12, 2009, at approximately 10:00 AM revealed that the records were disarrayed because there had been three	I 189		

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I 189	Continued From page 5 changes in the administrative staff within the last year.	I 189		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with state regulations pertaining to health (22DCMR 35, section 3509.6) for six (6) of eight (8) staff and three (3) of nine (9) consultants. The finding includes: The State regulatory agency conducted a review of personnel records on June 12, 2009, at approximately 3:00 PM, at which time there was no evidence of current health certificates on file for six out of eight direct care staff (Staff #1, #3, #4, #5, #6, and #7) and the nutritionist, the psychologist, and the pharmacist. Interview with the House Supervisor on June 12, 2009, at 4:00 PM confirmed the missing health certificates were not available.	I 206	All staff annual health certificates will be available by 8-3-09 or they will be roved from schedule	8-3-09
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be	I 227		

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I 227	Continued From page 6 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 CPR and first aid for all employees, for four (4) out of thirteen (13) staff. The finding includes: Review of the training records on June 12, 2009 at approximately 9:30 AM revealed the GHMRP failed to evidence documentation of staff training in cardiopulmonary resuscitation (CPR) for Staff #2 and #7 and First Aid for Staff #2 and #7. Subsequent interview with the interim Qualified Mental Retardation Professional later that day verified that the administrative office had not provided documentation of the aforementioned training for Staff #2 and #7.	I 227	Staff will show evidence of current CPR or be removed from the schedule	8-3-09
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 residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and record review, the facility	I 229		

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I 229	Continued From page 7 failed to ensure staff were trained on sexuality, for three (3) of thirteen (13) personnel records reviewed. The finding includes: Review of the personnel training records on June 11, 2009, at 4:00 PM revealed no evidence of training for human sexuality. Subsequent interview with the interim Qualified Mental Retardation Professional later that day verified that the administrative office had not provided documentation of the aforementioned training for Staff #2 and #7.	I 229	Staff training on sexuality scheduled	8-5-9
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS 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. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure professional services were provided in accordance with the assessed needs of two of the six residents in the GHMRP. (Residents #1 and #5) The findings include: 1. The facility failed to ensure preventive health services for one of the three Residents in the sample. (Resident #1) A. The facility failed to implement measures to ensure that Resident #1 received a	I 401	See Response to W227, W322, W323, W 331, W393	

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I 401	Continued From page 8 recommended colonoscopy as evidenced below: Interview with the DLPN on June 11, 2009 at approximately 3:15 PM revealed Resident #1 refused to go on some of his appointments and that they had to be rescheduled. The nurse indicated that this was largely due to the Resident not wanting to leave the facility more than once a week. Further interview with the DLPN revealed that the colonoscopy recommended for the Resident in 2007 had not been completed. Record review revealed the colonoscopy was recommended by the primary care physician due to Resident #1's weight loss in 2007. The review of a nursing assessment dated August 18, 2007 revealed the colonoscopy was scheduled for April 23, 2007, however the Resident refused to go on the appointment. Interview with the DLPN revealed preoperative studies were done for the colonoscopy on October 12, 2008 for the procedure on October 15, 2008. Further interview with the QMRP revealed the Resident refused to go on the appointment on that date, stating that he wanted to eat and that the promised painting of his bedroom had not been completed. The DLPN indicated the colonoscopy was then scheduled for November 15, 2008, however the Resident refused to be prepared for the procedure. At the time of the survey, there was no evidence that Resident #1's colonoscopy had been completed as recommended. B. the facility failed to provide an annual eye evaluation for Resident #1. The facility failed to ensure Resident #1 received a recommended vision examination as evidenced	I 401		

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I 401	Continued From page 9 below: a. Observation of Resident #1 on June 10, 2009 at 5:50 PM revealed he was wearing thick glasses as he sat in his bedroom watching television. At 6:27 PM, the nurse called the Resident several times to take his medications, however he did not come to the medication room. From 6:40 PM to 6:50 PM, the Resident was observed eating his dinner with his face close to the plate. The Resident was observed to accept the medications in the cup from the nurse, when she took them to his bedroom at 7:00 PM. Interview with the medication nurse on June 10, 2009 at 6:25 PM revealed that Resident #1 had a physician's order to self medicate under nursing supervision. Further interview with the medication nurse revealed the Resident had a program objective to take his medication with one verbal prompt. The medication nurse acknowledged that the Resident sometimes refused to come to the office to get his medications. According to the medication nurse, the Resident was only able to participate in his medication administration to a limited extent, due to his poor vision, and non-compliance at time for taking his medications. Record review on June 11, 2009 at 10:30 AM revealed a physician's order dated June 1, 2009 which stated "Resident may self-medicate under supervision of nurse." b. Interview with the Designated Licensed Practical Nurse (DLPN)on June 12, 2009 at 2:20 PM revealed the Resident's annual ophthalmology evaluation had been scheduled for	I 401		

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I 401	Continued From page 10 December 11, 2008. According to the DLPN, after arriving at the clinic, the Resident refused to be examined by the practitioner. Further interview with the nurse revealed the Resident's ophthalmology appointment had not been rescheduled. On June 11, 2009 at 3:12 PM the designated nurse revealed that the Resident wants to limit his appointments to three times a month. Further interview with the nurse revealed that the Resident considers each time that he leaves the facility as an appointment. Record review on June 11, 2009 at AM revealed the Resident's diagnoses included "Bilateral Partial Vision Loss compatible with legal blindness, Bipolar Disorder and Intermittent Explosive Disorder". The review of the annual individual support plan dated July 28, 2008, revealed a recommendation for an annual eye evaluation. Further record review revealed Resident #1's last Ophthalmology evaluation was completed on December 10, 2007. The specialist recommended "Needs glasses at all times; follow-up in one year." At the time of the survey, there was no evidence Resident #1 had received the annual ophthalmology assessment as recommended to monitor the status of his vision. C. The GHMRP failed to ensure nursing services were provided in accordance with the needs of Resident #5. a. [Cross Refer to W393] the GHMRP failed to ensure an effective system for glucose monitoring for Resident #5. - Observation of the medication administration on June 10, 2009 at 6:04 PM, revealed Resident #5 received Metformin 1000 mg, 1 tab. Interview with the Licensed Practical Nurse (LPN)	I 401		

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I 401	Continued From page 11 administering the medication revealed that Resident #5 had a diagnosis of Type II Diabetes Mellitus and that the purpose of the medication was to control his blood glucose level. Interview with the designated Designated (DLPN) on June 11, 2009 at 10:25 AM revealed that staff monitor Resident #5's blood sugar before he eats in the morning and prior to him eating a snack when he returns from his day program. According to the DLPN, this prevents the resident from having to wait for his food. Further interview with the DLPN revealed she trained all staff on how to administer the fingerstick to check the resident's blood sugar using the glucometer. The review of the Glucose Monitoring Sheet revealed staff failed to monitor and/or document Resident #5's glucose on some days as evidenced below: - April 3, 2009 - PM - April 5, 2009 - AM - April 23, 2009 - PM - April 27, 2009 - AM - May 1, 2009 - AM and PM - May 5, 2009 - AM - May 30, 2009 -AM - June 1, 2009 - AM - June 5, 2009 - AM Further review of the Glucose Monitoring Sheets revealed the individual performing the tests on May 11, 2009 (AM/PM) and May 15, 2009 (PM) failed to sign the form. Additionally, review of the April, May and June 2009 forms revealed that staff performing the testing in the AM initialed the form instead of signing them as required. There was no evidence that the documentation of	I 401		

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I 401	Continued From page 12 Resident #5's glucose monitoring was closely monitored by the DLPN to ensure that it was performed and documented as required. - On June 11, 2009, at approximately 11:00 AM, during the environmental inspection, a red container of used glucose blood testing needles were observed in an unlocked cabinet. There was no evidence the GHMRP's nursing services had ensure that the glucose testing needles were stored in a locked environment. - Interview with the DLPN on June 11, 2009 at approximately 10:05 AM revealed she trained all staff on how to administer the fingerstick to check the resident's blood sugar using the glucometer. Subsequent review of training records at that time revealed this training was included in the training on "Signs and Symptoms of Illness on December 1, 2008. Further interview with the DLPN revealed she instructed staff on the procedures that were outlined in the literature provided with the glucometer. At the time of the survey, the was no evidence that the GHMRP's nursing policy outlined procedures for using the glucometer.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure individual program plan objectives were implemented in accordance with the Individual Habilitation Plans (IHP) for two of the three residents in the sample. (Residents #1 and #3)	I 422	See Response to W 227, W237, W322, W323, W 331	

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	HFD03-0008	A. BUILDING B. WING	06/12/2009
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
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I 422	Continued From page 13 The finding includes: 1. The GHMRP failed to ensure the individual program plan (IPP) stated a specific objective that addressed an identified training need (improved compliance with treatment regimen) for Resident #1. On June 10, 2009 at 6:30 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed Resident #1 had a history of refusals, which interfered significantly with his active treatment and his health management. The review of Resident #1's Individual Support Plan (ISP) dated July 28, 2008 confirmed this history and the continuing concern of refusals in various aspects of his life. However, the Interdisciplinary Team (IDT) failed to design a plan to address the resident's non-compliance as evidenced by the following: A. The review of Resident #1's records revealed on June 11, 2009 revealed he refused to consistently participate in his active treatment programs as evidenced below: - Goal: To improve his self-Medication skills. [Resident] will take his medication daily (AM and PM as directed by his doctor with one verbal prompt under supervision of a licensed nurse...). The objective was to be implemented daily.) On June 10, 2009 at 6:27 PM, the nurse was observed to call Resident #1 several times to take his medications, however he did not come to the medication station. From 6:40 PM to 6:50 PM, the resident was observed in the dining room eating his evening meal. At 7:00 PM, while in his bedroom, Resident #1 accepted his prescribed	I 422		

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I 422	Continued From page 14 medications from the nurse. Interview with the medication nurse on June 10, 2009 at 6:29 PM confirmed that the resident refused to come to the medication closet located in the office to receive his prescribed medications. Further interview with the medication nurse revealed the resident participated in his medication administration only to a limited extent, due to his poor vision, and non-compliance at times for taking his medications. - Goal: To improve his personal hygiene. [Resident] will take a shower twice per week on two days of his choice independently for six consecutive months by 2/09. Interview with the QMRP on June 10, 2009 at 6:45 PM revealed that Resident #1 did not like to take baths and had not made progress in the objective. According to interview with staff on June 11, 2009 at 4:10 PM, they informed Resident #1 when it was time to take his shower. Continued staff interview revealed, if the resident refused to take a bath, they asked the resident to tell staff if he took a bath later, so that it could be documented. The review of the Resident #1's ISP dated July 28, 2008 revealed, the resident continued to refuse taking a daily bath. According to the ISP however, the resident agreed to take a shower on two days a week of his choice. On June 12, 2009 at 12:30 PM, the QMRP's Monthly Status Report for March 2009 and April 2009 documented that the resident took three (3) showers during each of the two months. According to the data collection form, the resident should take a shower twice a week (eight times a month). The review of	I 422		

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I 422	Continued From page 15 program data for May 2009 revealed that the resident had taken three showers during the month and that the last shower was on May 18, 2009. Program data for June 2009 revealed that the resident had refused all showers during the month. On June 12, 2009 at 12:30 PM, the review of a sheet of paper in the notebook kept by the resident indicated that he took a shower on May 6, May 18, June 2, and June 10, 2009. It should be noted that this information was contradictory to the data collection. The review of a staff note written on the June 2009 IPP revealed "Tried to encourage the resident to take shower on Monday and Friday, but he refused. He does it his way. Whenever he gets ready to shower, that's when he will shower." - Goal: To improve his money management skills. [Resident] will make change (with one verbal prompt) for $20.00 using $1, $5, $10 bills in different denominations for six consecutive months by February 2009. The objective was to be implemented two times a week (on Tuesdays and Thursdays). Review of the QMRP's Monthly Status for April 2009 revealed the resident refused the task to participate in the money management program when offered thirteen (13) times during the month. Record review on June 12, 2009 revealed the training should be implemented on Tuesdays and Thursdays. According to the data collection records for May 2009, data was collected for 2 of the 8 days the objective was scheduled to be implemented. Interview and record review at the time of the survey revealed no data was available for June 2009.	I 422		

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I 422	Continued From page 16 - Goal: To enhance his physical fitness skills. Three days per week, [Resident] will go for a walk in his neighborhood with one verbal prompt for six consecutive months by February 2009. Interview with staff on June 11, 2009 at 4:20 PM revealed Resident #1 refused to go on the scheduled walks identified in his IPP training objective. Record review revealed the program was scheduled to be implemented on Mondays, Wednesdays and Fridays. Program data revealed the following information concerning this objective: - 2/09: Walked 3 days; refused on 7 days offered - 3/09: Walked on 3 days; refused on 10 days offered - 4/09: Walked on 1 day; refused on 12 days offered - 5/09: Walked on 3 days; refused 6 of 13 days offered - 6/09: Refused on 3 of 5 days offered; on 2 of the 5 days scheduled, there was no documentation to determine if the resident was given an opportunity to walk. At the time of the survey, there was no evidence that the IDT had addressed the resident's persistent refusal to participate in his program objectives. There was no evidence the GHMRP had ensured continuous and aggressive active treatment to improve Resident 1's level of functioning in his environment. B. It should be further noted that Resident #1 failed to permit or participate in needed appointments. According to Resident #1's medical record he had failed to allow the following recommended appointments/procedures to be completed as evidenced below:	I 422		

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I 422	Continued From page 17 (1) A colonoscopy initially scheduled to be done on April 23, 2007 still had not been completed. (See W322) (2) An ophthalmology evaluation had been scheduled for December 11, 2008 in accordance with the specialist recommendation in 2007. (See W323) Interview with the Designated Licensed Practical Nurse (DLPN) on June 12, 2009 at 2:20 PM revealed the resident's annual ophthalmology had been scheduled for December 11, 2008, however after arriving at the clinic, the resident refused to be examined by the practitioner. Further interview with the DLPN on June 12, 2009 revealed the resident's ophthalmology had not been rescheduled. The nurse indicated that due to the resident's refusal to go on more that three appointments in a month, it had been difficult to ensure that each of the resident's needed assessments and follow-up appointments were completed. C. The GHMRP failed to identify a program to address Resident #1's refusals. Record review on June 11, 2009 at 2:34 PM revealed Resident #1 had a Psychiatric Assessment dated February 26 2009. The Psychiatric Assessment identified Resident #1's Axis I diagnosis of Intermittent Explosive Disorder and Bipolar Disorder. The record also included an Axis IV diagnosis of Occupational Disorder. However, the interdisciplinary team failed to design a plan to address the resident's non-compliance/refusal. On June 12, 2009 at 3:30 PM, the review of	I 422		

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I 422	Continued From page 18 Resident #1's Annual Psychological Assessment dated May 8, 2009 revealed it identified the following goals to address targeted behaviors: (1) Explosive episode will decrease to 0 a month for nine consecutive months. (2) Psychotic Ideations will decrease to zero a month for nine consecutive months. According to the psychological assessment psychotic ideations are statements made that have no basis in reality, that refer to the past; or that make no sense in the current setting; refusing medications. Interview with the DLPN on June 11, 2009 at 3:29 PM revealed that the resident was monitored monthly by the Psychiatrist during the Psychotropic Medication Reviews. According to the DLPN, the meetings were also attended by the Psychologist, the DLPN, the QMRP and the resident. According to the May 2009 PMR Meeting report, the resident had one behavioral episode in May 2009, and was clinically stable. The team recommended that the resident continue his BSP and continue therapy. At the time of the survey, however, there was no evidence that the IPP included a specific objective to address Resident #1's refusal to participate in his IPP objectives, other than for refusal of medication. 2. the GHMRP failed to implement resident's Behavior Support Plan (BSP) as written for Resident #3. During evening observation on June 10, 2009, at 6:28 PM, Resident #3 was observed slapping the right side of his face and his hand. At 6:32 PM, the resident was observed slapping the right side of his face and head. At 6:34 PM, the resident was punching his chest . At 6:39 PM, the	I 422		

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I 422	Continued From page 19 resident was observed slapping the right side of his face, eight times. Staff was observed in the room during the aforementioned behaviors, however failed to intervene. Interview with the direct care staff indicated that the resident has a BSP to address his behavior of self-injurious behaviors. Interview with the Interim Qualified Mental Retardation Professional (QMRP) on June 11, 2009 at approximately 10:00 AM revealed that all staff received training on Resident #3's BSP on December 1, 2008. Review of Resident #3's BSP dated June 20, 2008 on June 12, 2009 at 12:15 PM revealed, the resident had maladaptive behaviors of self-injurious behaviors, physical aggression, property destruction, inappropriate verbalization, and agitation. Further review of the BSP revealed the following consequences to target behaviors: a. Verbally direct the resident to stop the behavior; b. Redirect the resident immediately to an alternative activity; c. Encourage him to extend his hand to staff by asking and holding out. Say, "hands down, lease, not hitting, please", let's walk together. d. Provide praise as he calms himself; and e. When behaviors occurs, staff should document behaviors on ABC charts. There was no evidence that the GHMRP implemented Resident #3's BSP as instructed.	I 422		

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I 500	Continued From page 20	I 500		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure 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. 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) that governs the care and rights of persons with mental retardation. The finding includes: 1. The GHMRP failed to ensure that restrictive programs were used only after written consents had been obtained for Residents#2 and #3. a. [Cross-refer to W124,1]. The GHMRP failed to ensure that written informed consent was obtained from Resident #2's guardian prior to the administration of his psychotropic medications. Interview with the Qualified Mental Retardation Professional (QMRP) on June 10, 2009, at 4:30 PM, during the entrance conference indicated Resident #2 receives psychotropic medications to address his maladaptive behaviors. Further interview revealed the resident did not have the capacity to give informed consent for the use of medications and habilitation services. Observation of the evening medication administration on June 10, 2009 at 6:20 PM, revealed Resident #2 was administered Clonidine	I 500	See Response to W 124, W263	

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I 500	Continued From page 21 HCL 0.2 mg, Paxil 30 mg and Risperdal 0.5 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the resident's behaviors. Further interview was conducted with the QMRP revealed that the resident did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on June 11, 2009, at 2:28 PM through review of Resident #2's psychological assessment dated February 20, 2009. According to the assessment, Resident #2 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or financial matters. He can not execute a durable power of attorney." Continued interview with the QMRP, revealed that Resident #2 had several family members who were involved in his decision making and habilitation planning. Further review of Resident #2's record on June 11, 2009, at 3:00 PM revealed that the resident, in addition to taking psychotropic medications, also had a Behavior Support Plan dated February 15, 2009, to address his behaviors of explosive episodes and mood instability related to depression. At the time of the survey however, the GHMRP failed to provide written evidence that consent was obtained for the use of the psychotropic medication and Behavior Support Plan (BSP) that were designed/conducted to reduce Resident #2's behaviors. Record verification on June 11, 2009 3:43 PM revealed that Resident #2's guardian had given informed consent for the use of Risperdal 0.05	I 500		

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I 500	Continued From page 22 mg (only or less) and Paxil 30 mg (only or less) dated October 17, 2006. However there was no consent signed for the resident's current prescribed psychotropic medications. At the time of the survey, the GHMRP failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative prior to the administration of the psychotropic medication. 2. [Cross-refer to W124,2]. Observation of the morning medication administration on June 10, 2009 at 6:04 PM, revealed Resident #3 was administered Lithium Carbonate ER 600 mg, Revia 100 mg and Thorazine HCL 200 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the resident's behaviors. During the entrance conference on June 10, 2009, at 4:30 PM, an interview was conducted with the QMRP revealed that the resident did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on June 12, 2009, at 11:56 AM through review of Resident #3's psychological assessment dated June 20, 2008. According to the assessment, Resident #3 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to profound mental retardation. He can not execute a durable power of attorney." Continued interview with the QMRP, revealed that Resident #3 had a court appointed guardian. Further review of Resident #3's record on June	I 500		

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I 500	Continued From page 23 12, 2009, at 12:10 PM revealed that the resident, in addition to taking psychotropic medications, also had a Behavior Support Plan dated June 20, 2008, to address his behaviors of physical aggression, self injurious behaviors, property destruction, inappropriate verbalizations and agitation. According to the signed consent forms revealed that the resident's guardian had given informed consent dated August 29, 2009, for Thorazine 200 mg BID. Additional review revealed that the guardian signed a consent dated September 11, 2007. The consent was for Prozac 20 mg, Lithium Carbonate ER 300 mg, Risperdal 5 mg. It should be noted that the signed consents were not the resident's current prescribed psychotropic medications. At the time of the survey however, the GHMRP failed to provide evidence that consent was obtained for the use of the psychotropic medications as prescribed that was designed/conducted to reduce Resident #3's behaviors. The GHMRP failed to ensure that written informed consent was obtained from Resident #2's guardian prior to the administration of his psychotropic medications. Interview with the Qualified Mental Retardation Professional (QMRP) on June 10, 2009, at 4:30 PM, during the entrance conference indicated Resident #2 receives psychotropic medications to address his maladaptive behaviors. Further interview revealed the resident did not have the capacity to give informed consent for the use of medications and habilitation services.	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0008		06/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	4910 ARKANSAS AVENUE, NW 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
I 500	Continued From page 24 Observation of the evening medication administration on June 10, 2009 at 6:20 PM, revealed Resident #2 was administered Clonidine HCL 0.2 mg, Paxil 30 mg and Risperdal 0.5 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the resident's behaviors. Further interview was conducted with the QMRP revealed that the resident did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on June 11, 2009, at 2:28 PM through review of Resident #2's psychological assessment dated February 20, 2009. According to the assessment, Resident #2 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or financial matters. He can not execute a durable power of attorney." Continued interview with the QMRP, revealed that Resident #2 had several family members who were involved in his decision making and habilitation planning. Further review of Resident #2's record on June 11, 2009, at 3:00 PM revealed that the resident, in addition to taking psychotropic medications, also had a Behavior Support Plan dated February 15, 2009, to address his behaviors of explosive episodes and mood instability related to depression. At the time of the survey however, the GHMRP failed to provide written evidence that consent was obtained for the use of the psychotropic medication and Behavior Support Plan (BSP) that were designed/conducted to reduce Resident #2's behaviors.	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0008		06/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012

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I 500	Continued From page 25 Record verification on June 11, 2009 3:43 PM revealed that Resident #2's guardian had given informed consent for the use of Risperdal 0.05 mg (only or less) and Paxil 30 mg (only or less) dated October 17, 2006. However there was no consent signed for the resident's current prescribed psychotropic medications. At the time of the survey, the GHMRP failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative prior to the administration of the psychotropic medication. b. [Cross-refer to W124,2]. Observation of the morning medication administration on June 10, 2009 at 6:04 PM, revealed Resident #3 was administered Lithium Carbonate ER 600 mg, Revia 100 mg and Thorazine HCL 200 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the resident's behaviors. During the entrance conference on June 10, 2009, at 4:30 PM, an interview was conducted with the QMRP revealed that the resident did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on June 12, 2009, at 11:56 AM through review of Resident #3's psychological assessment dated June 20, 2008. According to the assessment, Resident #3 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to profound mental retardation. He can not execute a durable power of attorney." Continued interview with the QMRP, revealed that Resident #3 had a court	I 500		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0008	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012		

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I 500	Continued From page 26 appointed guardian. Further review of Resident #3's record on June 12, 2009, at 12:10 PM revealed that the resident, in addition to taking psychotropic medications, also had a Behavior Support Plan dated June 20, 2008, to address his behaviors of physical aggression, self injurious behaviors, property destruction, inappropriate verbalizations and agitation. According to the signed consent forms revealed that the resident's guardian had given informed consent dated August 29, 2009, for Thorazine 200 mg BID. Additional review revealed that the guardian signed a consent dated September 11, 2007. The consent was for Prozac 20 mg, Lithium Carbonate ER 300 mg, Risperdal 5 mg. It should be noted that the signed consents were not the resident's current prescribed psychotropic medications. At the time of the survey however, the GHMRP failed to provide evidence that consent was obtained for the use of the psychotropic medications as prescribed that was designed/conducted to reduce Resident #3's behaviors.	I 500		