

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

PRINTED: 10/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/12/2010
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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 6634 EASTERN AVENUE, NW WASHINGTON, DC 20012
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W 000	<p>INITIAL COMMENTS</p> <p>On Thursday June 17, 2010 the state agency received two Unusual Incident Reports via facsimile regarding Client #1. Both incidents were dated June 17, 2010. The first incident indicated that at approximately 6:10 a.m., Client #1 was noted to be unresponsive when the staff attempted to wake her for morning care. The staff contacted the house manager followed by the Emergency Medical Services (EMS). After soliciting information regarding Client #1's health status, the EMS personnel transported her to the Washington Hospital Center (WHC). The second incident report indicated that at approximately 9:30 p.m. Client #1 died.</p> <p>In addition, on Friday June 18, 2010, Complainant #1; who is the sister of Client #1 lodged a complaint with the state agency against the provider, Marjule Homes, Inc. and the Washington Hospital Center (WHC).</p> <p>1. Complainant #1 indicated that when her sister was hospitalized in May 2010 blood tests were performed. Complainant #1 alleged that her sister was discharged from WHC prior to the results of the blood work being evaluated by the hospital physicians.</p> <p>2. Complainant #1 voiced concerns regarding the short length of time between the May 31, 2010 discharge and the June 17, 2010 admission, emergency surgery, and subsequent death.</p> <p>Complainant #1 requested that an investigation be initiated concerning the May 29, 2010 admission/discharge from the WHC, and also the group home for potential neglect in health care.</p>	W 000	<p style="text-align: center;"> GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 11-12-10 </p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julia B. Nowson</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11-12-2010</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	<p>Continued From page 1</p> <p>Due to the nature of the incident and complaint, the OCQAID initiated an investigation regarding the death of Client #1 on June 23, 2010. The focus of the investigation was to determine if the provider met Federal, State and/or Industry standards of care for Client #1 prior to her death. It should be noted that the concerns regarding the care/services rendered by the WHC was referred to the Department of Health ' s Health Care Division.</p> <p>The findings of this investigation were based on observations at the group home, interviews with the Physician, the nurse, the QMRP and any other witnesses to the incident, as well as the review of the administrative and clinical/medical records.</p>	W 000		
W 114	<p>483.410(c)(4) CLIENT RECORDS</p> <p>Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.</p> <p>This STANDARD is not met as evidenced by: Based on record review the facility failed to ensure all persons making entries into the medical record dated his/her entry for one client in the investigation. (Client #1)</p> <p>The finding includes:</p> <p>Review of Client #1's medical record on June 23, 2010 revealed that the Primary Care Physician (PCP) failed to date documents initialed as reviewed as evidenced below:</p> <p>During the annual physical examination conducted by the PCP on April 14, 2009, it was noted that Client #1's blood pressure was</p>	W 114	<p>W114</p> <p>The administration of Marjul Homes Inc. recognizes the importance of responsive physician care for our individuals. As of August 1, 2010, Marjul Homes Inc. now has a new Primary Care Physician to provide the responsive care that our individuals are entitled to. Please find the attached policy entitled "Medical Appointments Policy". This policy addresses the expectations of f/u regarding medical / diagnostic testing.</p>	8-1-10

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W 114	Continued From page 2 elevated. The PCP ordered a cardiology consultation and an EKG. The EKG was completed May 11, 2009. It was noted that the EKG was interpreted by a physician who did not note any abnormalities. The PCP initialed that she reviewed the document however it could not be determined on what date she reviewed it. A Cardiology consultation was completed on July 22, 2009 to evaluate the hypertension. The Cardiologist indicated that Client #1's blood pressure was normal (120/75 in both arms) while at his office and that the hypertension at the PCP 's office was probably an isolated incident. The Cardiologist further indicated that Client #1 did not need any medication for hypertension and to follow up in one year. The PCP initialed that she reviewed the document however the PCP did not put the date on which she reviewed it. The Endocrinologist evaluated Client #1 November 20, 2009 due to an elevated Prolactin level (43 with normal values of 1.90 - 25.0). The Endocrinologist recommended discontinuing the medication Premarin, and questioned why she was not on progesterone. The PCP initialed the consultation form (date not documented) and gave no new orders. Laboratory results on January 19, 2010 reflected that Client #1 's prolactin level was 53.80. The PCP initialed the lab results (date not documented) and gave no new orders.	W 114			
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.	W 192			

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W 192	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure the staff received effective training related to emergency procedures and reporting changes in client condition for one of one client in the investigation. (Client #1)</p> <p>The findings include:</p> <p>1. The facility failed to ensure the staff followed the policies on emergency notifications as evidenced below:</p> <p>Review of the incident report dated June 17, 2010, on July 23, 2010 at approximately 11:00 a.m. revealed that the direct care staff documented that they called the house manager prior to calling for emergency medical assistance for Client #1. In a face to face interview conducted on June 23, 2010 at approximately 10:30 a.m. with the LPN Coordinator, she was asked about the provider's emergency contact policy. The LPN Coordinator indicated that the staff should have dialed 911 prior to making the notifications as indicated in the incident report.</p> <p>2. The facility failed to ensure the direct care staff received effective training on reporting changes in bowel habits as evidenced below:</p> <p>A review of Client #1's record on July 11, 2010 at approximately 11:00 a.m. revealed a "Daily BM Record." During a follow-up phone interview with the LPN Coordinator on July 12, 2010, at 10:45 a.m., she was asked why the BM record was initiated in April. She indicated that the Evans</p>	W 192	<p>W192 #1, I227 #1 The administration of Marjul Homes Inc. recognizes the importance of staff training on management of emergency medical conditions. Staff has been trained on how to respond to emergencies. Please find the attached protocol entitled "Management of Emergency Medical Conditions" and training sign in sheet.</p> <p>W192 #2, I227 #2 The administration at Marjul Homes Inc. recognizes the importance of staff training. The direct care staff have been trained on bowel movement monitoring and reporting. Please find attached protocol entitled "Bowel Movement Monitoring Protocol" and training sign in sheet.</p>	<p>11-10-10</p> <p>11-10-10</p>
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W 192	<p>Continued From page 4</p> <p>Monitor reviewed Client #1 ' s record and noted that there was no BM monitoring in place. The BM records were initiated at that time. The LPN Coordinator was asked if she reviewed the BM monitoring tool. The LPN Coordinator indicated that she reviewed the tool three times per month. When asked if the staff had been trained on the monitoring tool she indicated that she had provided training to the staff. When asked if there were any protocols developed regarding any alterations in Client #1's bowel habits; i.e. no BM in three or more day, she indicated that the staff was instructed to inform the nurse if Client #1 did not have a BM in three days. When asked if the staff had informed her that Client #1 did not have bowel movements for three days in May 2010 and June 2010, she stated "no".</p> <p>3. The facility failed to ensure the direct care staff received effective training on documenting the characteristics of Client #1's bowel movements as required on the bowel movement record as evidenced below:</p> <p>A review of Client #1' s record on July 11, 2010 at approximately 11:00 a.m. revealed a document titled " Daily BM Record. " The record had directions located at the bottom of the sheet for the staff to document " descriptions " of Client #1's BM ' s i.e. Soft, Hard, Loose/watery or Normal. Review of the April 2010 through June 2010 failed to contain evidence that the staff consistently documented the "description" as required.</p> <p>During a follow-up phone interview with the LPN Coordinator on July 12, 2010, at 10:45 a.m, an inquiry was made if the staff had been trained on the monitoring tool? The LPN Coordinator</p>	W 192	<p>W192 #3,</p> <p>The administration at Marjul Homes Inc. recognizes the importance of staff training. The direct care staff have been trained on bowel movement monitoring including characteristics of bowel movements to be identified. Please find attached protocol entitled "Bowel Movement Monitoring Protocol" and training sign in sheet.</p>	11-10-10
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W 192	Continued From page 5 indicated that she had provided training to the staff. When it was brought to the LPN Coordinators attention that the staff was not completing the documentation as required, she had no explanation to offer.	W 192		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review the facility failed to provide nursing services in accordance with the needs of one of one client in the investigation (Client #1).</p> <p>The findings include:</p> <p>1. The nursing staff failed to show evidence that laboratory studies were collected as ordered by the physician for client #1 as evidenced below:</p> <p>Review of Client #1 's medical record on June 25, 2010 at approximately 3:00 p.m. revealed that on June 1, 2010, the PCP completed a post hospitalization follow-up visit. The PCP noted that Client #1 was hospitalized for UTI, Hypotension and Hypoglycemia. The PCP indicated completing the course of antibiotics ordered at the hospital and to repeat the urine culture forty-eight (48) hours after the completion of the antibiotics. The record reflected that a urinalysis was collected on June 5, 2010; however, there was no evidence that a culture was performed.</p> <p>2. The nursing staff failed to show evidence that the Bowel Movement Records were reviewed and</p>	W 331	<p>W331 #1 The administration of Marjul Homes Inc. acknowledges the importance of obtaining labs as ordered. All nurses have been trained on follow up of lab orders to ensure completion. Please see attached sign in sheet.</p>	11-10-10

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W 331	<p>Continued From page 6</p> <p>changes in the Client #1's bowel habits as evidenced below:</p> <p>A review of Client #1 ' s record on July 11, 2010 at approximately 11:00 a.m. revealed a " Daily BM Record " (See below). During a phone interview with the LPN Coordinator on July 12, 2010, at 10:45 a.m. she was asked why the BM record was initiated in April. She indicated that the Evans Monitor reviewed Client #1 ' s record and noted that there was no BM monitoring in place. The BM records were initiated at that time. When asked if she reviewed the BM monitoring tool she indicated that she reviewed the tool three times per month. When asked what she would do if she was aware that Client #1 had not had a bowel movement in three days, she indicated that she would call the PCP and inform her. When she was asked if she was aware that Client #1 had not had a bowel movement for three days in May 2010 and June 2010, she stated she did not know Client #1 had not had a bowel movement in three days on the aforementioned occasions.</p> <p>3. There was no evidence that the nursing staff monitored the BM status of client #1.</p> <p>When asked if the staff had been trained on the monitoring tool she indicated that she had provided training to the staff. The LPN Coordinator was asked if there were any protocols developed regarding any alterations in Client #1 ' s bowel habits, such as having no BM in three or more days? She indicated that the staff was instructed to inform the nurse if Client #1 did not have a BM in three days.</p> <p>The nursing staff failed to have evidence that the direct care staff were trained on bowel movement</p>	W 331	<p>W331 #2</p> <p>The administration at Marjul Homes Inc. recognizes the importance of reviewing data on bowel habits to ensure effective practices. Nurses have been trained on bowel movement monitoring to include weekly reviews of monitoring sheets. Please find attached protocol entitled "Bowel Movement Monitoring Protocol" and training sign in sheet. See attached QA monitoring tool for flow sheets in IPP book.</p>	11-16-10
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W 331	Continued From page 7 monitoring and documentation. Review of the BM records from April 2010 through June 2010 revealed that the staff consistently did not document the characteristics of the BM i.e. large, loose, etc. (See W192).	W 331	<p>W331 #3</p> <p>The administration at Marjul Homes Inc. recognizes the importance of staff training. The direct care staff have been trained on bowel movement monitoring and reporting. Please find attached protocol entitled "Bowel Movement Monitoring Protocol" and training sign in sheet. The administration at Marjul Homes Inc. recognizes the importance of reviewing data on bowel habits to ensure effective practices. Nurses have been trained on bowel movement monitoring to include weekly reviews of monitoring sheets. Please find attached protocol entitled "Bowel Movement Monitoring Protocol" and training sign in sheet. See attached QA monitoring tool for flow sheets in IPP book.</p>	11-10-10
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I 000	<p>INITIAL COMMENTS</p> <p>On Thursday June 17, 2010 the state agency received two Unusual Incident Reports via facsimile regarding Client #1. Both incidents were dated June 17, 2010. The first incident indicated that at approximately 6:10 a.m., Client #1 was noted to be unresponsive when the staff attempted to wake her for morning care. The staff contacted the house manager followed by the Emergency Medical Services (EMS). After soliciting information regarding Client #1's health status, the EMS personnel transported her to the Washington Hospital Center (WHC). The second incident report indicated that at approximately 9:30 p.m. Client #1 died.</p> <p>In addition, on Friday June 18, 2010, Complainant #1; who is the sister of Client #1 lodged a complaint with the state agency against the provider, Marjule Homes, Inc. and the Washington Hospital Center (WHC).</p> <p>1. Complainant #1 indicated that when her sister was hospitalized in May 2010 blood tests were performed. Complainant #1 alleged that her sister was discharged from WHC prior to the results of the blood work being evaluated by the hospital physicians.</p> <p>2. Complainant #1 voiced concerns regarding the short length of time between the May 31, 2010 discharge and the June 17, 2010 admission, emergency surgery, and subsequent death.</p> <p>Complainant #1 requested that an investigation be initiated concerning the May 29, 2010 admission/discharge from the WHC and also, the group home for potential neglect in health care.</p>	I 000		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Julie Lawson*

STATE FORM 6889 TITLE: *Executive Director* (X6) DATE: *11-12-2010*

DQ5C11 If continuation sheet 1 of 4

Health Regulation Administration

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1 000	<p>Continued From page 1</p> <p>Due to the nature of the incident and complaint, the OCQAID initiated an investigation regarding the death of Client #1 on June 23, 2010. The focus of the investigation was to determine if the provider met Federal, State and/or Industry standards of care for Client #1 prior to her death. It should be noted that the concerns regarding the care/services rendered by the WHC was referred to the Department of Health 's Health Care Division.</p> <p>The findings of this investigation were based on observations at the group home, interviews with the Physician, the nurse, the QMRP and any other witnesses to the incident, as well as the review of the administrative and clinical/medical records.</p>	1 000		
1 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure the staff received effective training related to emergency procedures and reporting changes in client condition for one of one client in the investigation. (Client #1)</p> <p>The findings include:</p> <p>1. The GHMRP failed to ensure the staff followed</p>	1 227		

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I 227	<p>Continued From page 2</p> <p>the policies on emergency notifications as evidenced below:</p> <p>Review of the incident report dated June 17, 2010, on July 23, 2010 at approximately 11:00 a.m. revealed that the direct care staff documented that they called the house manager prior to calling for emergency medical assistance for Client #1. In a face to face interview conducted on June 23, 2010 at approximately 10:30 a.m. with the LPN Coordinator, she was asked about the provider ' s emergency contact policy. The LPN Coordinator indicated that the staff should have dialed 911 prior to making the notifications as indicated in the incident report.</p> <p>2. The GHMRP failed to ensure the direct care staff received effective training on reporting changes in bowel habits as evidenced below:</p> <p>A review of Client #1 ' s record on July 11, 2010 at approximately 11:00 a.m. revealed a " Daily BM Record " During a follow-up phone interview with the LPN Coordinator on July 12, 2010, at 10:45 a.m. she was asked why the BM record was initiated in April. The LPN indicated that the Evans Monitor reviewed Client #1 ' s record and noted that there was no BM monitoring in place. The BM records were initiated at that time. The LPN was also asked if she reviewed the BM monitoring tool she indicated that she reviewed the tool three times per month. When asked if the staff had been trained on the monitoring tool she indicated that she had provided training to the staff. When asked if there were any protocols developed regarding any alterations in Client #1 ' s bowel habits, such as no BM in three or more days? She indicated that the staff was instructed to inform the nurse if Client #1 did not have a BM</p>	I 227	<p>See 192 #1</p> <p>See 192 #2</p>	<p>11-10-10</p> <p>11-10-10</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/12/2010
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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 6634 EASTERN AVENUE, NW WASHINGTON, DC 20012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 227	<p>Continued From page 3</p> <p>in three days. When asked if the staff had informed her that Client #1 did not have bowel movements for three days in May 2010 and June 2010. She stated no.</p> <p>3. The GHMRP failed to ensure the direct care staff received effective training on documenting the characteristics of Client #1 ' s bowel movements as required on the bowel movement record as evidenced below:</p> <p>A review of Client #1 ' s record on July 11, 2010 at approximately 11:00 a.m. revealed a document titled " Daily BM Record. " The record had directions located at the bottom of the sheet for the staff to document " descriptions " of Client #1 ' s BM ' s i.e. Soft, Hard, Loose/watery or Normal. Review of the April 2010 through June 2010 failed to contain evidence that the staff consistently documented the " description " as required.</p> <p>When asked during a follow-up phone interview with the LPN Coordinator on July 12, 2010, at 10:45 a.m. if the staff had been trained on the monitoring tool she indicated that she had provided training to the staff. When it was brought to the LPN Coordinators attention that the staff was not completing the documentation as required, she had no explanation to offer.</p>	I 227	See 192 #3	11-16-10