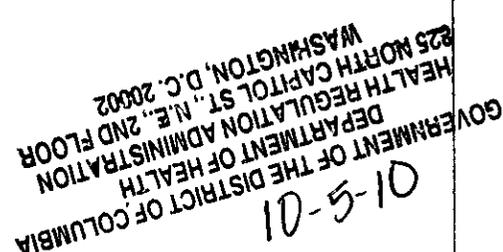


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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from 8/25/2010 through 8/27/2010. The survey was initiated using the fundamental survey process. A sample of three clients was selected from a resident population of five men with various degrees of intellectual and/or developmental disabilities.</p> <p>The findings of the survey were based on observations, interviews with clients and staff in the home and at three day programs, as well as a review of client and administrative records, including incident reports.</p>	W 000	<p style="text-align: center;">  </p>	
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's governing body failed to ensure the timely review, approval and implementation of a client's behavior support plan for one of three sampled clients. [Client #3]</p> <p>The finding includes:</p> <p>Observation on 8/25/2010 at 3:44 p.m. revealed, Client #3 slapped his head and his face approximately fourteen (14) times over a six (6) minute period. He had just returned home from his day program and one of the facility's staff had asked him to take part in brining in the groceries. Client #3 was also observed head slapping on several occasions again at approximately 4:00 p.m. after he arrived home</p>	W 104	<p>W 104</p> <p>The governing body recognizes the importance of timely HRC reviews of all individualized service plans (IPP). The agency will ensure that, if needed, an emergency BSC/ HRC is held to approve the BSP/HRC. Once the plan is approved, appropriate training will coordinated the psychologist as soon as possible.</p>	10-6-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julia Towson</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>9-30-10</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 104	<p>Continued From page 1</p> <p>from day program on the afternoon of 8/26/2010. On this occasion, he was holding the remote to the television and he appeared to be trying to get to a particular channel. On both occasions, staff was present in the room and also within eyesight of this client.</p> <p>Review of Client #3 ' s behavioral support plan (BSP) revealed an updated plan was put into place on 6/11/2010 to address his Self-Injurious Behaviors of " Hand biting, face slapping, attempting to choking himself, and hitting his hip for longer than 5 minutes. "</p> <p>Interview with the facility ' s qualified mental retardation professional (QMRP) on 8/27/2010 at approximately 1:37 p.m. revealed the 6/11/2010 BSP was not being implemented because the human rights committee (HRC) didn ' t meet and approve the plan until 8/25/2010. In addition, the QMRP indicated staff training was also being held pending the results of the HRC review. Now since the HRC approved the plan, the QMRP indicated he would arrange to have training implemented for all staff.</p> <p>The facility ' s governing body failed to ensure the implementation of an effective system to manage the timely HRC review of all individualized service plans (IPP).</p>	W 104		
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility</p>	W 154		

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W 154	<p>Continued From page 2</p> <p>failed to thoroughly investigate all allegations of abuse, for the one client (out of five in the facility) who was documented as having made such an allegation. (Client #2)</p> <p>The finding includes:</p> <p>During the Entrance Conference on 8/25/2010, at 10:45 a.m., the qualified mental retardation professional (QMRP) indicated that he had been instructed by an outside agency to interview two clients who were present during a 6/11/2010 incident involving Client #2 and two direct support staff persons. The initial (6/11/2010) incident had been categorized as one requiring emergency 911/police involvement. According to that initial incident report, Client #2 became angry about breakfast cereal on 6/11/2010, at 7:25 a.m. The staff reportedly offered a substitute cereal; however, the client's anger escalated and he hit the staff. Client #2 reportedly calmed down after 911 was called.</p> <p>Continued interview with the QMRP revealed that he had conducted a second investigation into the same incident after Client #2 made an allegation (on 7/9/2010) that the staff person he had hit on 6/11/2010, had choked him during the incident. The QMRP stated that the client had not alleged having been choked, prior to 7/9/2010. The staff person implicated was immediately placed on administrative leave. He then said that based on his follow-up investigation, the allegation of choking had been unsubstantiated. The staff, however, remained on administrative leave.</p> <p>According to the QMRP, outside investigators then interviewed some of Client #2's housemates regarding the 6/22/2010 incident after the QMRP</p>	W 154	<p>W 154</p> <p>The agency understands the importance of thoroughly investigating all allegations of abuse. In the future, all witnesses will be interviewed, and if the police are involved, a written report will be requested in a timely manner.</p>	10-6-10

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W 154	<p>Continued From page 3</p> <p>had issued his second investigative report dated 7/19/2010. The outside investigators then asked the QMRP to interview the other clients because their statements appeared to support Client #2's allegation that he had been choked. The QMRP said the client interviews had been unreliable and he was preparing (as of 8/25/2010) an addendum to his investigation report dated 7/19/2010 .</p> <p>1. The incident and investigation reports were reviewed upon receipt the next day, 8/27/2010, beginning at 12:48 p.m. The investigation reports dated 6/29/2010 and 7/19/2010, documented interviews with Client #2 and two direct support staff on duty on 6/11/2010. There was no evidence that the investigator sought to determine if there were any other witnesses to the incident available for interview. Neither investigation report indicated that Client #2's housemates (3 of whom were verbal) who were present on the morning of 6/11/2010 had been interviewed. At approximately 1:00 p.m., the QMRP acknowledged that he had not interviewed Client #2's housemates as part of his earlier investigations.</p> <p>2. On 8/27/2010, at approximately 12:54 p.m., review of a typed accounting of an interview conducted by the QMRP with Client #3 on 8/24/2010 (as an Addendum), revealed that Client #3 corroborated Client #2's allegation that he had been choked. When asked "what happened on that day during breakfast on 6/11/2010," Client #3 is documented as having replied "<name of Staff #1> was cooking; <name of Client #2> was fighting with <Staff #1>; <Staff #1> choked <Client #2>." This information had not been secured timely.</p>	W 154		

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W 154	<p>Continued From page 4</p> <p>3. During a follow-up interview on 8/27/2010, at approximately 1:05 p.m., the QMRP described when he interviewed the accused staff person (Staff #1) after Client #2 alleged having been choked, the staff reportedly told him that he had used his arms to block Client #2's attempts to hit him. The QMRP demonstrated by holding up his arms, with them crossed at the wrists. The QMRP said the staff person then told him that after blocking the client's punches, he had held the client from behind. The QMRP demonstrated what appeared to be a basket hold from behind. However, review of the initial investigation report, dated 6/29/2010, revealed no evidence that staff had reported applying any physical contact with the client during the incident. The two staff on duty reported having used "verbal prompts" and called 911 when the client became assaultive. There was no evidence on record that the staff were asked to describe what, if any, physical contact they may have had with Client #2 during the 6/11/2010 incident. Review of the second investigation report, dated 7/19/2010, revealed no indication from staff that one of them (Staff #1) had engaged in physical contact with Client #2. The blocking and body hold that the QMRP demonstrated on 8/27/2010 were not included in the second report.</p> <p>4. The second investigation report, dated 7/19/2010, included the following: "The police officer... who responded this time around and interviewed <Client #2>, indicated that <Client #2> was the aggressor, that she feels that staff held him down because of the safety of himself and other individuals, the <Client #2> had apologized to staff for his behavior, thus admitting guilt of assaulting staff." The report, however, did not provide the date or manner by which the</p>	W 154		

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W 154	Continued From page 5	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		
	<p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure the coordination of services to promote the health, safety and active treatment needs of three of the three sampled clients. (Clients #1, #2, and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross-refer to W194. The QMRP failed to ensure that all staff received effective training on the implementation of Client #3's behavior support plan. 2. Cross-refer to W192. The QMRP failed to ensure that all staff received effective training on monitoring Client #1's health care needs. 3. Cross-refer to W214. The QMRP failed to ensure the accurate assessment of Client #2's behavior support needs. 4. Cross-refer to W247. The QMRP failed to ensure that clients were afforded opportunities for choice and self-management during meals. 	<ol style="list-style-type: none"> 1 2 3 4 	<p>See response to W104 on page 1 of 23</p> <p>Training on his BM Chart was done 6/25/10. Will be repeated by 10-15-10</p> <p>The new agency psychologist will include this issue as part of his review.</p> <p>All future second helping requests from client #1 will be honored.</p>	<p>10-6-10</p> <p>10/15/10</p> <p>10/9/10</p> <p>Since 9/1/10</p>

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W 159	Continued From page 6 5. Cross-refer to W249. The QMRP failed to ensure that staff implemented Client #2's social support program involving visits to a local library to select a CD, DVD or magazine of interest. 6. Cross-refer to W252. The QMRP failed to ensure that staff documented all behavioral incidents in accordance with behavior support plans. 7. Cross-refer to W436. The QMRP failed to ensure that Client #3 had cotton gloves available to wear at night, as recommended to address a skin condition on both hands. 8. Cross-refer to W460 and W474. The QMRP failed to ensure that Client #1 received prune juice twice daily and foods served at a ground texture, in accordance with physician's orders.	W 159 5 6 7 8	All of client #2's IPP goals and psychological concerns will be reviewed and training will be done to address the concerns by See W159.5 response across. Cotton gloves are available for individuals to wear however current recommendations are for individual, dated, are for hands to be covered with Cordran tape at night with cotton gloves. This recommendation has been approved by PCP. Training was last done on 8/18/10 The house manager will ensure that Prune Juice is purchased with the groceries and available in the house. The prune juice will be added to the MAR for the nurse to administer the prune juice during the AM/PM med pass and sign off administration of prune juice	10/15/10 8/28/10 10-1-10
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff received training on the implementation of a client's behavior support plan, for one of the three sampled clients. (Client #3) The finding includes: Cross-refer to W194. Observation on 8/25/2010, at 3:44 p.m., revealed Client #3 slapped his head and his face approximately fourteen (14) times	W 189		

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W 189	<p>Continued From page 7</p> <p>over a six (6) minute period. He had just returned home from his day program and one of the facility's staff had asked him to take part in bringing in the groceries. Client #3 was also observed head slapping on several occasions again at approximately 4:00 p.m. after he arrived home from day program on the afternoon of 8/26/2010. On this occasion, he was holding the remote to the television and he appeared to be trying to get to a particular channel. On both occasions, staff was present in the room and also within eyesight of this client.</p> <p>Review of Client #3's behavioral support plan (BSP) dated 6/11/2010 revealed a "Verbal Redirection for Self-injury" plan was recommended and the plan outlined a proactive strategy for managing this client's maladaptive behavior of head/face slapping.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 8/27/2010, at approximately 1:37 p.m. revealed there had been no training on the 6/11/2010 BSP to date because the human rights committee had not convened until 8/26/2010. According to the QMRP, no program could be implemented without the consent of the HRC. In addition, now that the HRC met and approved the program, the psychologist could be called in to train the staff.</p>	W 189	See response to W104 page 1 of 23.	10-6-10
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record</p>	W 192		

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W 192	<p>Continued From page 8</p> <p>review, the facility failed to ensure that all staff received effective training on the monitoring of clients' health care needs, for one of the three sampled clients. (Client #1)</p> <p>The findings include:</p> <p>1. On 8/26/2010, Client #1's medical records were reviewed, beginning at 10:37 a.m. His chart included a Protocol for Maintenance of <Client #1's name> Gastrointestinal Health, dated 7/15/2010. The protocol mirrored his physician's orders, also dated 7/15/2010. The orders were for staff on each shift to document every bowel movement on a bowel movement (BM) chart. Staff were to notify the nurse if the client went more than 24 hours without a BM. The nurse was to administer 30 ml of Milk of Magnesia (MOM) as needed. If another 24 hours were to pass and the client did not have a BM, staff were to alert the nurse and the nurse would administer a mineral oil enema and notify the primary care physician.</p> <p>At 10:58 a.m., review of Client #1's BM chart revealed that some staff had not recorded whether or not he had a BM during their shift. For example, spaces on the BM chart were left blank during the 8 a.m. - 4 p.m. shift on 8/9/2010, 8/12/2010, 8/16/2010, 8/17/2010 and 8/20/2010, as well as the 12 a.m. - 8 a.m. shift on 8/24/2010.</p> <p>The registered nurse (RN) was interviewed by telephone later on that day (8/26/2010). At approximately 2:10 p.m., she stated that she routinely monitored the BM chart and had asked staff about the shifts for which there was no BM documented. Staff reportedly documented BMs in other places in the record, such as on behavior data sheets when he had smeared feces. She</p>	W 192	See response to W159.2 page on 6 of 23.	10-15-10

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W 192	<p>Continued From page 9</p> <p>further stated that on 8/18/2010, she had presented a "mandatory training" for all staff to address BM data collection and to review Client #1's gastrointestinal protocol.</p> <p>a. Staff in-service training records were reviewed in the facility on 8/26/2010, beginning at 4:24 p.m. The review revealed that four (4) of the eleven (11) direct support staff had not attended the 8/18/2010 training.</p> <p>b. On 8/26/2010, at 11:39 a.m., review of Client #1's BM chart indicated that he had been 24 hours without a BM. The LPN who administered medications that morning returned to the facility that afternoon to address what appeared to be a behavioral episode. When the LPN asked and was told that Client #1 had not had a BM, she administered the MOM in accordance with his POs. At 2:30 p.m., the LPN confirmed that staff had not informed her that morning that he had not had a bowel movement.</p> <p>c. Further review of the BM charts in Client #1's record revealed that a different chart had been initiated, beginning on 8/23/2010. The format was similar to the previous chart; however, the column headings had changed so that the first column no longer was for the 8am-4pm shift. The first column on the new chart was for use by the 12a.m. - 8a.m. shift. Review of the new chart revealed that the staff person who worked the 12a.m. - 8a.m. shift on 8/24/2010, 8/25/2010 and 8/26/2010, had mistakenly entered his data in the wrong column (where he previously had recorded BMs during his shift). That staff person was one of the 4 staff who had not attended the 8/18/2010 training.</p>	W 192	<p>All staff will be retrained on Bowel Movement Monitoring/Documentation by The bowel movement monitoring will be reviewed by the evening med pass nurse to determine if a PRN med is warranted. The RN/QMRP/Administration of MarJul Homes will be notified of all incomplete documentation of bowel movement monitoring.</p>	10/8/10

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W 192	<p>Continued From page 10</p> <p>It should be noted that on 8/27/2010, at 10:47 a.m., review of Client #1's behavior data sheets did show corroborating evidence that staff had documented feces smearing (example: 8/9/2010) without including the information on his BM chart.</p> <p>2. Client #1's Protocol for Maintenance of <Client #1's name> Gastrointestinal Health, dated 7/15/2010 and physician's orders, also dated 7/15/2010, prescribed 1 cup warm prune juice to be given twice daily.</p> <p>Cross-refer to W460.2. There was no evidence observed or documented, that Client #1 received prune juice in the morning or evening of 8/25/2010 or on the morning of 8/26/2010. Telephone interview with the RN on 8/26/2010, at approximately 2:15 p.m., revealed that although she had presented a "mandatory training" for all staff to review Client #1's gastrointestinal needs, she had not included in her training any discussion regarding the order for prune juice. Her impression was that the client received it with his breakfast and his dinner. That could not, however, be verified and there was no documentation being maintained regarding prune juice. Review of staff training records that afternoon revealed no evidence that staff had received training on the provision of 1 cup warm prune juice twice daily in accordance with physician's orders.</p>	W 192	See response to W159.2 on page of 6 of 23.	10-15-10
W 214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by:</p>	W 214		

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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012
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W 214	<p>Continued From page 11</p> <p>Based on observation, staff interview and record review, the facility failed to assess a client's non-compliance and implement an effective treatment plan for managing the maladaptive behavior, for one of the three sampled clients. (Client #2)</p> <p>The finding includes:</p> <p>Client #2 was observed to be at home on 8/27/2010. Interview with the qualified mental retardation professional (QMRP) on the same day at approximately 10:10 a.m. revealed Client #2 generally refused to attend his day program and a few medical appointments over the past year. According to the QMRP, Client #2 tried to enforce his independence by voicing his refusals.</p> <p>Record review on 8/27/2010 at 11:54 a.m. revealed, Client #2's Psychology assessment dated 7/3/2010, identified Client #2 was "not able to make independent decisions concerning residential or day placements, medical and psychological treatments, habilitation plans or financial affairs. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He should be provided the opportunity to participate in day-to-day activity decision-making."</p> <p>Further record review on the same day and time revealed his Social Work (SW) assessment dated 06/10/2010, identified Client #2 functioned "in the moderate range of mental retardation cognitively and adaptively ... He has a behavior support plan that targets physical aggression, property destruction, general noncompliance, verbal aggression, and refusing to attend day program." The SW assessment further detailed "there has</p>	W 214	<p>See response to W159.5 on page 7 of 23.</p> <p>See response to W159.3 on page 6 of 23.</p>	<p>10-15-10</p> <p>10-9-10</p>

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W 214	<p>Continued From page 12</p> <p>been an ongoing struggle in the home in which [Client #2] is noncompliant with his personal hygiene. At times, he will refuse to shower or bathe. He is quite capable of doing so but he continues to demonstrate his stubbornness in not doing so. [Client #2] is quite 'intelligent' given his developmental level and uses his knowledge of his rights to his advantage although his decisions or preferences may not be favorable. [Client #2] will clearly articulate what he will and will not do and non-compliance is a targeted behavior in his behavior support plan."</p> <p>Additional record review on 8/27/2010, at approximately 11:59 a.m., revealed the facility failed to ensure Client #2's 7/2010 updated behavior support plan addressed his non-compliance as mentioned in the SW assessment. Interview with the facility's qualified mental retardation professional on the same day and time revealed he would address the oversight immediately.</p>	W 214	See response to W104 on page 1 of 23.	10-6-10
W 247	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each client was provided opportunities for choice, encouraged and taught to make choices, for one of three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On 8/25/2010, at approximately 7:28 a.m., the</p>	W 247		

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W 247	<p>Continued From page 13</p> <p>medication nurse asked if Client #1 was ready for his medications. He had just finished eating the breakfast that was served. Client #1 asked if he could "please have more oatmeal." [Note: The hot cereal served that morning was grits, not oatmeal.] At 7:33 a.m., the nurse asked the client to "come in the living room with me please." The client responded "I want some oatmeal please." The nurse acknowledged his request and then administered his medication. At 7:36 a.m., the client again stated "I want some oatmeal" to which the nurse asked "didn't you already have some?" Direct support staff were present during the observation period and were within earshot of Client #1's three requests for more cereal. He was not offered additional cereal before he and his peers left the facility.</p> <p>On 8/25/2010, at 7:58 a.m., review of Client #1's physician's orders (POs) dated 7/1/2010, revealed that he was prescribed the following diet: regular, double portion, increased fiber, ground texture, and 1 cup prune juice two times a day. Breakfast observations that morning revealed that Clients #1, #3, #4 and #5 all received similar size portions. [Note: It was later determined that Client #3 was prescribed a 1500-calorie diet to promote weight loss.]</p> <p>The staff person who prepared and served breakfast earlier that morning (8/25/2010) was interviewed at the end of her shift. At 8:18 a.m., she confirmed that Client #1 had not received additional hot cereal. She said he "got the amount he's supposed to get... 1 cup measured grits." She also confirmed that the four clients received the same portion sizes.</p> <p>At the time of the survey, the facility failed to</p>	W 247	<p>See response to W159.4 on page 6 of 23.</p> <p>See response to W159.8on page 7 of 23.</p>	<p>9-1-10</p> <p>10-1-10</p>

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W 247	Continued From page 14 ensure Client #1, who was prescribed a regular, double-portion diet, was afforded opportunities for choice and/or self-management during meals.	W 247	See response to W159.8 on page 7 of 23.	10-1-10
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the prompt implementation of all active treatment programs, for one of the three sampled clients. (Client #2)</p> <p>The finding includes:</p> <p>Client #2 did not attend his day program on 8/27/2010, and was observed at home. Interview with the qualified mental retardation professional (QMRP) on the same day at approximately 10:10 a.m. revealed Client #2 generally refused to attend his day program over the past year and during his annual service plan meeting in 7/2010, he verbally agreed to attending the day program four days a week (Monday - Thursdays). According to the QMRP, Client #2 indicated he preferred to use Friday as his day off.</p> <p>Record review on 8/27/2010, at 11:54 a.m., revealed Client #2's Psychology assessment dated 7/3/2010, identified Client #2 was "not able</p>	W 249	See response to W159.5 on page 7 of 23.	10-15-10

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W 249	<p>Continued From page 15</p> <p>to make independent decisions concerning residential or day placements, medical and psychological treatments, habilitation plans or financial affairs. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He should be provided the opportunity to participate in day-to-day activity decision-making." The psychology assessment further outlined that "interpersonal contact is challenging and [Client #2] does not like to be in crowds. He engages in one to one contact; he is only somewhat less reluctant to socialize with his peers. He simply prefers to be alone or to interact with counselors."</p> <p>Further record review on the same day and time revealed his Social Work (SW) assessment dated 06/10/2010 recommended the facility improve his community integration skills by implementing a formal social support program. The SW assessment outlined the facility should implement the social support program of: "once per month, [Client #2] will select a CD/DVD/magazine from a public library with verbal assistance for 6 consecutive months by 1/11."</p> <p>Additional interview with the facility's QMRP on 8/25/2010, at approximately 10:35 a.m., revealed the above program was not in place. The QMRP further added he would meet with the house manager and ensure the oversight was addressed immediately to help Client #2 further improve his community integration skills.</p>	W 249		
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p>	W 252	See response to W159.5 on page 7 of 23.	10-15-10

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W 252	<p>Continued From page 16</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the accurate recording of a client's targeted behaviors for one of three sampled clients. (Client #3)</p> <p>The finding includes:</p> <p>Observation on 8/25/2010, at 3:44 p.m. revealed, Client #3 slapped his head and his face approximately fourteen (14) times over a six (6) minute period. He had just returned home from his day program and one of the facility's staff had asked him to take part in brining in the groceries. Client #3 was also observed head slapping on several occasions again at approximately 4:00 p.m. after he arrived home from day program on the afternoon of 8/26/2010. On this occasion, he was holding the remote to the television and he appeared to be trying to get to a particular channel.</p> <p>Record review on 8/27/2010, at 10:00 a.m., revealed Client #3's 6/11/2010 behavior support plan (BSP) recommended that the facility "record targeted behaviors on ABC charts." Further record review revealed the ABC data collection sheets for Client #3 reflected that he had "no" episodes of "head/face slapping" on 8/25/2010 and on 8/26/2010.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 8/27/2010, at 1:35 p.m., confirmed the staff should have documented the targeted behaviors.</p>	W 252	See response to W159.3 on page 6 of 23.	10-9-10

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W 252	Continued From page 17 The facility failed to ensure the staff accurately documented all observed episodes of Client #3's targeted behavior as recommended by his BSP.	W 252		
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients had available for use all adaptive and treatment devices identified as needed by the interdisciplinary team, for one of the three sampled clients. (Client #3)</p> <p>The finding includes:</p> <p>Client #3 was observed scratching his hands on 8/25/2010, at approximately 11:40 a.m. as he sat at the table drawing on a piece of paper at his day program. Client #3 was again observed on the same day, at approximately 4:30 p.m., scratching his hands as he sat at the dining room table in the home. It should be noted, Client #3 had large calluses near the thumb area on both of his hands.</p> <p>Record review on 8/26/2010, at approximately 9:30 a.m. revealed Client #3's 7/2010 Physician's Orders (POs) identified the diagnoses of Lichen Simplex Chronicus (a skin disorder that leads to chronic itching and scratching). The POs also</p>	W 436	See response to W159.7 on page 7 of 23.	8-28-10

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W 436	<p>Continued From page 18</p> <p>listed a prescription for "Lidex (Fluocinonide 0.05% ointment) apply to dryness on the back of hands for calluses." Further record review revealed Client #3's 1/5/2010 Dermatology assessment recommended the facility use "cotton gloves at night (to put over Lidex ointment)."</p> <p>Interview with the house manager at approximately 10:40 a.m., on 8/26/2010, confirmed there were no cotton gloves available for use.</p> <p>The facility failed to ensure that all recommended adaptive equipment was provided as recommended.</p>	W 436	See response to W159.7 on page 7 of 23.	8-28-10
W 460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nutritional intake in accordance with prescribed dietary orders, for one of the three sampled clients. (Client #1)</p> <p>The findings include:</p> <p>1. According to Client #1's physician's orders (POs), dated July 1, 2010, he was prescribed the following diet: regular, double portion, increased fiber, ground texture, and 1 cup prune juice two times a day. Breakfast was observed in the home on 8/25/2010, beginning at 7:21 a.m. The meal consisted of approximately 1/2 cup</p>	W 460	See response to W159.8 on page 7 of 23.	9-1-10

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W 460	<p>Continued From page 19</p> <p>scrambled Egg Beaters, 2 slices of wheat toast, a small bowl of warm grits and coffee. The four clients at the table at the time (#1, #3, #4 and #5) all received similar size portions. [One notable exception was when a staff gave Client #3 a glass of orange juice because "he doesn't drink coffee."] Minutes later, review of the menu in the kitchen revealed that persons prescribed a regular diet were to have a 2-egg cheese omelet, a 1/2 cup of grits, 1/2 cup of apple juice, 1 cup of 2% milk, and an English muffin with margarine. Individuals receiving a regular, ground texture diet were to receive a double portion of grits (1 cup) and no English muffin. Comparing the breakfast observations with the menu revealed the following deficient practices:</p> <p>a. Client #1 was served Egg Beaters instead of regular eggs. In addition, the portion size served was not equal to a 4-egg omelet (regular x 2).</p> <p>b. Client #1's portion of Egg Beaters was without cheese.</p> <p>c. Client #1 did not have milk or juice; whereas, the menu indicated that he should have received 2 cups of 2% milk (regular x 2) and 1 cup of juice (regular x 2).</p> <p>The staff person who prepared and served breakfast on 8/25/2010 was interviewed before she left the facility that morning (shift ends at 8:00 a.m.). At 8:18 a.m., she stated that Clients #1, #3, #4 and #5 had all received the same sized servings. She served 2 slices of toast as a substitute for the English muffin. The four clients had 1 cup grits and all had Egg Beaters. She also confirmed that Client #1 had not received prune juice.</p>	W 460	See response to W159.8 on page 7 of 23.	8-28-10

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W 460	<p>Continued From page 20</p> <p>2. On 8/25/2010, the client was not observed receiving prune juice that morning, from 6:23 a.m. until his 8:50 a.m. departure for day program. The overnight staff person who had prepared breakfast that morning said Client #1 did not routinely receive prune juice during her shift, which ends at 8:00 a.m. The client was observed in the facility from 1:56 p.m. until 7:15 p.m. on 8/25/2010 and he was not observed receiving prune juice during that period, including at dinner. On 8/26/2010, at 9:42 a.m., interview with a direct support staff person who routinely worked the 8:00 a.m. - 4:00 p.m. shift revealed that he had not seen Client #1 receive prune juice. He replied "no" when asked whether any of the clients routinely drank prune juice and if he ever saw prune juice in the facility. He further indicated that prune juice had not been on the shopping list he used on the day before, when he purchased groceries for the coming week.</p> <p>On 8/26/2010, beginning at 10:37 a.m., review of Client #1's records (Medication Administration Records, nurse progress notes, staff shift progress notes, etc.) failed to show evidence that the facility documented his getting a cup of prune juice twice daily.</p> <p>On 8/26/2010, the RN was interviewed by telephone beginning at approximately 2:00 p.m. The RN stated that her understanding was that staff routinely gave Client #1 a cup of prune juice with his breakfast and with dinner. She indicated that this was "part of his meal plan" and directed this surveyor to the house manager (HM). At approximately 3:40 p.m., the HM was asked about the prune juice. She indicated that Client #1 received prune juice with his meals and the</p>	W 460	See response to W159.8 on page 7 of 23.	10-1-10

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W 480	Continued From page 21 juice was reflected on the menus. She was unsure whether he got it at breakfast and/or at dinner. She further indicated that she typically arrived at the facility at approximately 10:00 a.m.; she did not, therefore, observe breakfast. The prune juice was kept in the refrigerator. At 3:48 p.m., observation of the refrigerator revealed there was no prune juice available. The staff in the kitchen at the time were unable to locate prune juice in the facility. Moments later, review of that week's menu revealed no listing of prune juice for any breakfasts, lunch or dinners. There was no evidence that the facility ensured that Client #1 received a cup of prune juice twice daily in accordance with his physician's orders.	W 480		
W 474	483.480(b)(2)(III) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency as prescribed, for one of the three sampled clients. (Client #1) The finding includes: On 8/25/2010, at 7:21 a.m., Client #1 was observed eating his breakfast. The meal consisted of scrambled Egg Beaters, toast, warm grits and coffee. The toast had been cut to bite size pieces. Later that morning, at 11:59 a.m., review of his physician's orders (POs) dated 7/1/2010, revealed that his food should be a "ground texture." Client #1's dinner was observed	W 474	Amended answer to W 474 The facility will ensure that all meals are prepared per doctor's orders by having the House Manager on a weekly basis, and the QMRP on a monthly basis, monitor meal preparation. Compliance with the required meal preparation will also be monitored via the weekly administrative report. (see attached).	9-1-10

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

UNITED STATES GOVERNMENT
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2010
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NAME OF PROVIDER OR SUPPLIER ARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012
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W 474	<p>Continued From page 22</p> <p>on 8/25/2010, beginning at 5:55 p.m. His baked fish, baked beans and broccoli were cut bite size and his slice of bread was cut in half, diagonally. On 8/26/2010, at 12:28 p.m., the client was served a lunch consisting of turkey bologna (cut bite size) mixed salad-style with chopped celery and carrots, a 2-slice bread with mayonnaise 'sandwich' that was cut into 6 bite-size pieces, and a bowl of small mandarin orange segments. None of the lunch had a ground consistency. Moments later, interview with the direct support staff person who had prepared his lunch revealed that he had been instructed to cut the client's foods bite-sized to ensure his safety; the client was known to eat quickly and swallow without thoroughly chewing his foods.</p> <p>It should be noted that on 8/26/2010, at approximately 4:15 p.m., review of the menu revealed that individuals receiving a "ground texture" were not to receive a second portion of grits with breakfast on 8/25/2010 as a substitution for the English Muffin. It should be further noted that staff did not honor Client #1's repeated requests that morning for more hot cereal. [See W247]</p>	W 474		
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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 08/27/2010
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1 000 INITIAL COMMENTS

A licensure survey was conducted from 8/25/2010 through 8/27/2010. A sample of three residents was selected from a population of five men with various degrees of cognitive and intellectual disabilities.

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

1 000

I 090

1 090 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 interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5)

The findings include:

On 8/26/2010, beginning at 10:30 a.m., inspection of the GHMRP with the house manager (HM) revealed the following:

Exterior:

1. The cement walkways at the front entrance

1 090

The agency has secured the services of a contractor who will provide an estimate of all needed repairs and will commence work as soon as the estimates have been approved. The repairs will be prioritized and are expected to be completed within 30 days, with the exception of "Exterior No. 1" - cement walkways and driveway which will require an additional 30 days.

Amended answer to I 090

The agency is securing the services of a property manager/handyman who will oversee the maintenance and upkeep of the houses. The handyman will be responsible for doing monthly inspections and performing preventive maintenance on all of the houses.

10-20-10

11-20-10

Health Regulation Administration

Julia Towson

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

Executive Director 9/30-10
(X5) DATE

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 08/27/2010
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1090	<p>Continued From page 1</p> <p>and in the back yard, as well as the driveway in the back, had numerous cracks and because the cracks created an uneven surface, they posed a potential trip hazard.</p> <p>Interior:</p> <p>2. Carpet on the first floor landing was torn, creating a potential a trip hazard. Paint on the banister at the same landing was worn and chipped.</p> <p>3. There was chipped and peeling paint on the baseboard in several places in Resident #1's bedroom.</p> <p>4. Resident #2's dresser drawer was broken and the bottom drawer was missing. The door to Resident #2's wardrobe was broken. In addition, there was a crack observed on the wall behind Resident #2's bed.</p> <p>5. There was a broken ironing board in the bathroom located on the second floor. In the same bathroom, there was chipped and peeling paint on the wall under the window. Also, the ceiling light over the bathtub did not work (for reasons not known).</p> <p>6. The plaster board on a wall in the closet used by Resident #4 was broken.</p> <p>7. The linen closet door handle was broken.</p> <p>8. Window shades in Resident #5's bedroom were torn and stained and the carpet had two burned iron prints on the floor. The handle was missing from the top left drawer of Resident #5's dresser.</p>	1090		

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1090	<p>Continued From page 2</p> <p>9. There was a hole approximately 1-inch in diameter in a wall to the left of a window in the living room. The carpet was soiled in several spots. In addition, there was chipped and peeling paint in several places on the baseboards in the living room.</p> <p>10. The six dining room chairs were soiled and stained.</p> <p>11. In the hallway near the time clock, there was rust on a vent and a 2-inch hole was observed in the wall.</p> <p>12. Caulking around the kitchen sink was either cracked or missing. The cabinet under the sink was missing a right door.</p> <p>13. Vegetable bins in the refrigerator were broken.</p> <p>14. The counter on top of the dishwasher was broken and several tiles were broken on the floor under the dishwasher.</p> <p>15. There was chipped and peeling paint on a wall by the kitchen stove.</p> <p>16. The freezer was missing an inside door and was in need of defrosting.</p> <p>17. The threshold between the dining room and the kitchen was not secured to the floor, creating a potential tripping hazard. There was chipped and peeling paint on door between the dining room and the kitchen. In addition, there was a hole in a wall in the dining room, to the right of the entrance to the kitchen.</p> <p>18. There was a 2-inch hole in a wall in the</p>	1090		

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1 090	Continued From page 3 bathroom located on the first floor. 19. Furniture and carpeting in the TV room was soiled. A tear in the carpet presented a potential trip hazard. In addition, there were several missing blades/slats on the venetian blinds hanging in the TV room windows. 20. The basement carpet was wet and showed several large stains. The HM, who was present throughout the inspection process, acknowledged the above deficiencies cited above.	1 090		
1 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review and staff interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to document annual reviews of job descriptions, for two out of fourteen staff. (Staff #3 and #7). The finding includes: On August 26, 2010, beginning at 11:45 a.m., interview with the house manager and review of the GHMRP's personnel files revealed the GHMRP failed to provide evidence that the facility discussed the contents of job descriptions with Staff #3 and #7.	1 203	Amended answer to I 203 With oversight by the Executive Director and the Quality Assurance Manager, the agency will ensure that all DSP's job descriptions are reviewed at the beginning of employment and on an annual basis. Reviews of the job descriptions will be done by the respective house managers. The ongoing tracking to ensure compliance will be done by the Office Manager who will retain a signed copy of the job description.	10-6-10
1 206	3509.6 PERSONNEL POLICIES	1 206		

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I 206	<p>Continued From page 4</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all employees had current health certificates, for one of the fourteen staff and four out of sixteen consultants. (Staff #7, Consultants #3, #4, #9 and #15)</p> <p>The finding includes:</p> <p>On August 26, 2010, beginning at approximately 1:45 p.m., review of the personnel records revealed the GHMRP failed to provide evidence that current health certificates were on file for one of fourteen staff (Staff #7), and four consultants (Consultants #3, #4, #9 and #15).</p> <p>The house manager acknowledged the findings at approximately 4:30 p.m.</p>	I 206	<p>Amended answer to I 206</p> <p>With oversight by the Executive Director and the Quality Assurance Manager, the agency will ensure that all employees and consultants have current health certificates on file. The Office Manager has identified when all health certificates expire and has disturbed the list to the House Managers and to the Consultants. Employees and Consultants will be notified two months in advance of their expiration date.</p>	10-11-10
I 229	<p>3510.5(f) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(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;</p>	I 229		

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1 229	<p>Continued From page 5</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all staff received effective training on the monitoring of residents' health care needs and behavior support plans, for two of the three sampled residents. (Residents #1 and #3)</p> <p>The findings include:</p> <p>1. On 8/26/2010, Resident #1's medical records were reviewed, beginning at 10:37 a.m. His chart included a Protocol for Maintenance of <Resident #1's name> Gastrointestinal Health, dated 7/15/2010. The protocol mirrored his physician's orders, also dated 7/15/2010. The orders were for staff on each shift to document every bowel movement on a bowel movement (BM) chart. Staff were to notify the nurse if the resident went more than 24 hours without a BM. The nurse was to administer 30 ml of Milk of Magnesia (MOM) as needed. If another 24 hours were to pass and the resident did not have a BM, staff were to alert the nurse and the nurse would administer a mineral oil enema and notify the primary care physician.</p> <p>At 10:58 a.m., review of Resident #1's BM chart revealed that some staff had not recorded whether or not he had a BM during their shift. For example, spaces on the BM chart were left blank during the 8 a.m. - 4 p.m. shift on 8/9/2010, 8/12/2010, 8/16/2010, 8/17/2010 and 8/20/2010, as well as the 12 a.m. - 8 a.m. shift on 8/24/2010.</p> <p>The registered nurse (RN) was interviewed by telephone later on that day (8/26/2010). At approximately 2:10 p.m., she stated that she</p>	1 229	See response to W159.2 on page 6 of 23.	10-15-10

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1 229	<p>Continued From page 6</p> <p>routinely monitored the BM chart and had asked staff about the shifts for which there was no BM documented. Staff reportedly documented BMs in other places in the record, such as on behavior data sheets when he had smeared feces. She further stated that on 8/18/2010, she had presented a "mandatory training" for all staff to address BM data collection and to review Resident #1's gastrointestinal protocol.</p> <p>a. Staff in-service training records were reviewed in the facility on 8/26/2010, beginning at 4:24 p.m. The review revealed that four (4) of the eleven (11) direct support staff had not attended the 8/18/2010 training.</p> <p>b. On 8/26/2010, at 11:39 a.m., review of Resident #1's BM chart indicated that he had been 24 hours without a BM. The LPN who administered medications that morning returned to the facility that afternoon to address what appeared to be a behavioral episode. When the LPN asked and was told that Resident #1 had not had a BM, she administered the MOM in accordance with his POs. At 2:30 p.m., the LPN confirmed that staff had not informed her that morning that he had not had a bowel movement.</p> <p>c. Further review of the BM charts in Resident #1's record revealed that a different chart had been initiated, beginning on 8/23/2010. The format was similar to the previous chart; however, the column headings had changed so that the first column no longer was for the 8am-4pm shift. The first column on the new chart was for use by the 12a.m. - 8a.m. shift. Review of the new chart revealed that the staff person who worked the 12a.m. - 8a.m. shift on 8/24/2010, 8/25/2010 and 8/26/2010, had mistakenly entered his data in the wrong column (where he previously had recorded</p>	1 229		

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I 229	<p>Continued From page 7</p> <p>BMs during his shift). That staff person was one of the 4 staff who had not attended the 8/18/2010 training.</p> <p>It should be noted that on 8/27/2010, at 10:47 a.m., review of Resident #1's behavior data sheets did show corroborating evidence that staff had documented feces smearing (example: 8/9/2010) without including the information on his BM chart.</p> <p>2. Resident #1's Protocol for Maintenance of <Resident #1's name> Gastrointestinal Health, dated 7/15/2010 and physician's orders, also dated 7/15/2010, prescribed 1 cup warm prune juice to be given twice daily.</p> <p>Cross-refer to Federal Deficiency Report - Citation W460.2. There was no evidence observed or documented, that Resident #1 received prune juice in the morning or evening of 8/25/2010 or on the morning of 8/26/2010. Telephone interview with the RN on 8/26/2010, at approximately 2:15 p.m., revealed that although she had presented a "mandatory training" for all staff to review Resident #1's gastrointestinal needs, she had not included in her training any discussion regarding the order for prune juice. Her impression was that the resident received it with his breakfast and his dinner. That could not, however, be verified and there was no documentation being maintained regarding prune juice. Review of staff training records that afternoon revealed no evidence that staff had received training on the provision of 1 cup warm prune juice twice daily in accordance with physician's orders.</p> <p>3. Observation on 8/25/2010 at 3:44 p.m. revealed, Resident #3 slapped his head and his</p>	I 229		

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I 229	<p>Continued From page 8</p> <p>face approximately fourteen (14) times over a six (6) minute period. He had just returned home from his day program and one of the facility's staff had asked him to take part in bringing in the groceries. Resident #3 was also observed head slapping on several occasions again at approximately 4:00 p.m. after he arrived home from day program on the afternoon of 8/26/2010. On this occasion, he was holding the remote to the television and he appeared to be trying to get to a particular channel. On both occasions, staff was present in the room and also within eyesight of this resident.</p> <p>Review of Resident #3's behavioral support plan (BSP), dated 6/11/2010, revealed a "Verbal Redirection for Self-injury" plan was recommended. The plan outlined the following:</p> <p>"If he is slapping verbally direct him to stop the behaviors and redirect him immediately to an alternative activity. These behaviors are best interrupted with redirection to another Physically Engaging Activity different from slapping. Alternative activities include his using his hands in another task. For safety, have a soft pillow available to place between his hand and his head or side. Allow him to hold something in each hand when redirecting. He may also hold the pillow. Provide supervision for as long as it takes for him to calm. Redirect him every 5 minutes as he quiets. Verbal redirection follows techniques outlined in Crisis Verbal De-escalation Procedures."</p> <p>None of these interventions were observed being implemented by staff on either 8/25/2010 or on 8/26/2010. In addition, there was no "small pillow" observed in any of the surrounding areas of the dining room, TV room, or the living room.</p>	I 229		

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I 229	Continued From page 9 Interview with the facility's qualified mental retardation professional (QMRP) on 8/27/2010 at approximately 1:37 p.m. revealed the staff should have taken measures to redirect Resident #3 when he was observed engaging in any "slapping" behavior. The QMRP further added he would address the concern immediately.	I 229		
I 422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to provide training and assistance in accordance with Individual Support Plans, for two of the three sampled residents. (Residents #1 and #2)</p> <p>The findings include:</p> <p>1. On 8/25/2010, Resident #1 was not observed receiving prune juice that morning, from 6:23 a.m. until his 8:50 a.m. departure for day program. The overnight staff person who had prepared breakfast that morning said Resident #1 did not routinely receive prune juice during her shift, which ends at 8:00 a.m. The resident was observed in the GHMRP from 1:56 p.m. until 7:15 p.m. on 8/25/2010 and he was not observed receiving prune juice during that period, including at dinner. On 8/26/2010, at 9:42 a.m., interview with a direct support staff person who routinely worked the 8:00 a.m. - 4:00 p.m. shift revealed that he had not seen Resident #1 receive prune juice. He replied "no" when asked whether any of</p>	<p>I 422</p> <p>1</p> <p>2</p> <p>3</p> <p>4</p>	<p>See response to W159.2 on page 6 of 23.</p> <p>See response to W159.8 on page 7 of 23.</p> <p>See response to W104 on page 1 of 23.</p> <p>See response to W159.1 on page 6 of 23</p>	<p>10-15-10</p> <p>10-1-10</p> <p>10-6-10</p> <p>10-6-10</p>

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 08/27/2010
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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 422	<p>Continued From page 10</p> <p>the residents routinely drank prune juice and if he ever saw prune juice in the facility. He further indicated that prune juice had not been on the shopping list he used on the day before, when he purchased groceries for the coming week.</p> <p>On 8/26/2010, beginning at 10:37 a.m., review of Resident #1's records (Medication Administration Records, nurse progress notes, staff shift progress notes, etc.) failed to show evidence that the facility documented his getting a cup of prune juice twice daily.</p> <p>On 8/26/2010, the RN was interviewed by telephone beginning at approximately 2:00 p.m. The RN stated that her understanding was that staff routinely gave Resident #1 a cup of prune juice with his breakfast and with dinner. She indicated that this was "part of his meal plan" and directed this surveyor to the house manager (HM). At approximately 3:40 p.m., the HM was asked about the prune juice. She indicated that Resident #1 received prune juice with his meals and the juice was reflected on the menus. She was unsure whether he got it at breakfast and/or at dinner. She further indicated that she typically arrived at the facility at approximately 10:00 a.m.; she did not, therefore, observe breakfast. The prune juice was kept in the refrigerator. At 3:48 p.m., observation of the refrigerator revealed there was no prune juice available. The staff in the kitchen at the time were unable to locate prune juice in the facility. Moments later, review of that week's menu revealed no listing of prune juice for any breakfasts, lunch or dinners.</p> <p>There was no evidence that the facility ensured that Resident #1 received a cup of prune juice twice daily in accordance with his Individual Support Plan.</p>	I 422		

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I 422	<p>Continued From page 11</p> <p>2. On 8/25/2010, at 7:21 a.m., Resident #1 was observed eating his breakfast. The meal consisted of scrambled Egg Beaters, toast, warm grits and coffee. The toast had been cut to bite size pieces. Later that morning, at 11:59 a.m., review of his physician's orders (POs) dated 7/1/2010, and his Individual Support Plan, revealed that his food should be a "ground texture." Resident #1's dinner was observed on 8/25/2010, beginning at 5:56 p.m. His baked fish, baked beans and broccoli were cut bite size and his slice of bread was cut in half, diagonally. On 8/26/2010, at 12:28 p.m., the resident was served a lunch consisting of turkey bologna (cut bite size) mixed salad-style with chopped celery and carrots, a 2-slice bread with mayonnaisse 'sandwich' that was cut into 8 bite-size pieces, and a bowl of small mandarin orange segments. None of the lunch had a ground consistency. Moments later, interview with the direct support staff person who had prepared his lunch revealed that he had been instructed to cut the resident's foods bite-sized to ensure his safety; the resident was known to eat quickly and swallow without thoroughly chewing his foods.</p> <p>It should be noted that on 8/26/2010, at approximately 4:15 p.m., review of the menu revealed that individuals receiving a "ground texture" were not to receive a second portion of grits with breakfast on 8/25/2010 as a substitution for the English Muffin. It should be further noted that staff did not honor Resident #1's repeated requests that morning for more hot cereal. [See Federal Deficiency Report - Citation W247]</p> <p>3. Resident #2 did not attend his day program on 8/27/2010, and was observed at home. Interview with the qualified mental retardation professional</p>	I 422	<p>Amended answer to I 422</p> <p>The facility will ensure that all meals are prepared per doctor's orders by having the House Manager on a weekly basis, and the QMRP on a monthly basis, monitor meal preparation. Compliance with the required meal preparation will also be monitored via the weekly administrative report. (see attached).</p>	10-18-10

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1422	<p>Continued From page 11</p> <p>2. On 8/25/2010, at 7:21 a.m., Resident #1 was observed eating his breakfast. The meal consisted of scrambled Egg Beaters, toast, warm grits and coffee. The toast had been cut to bite size pieces. Later that morning, at 11:59 a.m., review of his physician's orders (POs) dated 7/1/2010, and his Individual Support Plan, revealed that his food should be a "ground texture." Resident #1's dinner was observed on 8/25/2010, beginning at 5:55 p.m. His baked fish, baked beans and broccoli were cut bite size and his slice of bread was cut in half, diagonally. On 8/26/2010, at 12:28 p.m., the resident was served a lunch consisting of turkey bologna (cut bite size) mixed salad-style with chopped celery and carrots, a 2-slice bread with mayonnaise 'sandwich' that was cut into 6 bite-size pieces, and a bowl of small mandarin orange segments. None of the lunch had a ground consistency. Moments later, interview with the direct support staff person who had prepared his lunch revealed that he had been instructed to cut the resident's foods bite-sized to ensure his safety; the resident was known to eat quickly and swallow without thoroughly chewing his foods.</p> <p>It should be noted that on 8/26/2010, at approximately 4:15 p.m., review of the menu revealed that individuals receiving a "ground texture" were not to receive a second portion of grits with breakfast on 8/25/2010 as a substitution for the English Muffin. It should be further noted that staff did not honor Resident #1's repeated requests that morning for more hot cereal. [See Federal Deficiency Report - Citation W247]</p> <p>3. Resident #2 did not attend his day program on 8/27/2010, and was observed at home. Interview with the qualified mental retardation professional</p>	1422	<p>1 See response to W104 on page 1 of 23.</p> <p>2 See response to W159.3 on page 6 of 23.</p> <p>3 See response to W159.5 on page 7 of 23.</p>	<p>10-6-10</p> <p>10-9-10</p> <p>10-15-10</p>

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1422	<p>Continued From page 12</p> <p>(QMRP) on the same day at approximately 10:10 a.m. revealed Resident #2 generally refused to attend his day program over the past year and during his annual service plan meeting in 7/2010, he verbally agreed to attending the day program four days a week (Monday - Thursdays). According to the QMRP, Resident #2 indicated he preferred to use Friday as his day off.</p> <p>Record review on 8/27/2010, at 11:54 a.m., revealed Resident #2's Psychology assessment dated 7/3/2010, identified Resident #2 was "not able to make independent decisions concerning residential or day placements, medical and psychological treatments, habilitation plans or financial affairs. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He should be provided the opportunity to participate in day-to-day activity decision-making." The psychology assessment further outlined that "interpersonal contact is challenging and [Resident #2] does not like to be in crowds. He engages in one to one contact; he is only somewhat less reluctant to socialize with his peers. He simply prefers to be alone or to interact with counselors."</p> <p>Further record review on the same day and time revealed his Social Work (SW) assessment dated 06/10/2010 recommended the facility improve his community integration skills by implementing a formal social support program. The SW assessment outlined the facility should implement the social support program of: "once per month, [Resident #2] will select a CD/DVD/magazine from a public library with verbal assistance for 6 consecutive months by 1/11."</p>	1422		

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I 422	Continued From page 13 Additional interview with the facility's QMRP on 8/25/2010, at approximately 10:35 a.m., revealed the above program was not in place. The QMRP further added he would meet with the house manager and ensure the oversight was addressed immediately to help Resident #2 further improve his community integration skills.	I 422		
I 474	<p>3522.5 MEDICATIONS</p> <p>Each GHMRP shall maintain an individual medication administration record for each resident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP)'s nursing staff failed to maintain medication administration records accurately, for one of the five residents of the facility. (Resident #2)</p> <p>The finding includes:</p> <p>The morning medication pass was observed on 8/25/2010, beginning at 6:57 a.m. At 8:39 a.m., review of Resident #2's physician's orders (POs), dated 7/1/2010, revealed that he was prescribed "multi-vitamins w/iron tablet, 1 tab by mouth every day to treat a vitamin deficiency." The resident's Medication Administration Record (MAR) indicated that the designated administration time was 7:00 a.m. Further review revealed that the nurse had initialed the MAR that morning, as if she had administered the multi-vitamin w/iron. The nurse, however, had not been observed administering a multi-vitamin w/iron tablet to Resident #2 that morning.</p> <p>At 10:17 a.m., the medication nurse opened the</p>	I 474	<p>Medication Administration The administration acknowledges the importance of maintaining accurate medication administration records. 1) A policy regarding the procedures for "checking in" the monthly meds has been developed. All nurses involved in this process will be trained by 2) Problems with mislabeling of medications (ex: AM/PM stickers) have been addressed with the pharmaceutical representative. 3) All nurses who pass medications will be retained on the Medication Administration Policy and Procedure by.</p>	10/8/10

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I 474	Continued From page 14 medication cabinet and did not find the blister pack of multi-vitamin w/iron tablets in Resident #2's morning medications (bundled with a rubber band). She found the blister pack mixed in with the resident's evening medications and determined that the pharmacy had mistakenly labeled it for evening administration. She acknowledged that the tablet for 8/25/2010 remained in the blister pack and had not been administered.	I 474		