A re Augu sam popu and initia The obse in th as a inclu	ER OR SUPPLIER ES SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR L TIAL COMMENTS recertification surve gust 31, 2011 throu nple of three client bulation of five mer d developmental di iated utilizing the fu e findings of the su servations and inte	ey was conducted from ugh September 2, 2011. A s was selected from a a with various intellectual sabilities. This survey was undamental survey process. rvey were based on rviews with staff and clients ree day programs, as well	B. WIN ID PREF TAG	09/02/201 STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012 D PROVIDER'S PLAN OF CORRECTION COM PROVIDER'S PLAN OF CORRECTION COM COM PROVIDER'S PLAN OF CORRECTION COM COM COM COM COM PROVIDER'S PLAN OF CORRECTION COM PROVIDER'S PLAN OF CORRECTION COM COM COM COM COM COM OPACH Department of Health Intermediate of Administration	1 (X5) IPLETION DATE
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X4) ID PREFIX TAG W 000 INIT A re Augu sam popu and initia The obse in th as a inclu	ES SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR L TIAL COMMENTS recertification surve gust 31, 2011 throu nple of three client bulation of five mer d developmental di iated utilizing the fu e findings of the su servations and inter the home and at the	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ey was conducted from ugh September 2, 2011. A s was selected from a a with various intellectual sabilities. This survey was undamental survey process. rvey were based on rviews with staff and clients ree day programs, as well	PREF	STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012 D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 000 V 000 V 000	(X5)
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(X4) ID PREFIX TAG W 000 INIT A re Augu sam popu and initia The obse in th as a inclu	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L TIAL COMMENTS recertification surve gust 31, 2011 throu nple of three client bulation of five mer d developmental di iated utilizing the fu e findings of the su servations and inte he home and at the	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) by was conducted from ugh September 2, 2011. A s was selected from a to with various intellectual sabilities. This survey was undamental survey process. rvey were based on rviews with staff and clients ree day programs, as well	PREF	D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 000 V 000 V 000 Accent for the appropriate Department of Health Intermediate of Loanning Administration	PLETION
PREFIX TAG W 000 INIT A re Augu sam popu and initia The obse in th as a inclu	(EACH DEFICIENCY REGULATORY OR L TIAL COMMENTS recertification surve gust 31, 2011 throu nple of three client bulation of five mer d developmental di iated utilizing the fu e findings of the su servations and inte he home and at thi	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) by was conducted from ugh September 2, 2011. A s was selected from a to with various intellectual sabilities. This survey was undamental survey process. rvey were based on rviews with staff and clients ree day programs, as well	PREF	FIX (EACH CORRECTIVE ACTION SHOULD BE AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 000 V 000 ACCENDENT OF Health Intermediate of Health Intermediate of Health	PLETION
A re Augu sam popu and initia The obse in th as a inclu	recertification surve gust 31, 2011 throu nple of three client pulation of five mer d developmental di lated utilizing the fu e findings of the su servations and inte he home and at thi	ey was conducted from ugh September 2, 2011. A s was selected from a a with various intellectual sabilities. This survey was undamental survey process. rvey were based on rviews with staff and clients ree day programs, as well	W	Received 9/23/11 Department of Health Intermediate a Licensing Administration	
Aug sam popu and initia The obse in th as a inclu	gust 31, 2011 throu nple of three client pulation of five mer d developmental di iated utilizing the fu e findings of the su servations and inte he home and at thi	ugh September 2, 2011. A s was selected from a o with various intellectual sabilities. This survey was undamental survey process. rvey were based on rviews with staff and clients ree day programs, as well		Intermediate Concerning Administration	
	luding incident repo		:	899 North Capitol St., N.E. Weshington, D.C. 20002	
(QM disa W 120 483.	MRP) will be referre abilities profession	rdation professional ed to as qualified intellectual al (QIDP) within this report.] CES PROVIDED WITH		V 120	
	e facility must assu et the needs of eac	re that outside services ch client.			
Bas facili all cl form	sed on observation ility failed to ensure clients received the	not met as evidenced by: n and staff interview, the e outside services provided eir meals in the prescribed for one of three sampled			
The	e finding includes:				
(Cro	oss Reference W4	74)	i		
8/31	1/2011 at 12:57 p.r	#1's day program on m. revealed his meal was inevenly sized chunks			
ORATORY DIRECT	TOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE O O / (X6) DA	TE

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

AND PLAN OF	CORRECTION	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILD	NG	COMPLET	ED	
		09G145	B. WING		09/0	09/02/2011	
NAME OF PRO	OVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••	5	TREET ADDRESS, CITY, STATE, ZIP CO	DE		
MARJUL H	OMES			4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETION	
W 120	Continued From pag	e 1	W 1	20 QIDP will continue to insu	re Client #1' meals	9/5/11	
Ì	(approximately 1 - 2	inches square). Client #1		are prepared and served in	accordance to his		
İ		ating at a fast pace and		prescribed diet. Staff was in			
		of food into his mouth.		#1' Diet. In the future QID			
	Interview with the da	y program staff at the time of		ensure all staff is in-service			
		ient #1's food should be cut					
	•	ut she was not sure of the		QIDP will ensure the day p	rogram prepares and	9/5/11	
	consistency it should	be served.		serves Client #1' meals in a	accordance to his		
	Record review on 9/1	1/2011 at 10:00 a m		prescribed diet.			
		Initial Nutrition Assessment		-			
		ommended that he receive a				1	
		tose (2000 calories) -	:			1	
		diet. Additional record					
		nt #1's physician also	Ì				
	prescribed on 7/6/20	11 that he receives a					
	"ground consistency	" diet.					
	The facility failed to a	anaura an autoida aonvica					
ſ	provided Client #1's	ensure an outside service					
	prescribed by his pri		1	1			
W 140			W 1	40			
11 140	-0020(0)(1)(1) 02.1						
	The facility must esta	ablish and maintain a system		i.			
	that assures a full an	id complete accounting of				1	
	•	ts entrusted to the facility on				ĺ	
	behalf of clients.						
	This STANDARD is	not met as evidenced by:					
		view and staff interview, the	:			1	
1		re a full and accurate				1	
		nal funds for three of three				1	
	sampled clients. (Cl	ients #1, #2 and #3)					
	The findings include:	:					
	The facility failed to	ensure receipts were on file					
		drawals and banking		:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G145	B. WIN	G		09/0	2/2011
NAME OF PR	ROVIDER OR SUPPLIER			49	EET ADDRESS, CITY, STATE, ZIP CODE 910 Arkansas Avenue, NW Vashington, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 140	transfers for Clients # below: 1. Record review or revealed Client #1's f missing receipts for th banking transfers: a. $09/14/2010 - 10 b. $09/17/2010 - 12 c. $10/08/2010 - 58 d. $10/12/2010 - 12 g. $03/11/2010 - 12 g. $03/11/2011 - 20 Transfer h. $04/11/2011 - 22 Transfer i. $06/24/2011 - 26 j. $07/07/2011 - 26 j. $07/07/2011 - 27 c. $03/11/2011 - 26 missing receipts for th a. $06/24/2011 - 28 b. $03/25/2011 - 79 c. $03/11/2011 - 27 d. $02/04/2011 - 28 f. $11/08/2010 - 18 f. $11/08/2010 - 18 f. $11/08/2010 - 18 3. Record review o revealed Client #3's f missing receipts for th a. $06/24/2011 - 20 b. $05/17/2011 - 20 b. $05/17/2011 - 10 d. $12/10/2010 - 18	1, #2 and #3 as evidenced n 9/2/2011 at 10:00 a.m. inancial records were he following withdrawals and 00.00 - Check 8.00 - Cash Withdrawal 8.00 - Cash Withdrawal 8.00 - Cash Withdrawal 8.00 - Cash Withdrawal 8.00 - Cash Withdrawal 9.00 - Cash Withdrawal 9.00 - Online Banking 8.00 - Withdrawal 9.00 - Online Banking 8.00 - Withdrawal 9.00 - Withdrawal 9.00 - Withdrawal 9.00 - Cash Withdrawal 9.0	W	140	QIDP has incorporated a more co financial review system which ha developed for use in tracking and individuals' funds. With this syste received for funds used will be ac in a timely and consistent manner financial records will be reconcile reviewed weekly.	s been reconciling m, all receipts curately filed, , and all	

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		MEDICAID SERVICES				. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G145	B. WING		09/02	2/2011
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				4910 ARKANSAS AVENUE, NW		
MARJUL H	IUMES			WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 140	Continued From page	e 3	/ W 1	40		
W 159	qualified intellectual of on 9/2/2011 at 3:45pr receipts on file at the transactions listed ab 483.430(a) QUALIFIE RETARDATION PRO Each client's active tr integrated, coordinate	ED MENTAL DFESSIONAL reatment program must be ed and monitored by a	W 1	59		
	Based on observation review, the facility's of disabilities profession the coordination of se	not met as evidenced by: on, staff interview and record qualified intellectual nal (QIDP) failed to ensure ervices to promote the health f three sampled clients.		QIDP was in-serviced by Pr 9/5/2011. To ensure the coordinatio	on of outside	9/5/11
	provided clients' mea consistency prescrib clients. (See W120) 2. The QIDP failed accounting of clients three sampled clients 3. The QIDP failed provided opportunitie	to ensure outside services als in the form and ed, for one of three sampled to ensure a full and accurate personal funds, for three of s. (See W140) to ensure that clients were es for choice, encouraged choices, for one of three		services to promote the h of Client' #1, #2, and #3. QIDP will continue to insur to Client' are provided with documentation in which the and served in accordance to QIDP has developed a ne to accurately, in a timely manner; all financial reco reconciled and reviewed QIDP will ensure all individ provided the encouragemen community activities/outing	re all outside services the proper e meals are prepared their prescribed diet ew tracking system and consistent ords will be weekly. duals will be t of choosing which	

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Facility ID: 09G145

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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SURVEY COMPLETED	
		09G145	B. WIN	IG		09/02/2011	
NAME OF PR	IOVIDER OR SUPPLIER			4	EET ADDRESS, CITY, STATE, ZIP CODE 910 ARKANSAS AVENUE, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 159	 The QIDP failed accurately document training objectives, for the sample. (See W2 The QIDP failed their meals in the tex primary care physicia clients. (See W474) On 9/2/2011, at #3's ISP revealed that The training program addressed goals and expire in August 201 at 3:33 p.m., if Client (IDT) had met to revit the QIDP replied affin revised the ISP on 7/ however, revealed the specific goals and ob upon by the team for acknowledged the ne been implemented. 	to ensure that staff ed data relative to clients' r one of the three clients in		159	 QIDP was in-serviced by Program D 9/5/2011. To ensure accuracy of data with f goals progress based on program In the future programs will be re- warranted. QIDP will ensure that all the individ are prepared and served in accordan prescribed diet. QIDP was in-serviced by Program D 9/5/2011. To ensure implementation of new objectives that are implemented documented per the IDT team re- the annual plan for all individual future programs will be revised a warranted. QIDP was in-serviced by Program I 9/5/2011. To ensure goals are implemented #3 ISP. In the future programs wiinplemented per efforts made b 	training nobjectives vised as luals'meals ce to their Director on v goals and view of ls. In the as Director on d of Client <i>t</i> ill be	9/5/11 9/5/11
	who would then imple objectives. The QIDP failed to el of Client #3's ISP afte plan. There was also the time of the surve	nsure timely implementation er the IDT had formalized the no evidence presented at y to substantiate that the			IDT team annual plan.	,	
W 247	timely implementatio	o obtain the plan to ensure n. NVIDUAL PROGRAM PLAN	 w	247	1 : 		

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DATE COMPL					
			A. BUIL	DING						
		09G145	B. WIN	3 <u> </u>		/02/2011				
NAME OF PR	OVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STR	EET ADDRESS, CITY, STATE, ZIP CODE					
MARJUL	OMES				10 ARKANSAS AVENUE, NW					
				W	ASHINGTON, DC 20012					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE				
W 247	Continued From page The individual progra opportunities for clien self-management.	m plan must include	W	247	QIDP will ensure Client #3 participates in community activities/outings of his cho on a regular basis.	9/5/11 ice				
	Based on observation failed to ensure that of opportunities for choi	not met as evidenced by: on and interview, the facility clients were provided ice, encouraged and taught one of three clients in the								
	The finding includes:									
	8/31/2011. At 1:57 p liked to go with staff grocery store. When grocery shopping, Cl	ewed at his day program on o.m., the client stated that he when they went to the a asked when he last went ient #3 replied "Not in a long ar tell me they're going to the								
	Coordinator and a di were interviewed tog room. They all confi going shopping with generally done on W morning and afternoo that Client #3 had ac grocery store on the if they ever went gro weekends, the QIDP	s professional (QIDP), LPN rect support staff person ether in the facility's dining rmed that Client #3 enjoyed staff. Grocery shopping was rednesdays, between the on van runs. They stated companied staff to the week before. When asked cery shopping on evenings or replied "rarely." He further a to document outings in the			A staff documentation schedule has been created which identifies each staff who shall responsible for tracking and recording Client #3 daily/shift, progress notes, and activity lo as required. This will allow Client #3' QIDP identify and train staff who has incompletely or inaccurately documented on client #3, daily/shift, progress notes, and activity log, of as required.	, gs to				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	JLTIPLE CONSTRUCTION	(X3) DATE SUF	
		09G145	B. WIN	G	09/0	2/2011
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 4910 ARKANSAS AVENUE, M WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ID TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
W 247 W 252	Client #3's "Monthly / "Daily/Shift Progress to show evidence of (May, June, July or Ar review of the client's show evidence that to opportunities for choi with regards to shopp 483.440(e)(1) PROG Data relative to accor specified in client ind	ng at 11:42 a.m., review of Activity Sheets" and Notes" in his IPP book failed grocery shopping with staff in ugust 2011. Subsequent Activity Schedule failed to he facility afforded Client #3 ice and self-management, bing for groceries. RAM DOCUMENTATION mplishment of the criteria		247 252		
	Based on observation review, facility staff fa data relative to client	not met as evidenced by: on, interview and record ailed to accurately document s' training objectives, for one the sample. (Client #2)				
	in the TV room, and come with her to get who is non-verbal, st once (hard) on the flo out of the room. Mon Client #2 stomped hi medication nurse cal medications.			revised data sheet. A sheets from Client # future, the facility w ABC data sheet is de	Staff was trained on the	
FORM CMS-25	57(02-99) Previous Versions Ob		11	Facility ID: 09G145	if continuation she	et Page 7 of 12

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE W 252 Continued From page 7 W 252	STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IULTIPI LDING		(X3) DATE SURVEY COMPLETED	
MARJUL HOMES 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG OMPLET COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE W 252 Continued From page 7 W 252 W 252			09G145	B. WING			09/02/2011	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE W 252 Continued From page 7 W 252					49	10 ARKANSAS AVENUE, NW		
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
teleptone interview with the facility's Registered Nurse (RN) revealed that staff had reported seeing Client #2 displaying new behaviors in July 2011. One of the new behaviors was a 'loot stomp 'when staff asked hin to do something. The behaviors had been shared with the psychologist and others participating on the psychologist medication review team in June 2011. Beginning in late June or early July 2011, the psychiatry trescribed Prozea to address "anxiety." The RN further stated that taff had been instructed to record any behavior they observe and there had been no incidents of 'loot stomping' behavior lately. On 9/2/2011, at 11:18 a.m., interview with the qualified intellectual disabilities professional (ICIDP) confirmed Client #2 Ad begun displaying new behaviors, including foot stomping, in June 2011. The QIDP further stated that the new behaviors with the morning medication nurse and the house manager. 2. The morning medication administration pass was observed on 8/31/2011. At 7:14 a.m., the medication nurse was observed providing Client #2 with hard-over-hard (HOH) assistrate while he struggled to punch his three medication	W 252	telephone interview v Nurse (RN) revealed seeing Client #2 disp 2011. One of the ner stomp' when staff as The behaviors had be psychologist and othe psychotropic medical 2011. Beginning in la the psychiatrist preso "anxiety." The RN fur been instructed to re- observe and there has stomping' behavior la On 9/2/2011, at 11:1 qualified intellectual of (QIDP) confirmed Cli- new behaviors, inclu- 2011. The QIDP furt behaviors were being review of the client's revealed staff had we 8/31/2011, even thou the behaviors with th and the house mana 2. The morning med was observed on 8/3 medication nurse wa #2 with hand-over-ha he struggled to punc their respective bliste cup. At 8:13 a.m., review administration record	with the facility's Registered that staff had reported laying new behaviors in July w behaviors was a 'foot ked him to do something. een shared with the ers participating on the tion review team in June ate June or early July 2011, cribed Prozac to address ther stated that staff had cord any behavior they ad been no incidents of 'foot ately. 8 a.m., interview with the disabilities professional ient #2 had begun displaying ding foot stomping, in June ther stated that the new g "base lined." At 11:31 a.m., behavior data sheets ritten "no behaviors" on ugh the client had displayed e morning medication nurse ger. lication administration pass 11/2011. At 7:14 a.m., the s observed providing Client and (HOH) assistance while h his three medications from er packs into the medication ds (MARs) revealed that he		252	medication program. In the fu designated nurse will ensure t documentation is completed for	ture the hat accurate	9/5/11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3)	(X3) DATE SURVEY COMPLETED - 09/02/2011	
09G145 B. WING		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MARJUL HOMES 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012 WASHINGTON, DC 20012		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) DEFICIENCY) DEFICIENCY DEFICIENCY	BE COMPLETION	
W 252 Continued From page 8 W 252 Self-medication administration skills. Review of the corresponding data collection sheet revealed that on the line for "punch out medication into cup," the nurse had documented "V/P." The key indicated that a V meant verbal instructions and P meant physical assistance. Further review of the key, however, revealed that HOH was to be written if/when a nurse provided the client hand-over-hand assistance. The nurse did not accurately record Client #2's performance during his self-medication training program on the moming of 8/31/2011. 3. Facility staff failed to document Client #3's community outings in accordance with the facility's managers' expectations, as follows: [Cross-refer to W247] On 8/31/2011, at 1:57 p.m., Client #3 stated that he liked to go with staff when they went to the grocery store. When asked when he last went grocery store." On 9/2/2011, at 11:09 a.m., the QIDP, LPN Coordinator and a direct support staff person were interviewed together in the facility's dining room. They all confirmed that Client #3 enjoyed going shopping with staff. They stated that taff were to document outings in the clients "Activity Sheets" and "Daily/Shiff progress Notes" in his 11:42 a.m., review of Client #3's "Monthly Activity Sheets" and "Daily/Shiff progress Notes" in his IPP book revealed that staff had not documented any trips to the grocery store with staff in May, June, July or August 2011. Surveyors, therefore,	s shall be g Client' is will I train rately	

FORM CMS-2567(02-99) Previous Versions Obsolete

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

PRINTED: 09/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G145	B. WING			09/0	2/2011
NAME OF PR	OVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 1910 ARKANSAS AVENUE, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
W 252 W 356	were unable to verify interviews. 483.460(g)(2) COMP TREATMENT	the information shared in REHENSIVE DENTAL		252 356			9/5/11
	treatment services th needed for relief of p	ure comprehensive dental at include dental care ain and infections, and maintenance of dental					
	Based on observation review revealed the f effective monitoring a						
	Observation on 8/31/ a.m. revealed Client discolored and he als few teeth. Record re	2011 at approximately 11:40			At the time of Survey, there was		9/5/11
	following findings: "T poor. He needs freque patient has gingival i He also has generali There is pocketing in Recommend this pate brushes his teeth 2 to toothbrush and floss	tal Assessment outlined the his patient (oral health) is lient dental treatment. This inflammation (generalized). zed calculus and plaque. idicating disease present. ient's care provider tooth imes a day with an electric 1 times a day." tal Assessment outlined the			evidence of client #1 brushing his times a day with soft toothbrush with an oral mouth rinse 1 time a the future the designated nurse a will make sure staff is documentin toothbrush & rinse is completed. This will ensure recommendations n Dentist are completed.	& rinsing a day. In and QIDP g after each	

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 09/19/2011 MAPPROVED D: 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G145	B. WIN	۱G	09/0	2/2011	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE		
MARJUL I	IOMES			4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX (EACH CORRECTIVI	IN OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
W 356	Continued From page	e 10	w	356			
	following findings: "Ti taker brush his teeth toothbrush & rinse wi a day." 3. 2/10/2011 Denta following findings: "Ti generalized plaque pocket depths greate gingival hyperplasia inflammation. This pa furcation involvemen infection & carious de very resistant to treat Further record review approximately 12:15 not taken measures declining oral health. Interview with Licens and qualified intellec (QIDP) on 9/2/2011 a facility had not re-ass treatment plan for eff developed a formaliz client's declining oral indicated she would	his patient is to have his care 2 times a day with a soft th an oral mouth rise 1 times A Assessment outlined the his patient has excessive . he also has BOP and r than 5mm. There is & excessive gingival attent has localized areas of t, bone loss, areas of ecay. This patient can be timent." y on 9/1/2011 beginning at p.m. revealed the facility had to address Client #1's ed Practical Nurse (LPN) tual disability professional at 2:49pm confirmed the sessed this client's current fectiveness and had not ed plan to address this health. The LPN also meet with the dentist to draft t to better manage and		QIDP and DDS Service that the resident was pre device for the individual 1, 2011 at 1:00 pm. Alth vendor for the device div in a timely manner.	escribed supportive I was delivered January hough the Medicaid	9/5/11	
W 474		l in a form consistent with the	N	1 474			
	Based on observation	not met as evidenced by: on, staff interview and record iled to ensure all clients					
FORM CMS-25	87(02-99) Previous Versions Ot	solete Event ID: NN24	11	Facility ID: 09G145	If continuation she	et Page 11 of 12	

PRINTED: 09/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G145	B. WING		09/0	2/2011	
NAME OF PR	OVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	5	TREET ADDRESS, CITY, STATE, ZIP C 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A(CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE	
W 474	the primary care physisampled clients. (Cli The finding includes: Observation on 8/31/ p.m., revealed he return program and receive consisted of a bag of The Sunchips and the whole. Later the sam p.m., Client #1 receive ground chicken pattie potatoes, (whole) sw garden salad. He was fast pace. Record review on 9/1 revealed Client #1's dated 6/24/2011 recor "High Fiber, Low Lac Ground consistency" review revealed Client prescribed on 7/6/20 "ground consistency" Interview with the LP revealed Client #1's "ground" texture as p care physician.	in the texture prescribed by sician for one of three ent #1) 2011 at approximately 4:15 urned home from his day d his afternoon snack which 5 Sunchips and a banana. e banana were served ne day, at approximately 6:45 wed a meal of cauliflower, es, (mashed) sweet eet potato fries, and a as also observed eating at a 1/2011 at 10:00 a.m. Initial Nutrition Assessment commended that he receive a tose (2000 calories) - diet. Additional record int #1's physician also 11 that he receives a	W 4	74 QIDP will ensure that all t are prepared and served in prescribed diet.		9/5/11	
FORM CMS-25	87(02-99) Previous Versions Ob	solete Event ID: NN2	411	Facility ID: 09G145	If continuation she	et Page 12 of 12	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING B. WING		(X3) DATE S COMPLI		
NAME OF PR	OVIDER OR SUPPLIER	HFD03-0008	4910 ARKAN	DDRESS, CITY, STATE, ZIP CODE RKANSAS AVENUE, NW IGTON, DC 20012				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
1 000		as conducted from Aug ptember 2, 2011. A sar		1 000				
	of five men with vario developmental disab	ilities.	lation					
		erviews with staff and e and at three day prog f resident and administ						
		ardation professional red to as qualified intell nal (QIDP) within this re						
I 047	that meals, which are	be responsible for ensure served away from the the dietary needs of	ring	1047				
	facility failed to ensur all residents received	n and staff interview, th re outside services prov I their meals in the consistency for one of t	rided					
	The finding includes:							
	p.m., revealed he ret program and receive consisted of a bag of	2011 at approximately urned home from his da d his afternoon snack w Sunchips and a banan e banana were served	ay /hich					
alth Regulat	tion & Licensing Administrat	lion	/	$\frac{1}{1}$	TITLE	Q /	(X6) DATE	
BORATORY I		SUPPLIER REPRESENTATIVE	SIGNATURE	Simil	Tillion Pronem	1 Director	9-28-2	

Health Regulation & Licensing Administration

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Health Regulation & Licensing Administration

	OVIDER OR SUPPLIER	IDENTIFICATION NUMB		A. BUILDING B. WING DDRESS, CITY, STATE, ZIP CODE			09/02/2011	
MARJUL H			4910 ARK	ANSAS AVEN TON, DC 200	IUE, NW			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
I 047	Continued From page 1 whole. Later the same day, at approximately 6:45 p.m., Resident #1 received a meal of cauliflower, ground chicken patties, (mashed) sweet potatoes, (whole) sweet potato fries, and a garden salad. He was also observed eating at a fast pace.			1 047	QIDP will ensure that all the are prepared and served in prescribed diet.		9/5/2011	
	he receive a "High Fi calories) - Ground co record review reveale	's Initial Nutrition 24/2011 recommended ber, Low Lactose (2000 nsistency" diet. Additio ed Resident #1's physic 6/2011 that he receives) Inal ian					
	revealed Resident #1	N on 9/2/2011 at 2:38p 's meals should be sen prescribed by the prim	ved in					
	•	ensure all resident's meaning anner prescribed by the n.						
1 090	3504.1 HOUSEKEEF	PING		1 090				
	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.							
	home for persons wit (GHPID) maintained	n and interview, the gro h intellectual disabilities the interior and exterior clean, orderly, attractive ept for the following	of					

Health Regulation & Licensing Administration STATE FORM

NN2411

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI HFD03-0008		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SUI COMPLET 09/0			
NAME OF PR	OVIDER OR SUPPLIER	1	STREET ADD	ET ADDRESS, CITY, STATE, ZIP CODE					
MARJUL H	IOMES			NSAS AVEN ON, DC 200	-				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE			
1 090	observations, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) The findings include:			1 090	MarJul Homes, Inc. will pur for the five residents of the f house manager will continue ensure all individual' enviro safe and pleasant.	acility. QIDP and to monitor and	e 10/31/20		
	fabric was observed sofa located in the T 2. On 8/31/2011, at 8 (approximately 3 ft. in carpet located in the presented a potentia 3. On 8/31/2011, at 9 were observed in the	3:30 a.m., a large tear n length) was observed TV room. The tear I trip hazard. 9:33 a.m., two large tear carpet located in the side of the bathroom. T	in the		MarJul Homes, Inc. replace home for the five residents.	d the carpet in the	10/31/201		
	observed backed up bathroom when it wa	9:33 a.m., rinse water w in the sink in the upstai is used for hand washin revealed that the sink w just the drain.	rs g.		MarJul Homes, Inc. has had upstairs bathroom repaired.	the sink in the	9/5/2011		
	observed on the pair A direct support staff resident was known	On 9/2/2011, at 2:52 p.m., large scrapes were oserved on the paint in Resident #3's bedroom. direct support staff person stated that the sident was known to push a chair, his TV and ther items against the walls.			MarJul Homes, Inc. had ind repainted September 22, 20		9/22/2011		
I 108		assure that each resider anges of clothing appro		I 108					
	This Statute is not m Based on observatio tion & Licensing Administra	n, interview and record					I		

STATE FORM

6899

NN2411

If continuation sheet 3 of 10

		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME HFD03-0008		(X2) MULT A. BUILDIN B. WING _	IPLE CONSTRUCTION	(X3) DATE S COMPLI	
NAME OF PR	AME OF PROVIDER OR SUPPLIER STREET				TATE, ZIP CODE		
MARJUL	OMES		t	KANSAS AVEN GTON, DC 200	-		
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
I 108	Continued From page review, the group hor intellectual disabilities an adequate supply of one of the three resid (Resident #3) The findings include: On 8/31/2011, at 1:50 Resident #3 revealed a sufficient number of shoes he was wearin pair. He further indic shoes, describing the resident also stated to Observations in Resi 9/2/2011, beginning a long sleeve shirt han There were another 4 of his bed. The direct time stated those shii advised against inspe There were four pairs a dresser drawer, and observed in a laundry pairs of socks in a dri no shoes observed ir person said Resident pair of shoes several	e 3 me for persons with s (GHPID) failed to enso of shoes and clothing, f lents in the sample. 5 p.m., interview with I that he did not think h f clothes items and tha g at the time were his of ated that he did not like em as "too soft." The hat he enjoyed shoppin dent #3's bedroom on at 2:35 p.m., revealed of ging in his bedroom close s shirts balled up at the t support staff present rts were soiled and she ecting them more close s of clean slacks obsend d two pairs of slacks y basket. There were fi esser drawer. There w his bedroom. The stat #3 had destroyed ano months before the sur	e had t the only e the ng. one set. foot at the e ly. ved in our ere iff ther vey	108		r will continue to dual' #3 has	9/5/2011
	pair of shoes. A shor qualified intellectual of (QIDP) stated that Re recent offers to go sh	the confirmed that he was wearing his only i shoes. A short time later, at 3:45 p.m., the ed intellectual disabilities professional) stated that Resident #3 had declined i offers to go shopping. Further interview					
	with the QIDP revealed that the resident's alleged refusals to go shopping for clothes and/or shoes had not been documented in the resident's records; therefore, the alleged refusals could not be verified.						

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Health Regulation & Licensing Administration

NN2411

If continuation sheet 4 of 10

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 09/02/2011		
		HFD03-0008					
		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIC		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE	
I 180	3508.1 ADMINISTRA	ATIVE SUPPORT	180				
		provide adequate It to efficiently meet the ts as required by their					
	review, the group hor intellectual disabilities adequate administrat the residents' needs,	n, staff interview and rec	re eet ents				
	The findings include:						
	services provided re-	failed to ensure outside sidents' meals in the forn scribed, for one of three	n	(See W120)		9/5/2011	
		o ensure a full and accur nts' personal funds, for ti idents. (See W140)		(See W140)		9/5/201	
	provided opportunitie	o ensure that residents w as for choice, encourage choices, for one of three ple. (See W247)		(See W247)		9/5/201	
	documented data rel	o ensure that staff accura ative to residents' trainin f the three residents in th)	9	(See W252)		9/5/201	
	provided the prescrit	o ensure residents were bed supportive device, fo d residents. (See W436)		(See W252)		9/5/201	

NN2411

If continuation sheet 5 of 10

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			(X3) DATE SURVEY COMPLETED			
		HFD03-0008			09	/02/2011		
MARJUL I	ovider or supplier		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE	(X5) COMPLET DATE		
I 180	Continued From page	e 5	180					
	the primary care physical	in the texture prescribed sician, for one of three	by	(See W474)		9/5/201		
	received their meals in the texture prescribed by the primary care physician, for one of three sampled residents. (See W474) 8. On 9/2/2011, at 10:45 a.m., review of Resident #3's ISP revealed that it was dated 7/28/2010. The training programs in the resident's IPP book addressed goals and objectives identified to expire in August 2011. When asked on 9/2/2011, at 3:33 p.m., if Resident #3's interdisciplinary team (IDT) had met to review the resident's annual plan, the QIDP replied affirmatively, stating the IDT had revised the ISP on 7/28/2011. Further interview, however, revealed that the QIDP did not recall the specific goals and objectives that were agreed upon by the team for the coming year and he acknowledged the new programs had not yet been implemented. When asked when the programs would start, the QIDP replied the ISP should be posted online "within 30 days" of the 7/28/2011 meeting. Once he had a copy of the ISP, he would provide in-service training for staff, who would then implement the goals and objectives.). pok 011, 011. 011. of for sw hen DP in 30 d a					
	of Resident #3's ISP the plan. There was a at the time of the sur	DP failed to ensure timely implementation dent #3's ISP after the IDT had formalized n. There was also no evidence presented ime of the survey to substantiate that the nade efforts to obtain the plan to ensure mplementation.						
I 189	3508.7 ADMINISTRA	TIVE SUPPORT	I 189					
	Each GHMRP shall maintain records of residents		ents					
	This Statute is not m Based on record revi		he			:		

STATE FORM

6899

NN2411

If continuation sheet 6 of 10

Health Regulation & Licensing Administration

ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		(X2) MULT A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		HFD03-0008				09/02	2/2011
AME OF PR	OVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
MARJUL H	IOMES			ANSAS AVEN TON, DC 200			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
I 18 9	Continued From page 6 facility failed to ensure a full and accurate accounting of personal funds for three of three sampled residents. [Residents #1, #2 and #3]			I 189			
	The findings include: [Cross Reference Fee	deral Deficiency Citatio	n				
	W140] The facility failed to ensure receipts were on file for the following withdrawals and banking transfers for Residents #1, #2 and #3 as evidenced below:						
	revealed Resident #1 missing receipts for \$	king transfers between	e		QIDP has incorporated a m financial review system wh developed for use in trackin individuals' funds. With this received for funds used will	ich has been ng and reconciling s system, all receipts l be accurately filed,	9/5/201
-	revealed Resident #2 missing receipts for \$	 Record review on 9/2/2011 at 11:58 a.m. evealed Resident #2's financial records were tissing receipts for \$758.00 worth of withdrawals etween the dates of 11/8/2010 and 6/24/2011. Record review on 9/2/2011 at 11:38 a.m. evealed Resident #3's financial records were hissing receipts for \$880.00 worth of withdrawals etween the dates o f11/8/2010 and 6/24/2011. 			in a timely and consistent n financial records will be rea reviewed weekly.		
	revealed Resident #3 missing receipts for \$						
	QMRP on 9/2/2011 a	ility's lead staff and the t 3:45pm confirmed the ile at the time of survey d above.	re				
1 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been			I 206			

STATE FORM

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Health Reg	ulation & Licensir	g Administration					M APPRO
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPLE A. BUILDING		(X3) DATE SU COMPLET	
		HFD03-0008		B. WING		09/(2/2011
NAME OF PROV	IDER OR SUPPLIER		STREET ADD	RESS, CITY, STATI	E, ZIP CODE		
MARJUL HO	MES			NSAS AVENUE ION, DC 20012			
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES	ULL	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S		(X5) COMPLI

(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 206	Continued From page 7 performed and that the employee 's health status would allow him or her to perform the required duties.	I 206	MarJul Homes, Inc. submitted all health certificates, for the five consultants to the Department of Health September 22, 2011	9/22/201
	This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that health care professionals had current health certificates, for five of the ten consultants. (occupational therapist, physical therapist, pharmacist, speech language pathologist and podiatrist) The findings include: On 9/2/2011, beginning at 12:35 p.m., review of the personnel records failed to show evidence of a current physician's health inventory/ certificate for the following: - occupational therapist (OT); - physical therapist (PT); - pharmacist; - speech language pathologist; and, - podiatrist.			
	At approximately 5:20 p.m., the qualified intellectual disabilities professional and the program director acknowledged that there was no evidence of a health inventories performed by a physician for the aforementioned health consultants. They stated they would seek additional information from their corporate office. [Note: The health screenings on file for the OT, PT, and pharmacist had not been performed and certified by a physician.]			

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		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB HFD03-0008		(X2) MULT A. BUILDIN B. WING _	IPLE CONSTRUCTION	(X3) DATE SUI COMPLET 09/0	
IAME OF PR	OVIDER OR SUPPLIER	A	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
MARJUL I	IOMES			ANSAS AVEN TON, DC 200	•		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
I 232 I 232	Continued From page 3510.5(i) STAFF TR/ Each training program limited to, the followin (i) Training of the ress oral health and hygie This Statute is not m Based on observation review revealed the f effective treatment pr resident's declining of sampled residents. [F The finding includes: Observation on 8/31/ a.m. revealed Reside discolored and he als few teeth. Record re at 11:00 a.m., revealed history:	cord t ee 11:40 ing a	1 232	MarJul Homes, Inc. has init all DSP' on oral health and importance of accurate doc as the importance of consis all entries, including data sl MarJul Homes, Inc. has imp of on-going training of DSH re-training, whenever the ne	hygiene. Also the umentation as well tent completion of heets and log notes. plemented a program Ps, as well as	9/5/2011	
	 12/13/2010 Dental Assessment outlined following findings: "This patient (oral health) poor. He needs frequent dental treatment. The patient has gingival inflammation (generalized He also has generalized calculus and plaque There is pocketing indicating disease present Recommend this patient's care provider tooth brushes his teeth 2 times a day with an elect toothbrush and floss 1 times a day." 12/28/2010 Dental Assessment outlined following findings: "This patient is to have his taker brush his teeth 2 times a day with a so toothbrush & rinse with an oral mouth rise 1 a day." 2/10/2011 Dental Assessment outlined to following findings: "This patient has excessive 		is his ed). e. ht. tric ft s care ft times the				

STATE FORM

Health Regulation & Licensing Administration

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING_ HFD03-0008 09/02/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW MARJUL HOMES WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 1232 Continued From page 9 1232 generalized plaque ... he also has BOP and pocket depths greater than 5mm. There is gingival hyperplasia & excessive gingival inflammation. This patient has localized areas of furcation involvement, bone loss, areas of infection & carious decay. This patient can be very resistant to treatment." Further record review on 9/1/2011 beginning at approximately 12:15 p.m. revealed the facility had not taken measures to address Resident #1's declining oral health. Interview with Licensed Practical Nurse (LPN) and qualified intellectual disability professional (QIDP) on 9/2/2011 at 2:49pm confirmed the facility had not re-assessed this resident's current treatment plan for effectiveness and had not developed a formalized plan to address this resident's declining oral health. The LPN also indicated she would meet with the dentist to draft a course of treatment to better manage and improve this resident's oral health. Health Regulation & Licensing Administration

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