STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G145	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from August 31, 2011 through September 2, 2011. A sample of three clients was selected from a population of five men with various intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with staff and clients in the home and at three day programs, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000	Received 9/28/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure outside services provided all clients received their meals in the prescribed form and consistency for one of three sampled clients. (Client #1) The finding includes: (Cross Reference W474) Observation at Client #1's day program on 8/31/2011 at 12:57 p.m. revealed his meal was cut up and served in unevenly sized chunks	W 120		

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

Program Director 9-28-2011

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 120	Continued From page 1 (approximately 1 - 2 inches square). Client #1 was also observed eating at a fast pace and taking large spoons of food into his mouth. Interview with the day program staff at the time of the meal revealed Client #1's food should be cut up before he eats, but she was not sure of the consistency it should be served. Record review on 9/1/2011 at 10:00 a.m. revealed Client #1's Initial Nutrition Assessment dated 6/24/2011 recommended that he receive a "High Fiber, Low Lactose (2000 calories) - Ground consistency" diet. Additional record review revealed Client #1's physician also prescribed on 7/6/2011 that he receives a "ground consistency" diet. The facility failed to ensure an outside service provided Client #1's meals in the manner prescribed by his primary care physician.	W 120	QIDP will continue to insure Client #1' meals are prepared and served in accordance to his prescribed diet. Staff was in-serviced on Client #1' Diet. In the future QIDP and nurse will ensure all staff is in-serviced on client' diet. QIDP will ensure the day program prepares and serves Client #1' meals in accordance to his prescribed diet.	9/5/11 9/5/11
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a full and accurate accounting of personal funds for three of three sampled clients. (Clients #1, #2 and #3) The findings include: The facility failed to ensure receipts were on file for the following withdrawals and banking	W 140		

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W 140	Continued From page 2 transfers for Clients #1, #2 and #3 as evidenced below: 1. Record review on 9/2/2011 at 10:00 a.m. revealed Client #1's financial records were missing receipts for the following withdrawals and banking transfers: a. 09/14/2010 - $100.00 - Check b. 09/17/2010 - $198.00 - Cash Withdrawal c. 10/08/2010 - $58.00 - Cash Withdrawal d. 10/12/2010 - $128.00 - Cash Withdrawal e. 11/08/2010 - $150.00 - Cash Withdrawal f. 12/10/2010 - $121.00 - Cash Withdrawal g. 03/11/2011 - $20.00 - Online Banking Transfer h. 04/11/2011 - $25.00 - Online Banking Transfer i. 06/24/2011 - $268.00 - Withdrawal j. 07/07/2011 - $57.00 - Withdrawal 2. Record review on 9/2/2011 at 11:58 a.m. revealed Client #2's financial records were missing receipts for the following withdrawals: a. 06/24/2011 - $280.00 - Cash Withdrawal b. 03/25/2011 - $79.00 - Cash Withdrawal c. 03/11/2011 - $79.00 - Cash Withdrawal d. 02/04/2011 - $20.00 - Cash Withdrawal e. 12/10/2010 - $150.00 - Cash Withdrawal f. 11/08/2010 - $150.00 - Cash Withdrawal 3. Record review on 9/2/2011 at 11:38 a.m. revealed Client #3's financial records were missing receipts for the following withdrawals: a. 06/24/2011 - $280.00 - Cash Withdrawal b. 05/17/2011 - $200.00 - Cash Withdrawal c. 03/11/2011 - $100.00 - Cash Withdrawal d. 12/10/2010 - $150.00 - Cash Withdrawal e. 11/08/2010 - $150.00 - Cash Withdrawal	W 140	QIDP has incorporated a more comprehensive financial review system which has been developed for use in tracking and reconciling individuals' funds. With this system, all receipts received for funds used will be accurately filed, in a timely and consistent manner, and all financial records will be reconciled and reviewed weekly.	9/5/11

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W 140	Continued From page 3 Interview with the facility's lead staff and the qualified intellectual disability professional (QIDP) on 9/2/2011 at 3:45pm confirmed there were no receipts on file at the time of survey for the transactions listed above.	W 140		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure the coordination of services to promote the health and safety of three of three sampled clients. (Clients #1, #2 and #3) The findings include: 1. The QIDP failed to ensure outside services provided clients' meals in the form and consistency prescribed, for one of three sampled clients. (See W120) 2. The QIDP failed to ensure a full and accurate accounting of clients' personal funds, for three of three sampled clients. (See W140) 3. The QIDP failed to ensure that clients were provided opportunities for choice, encouraged and taught to make choices, for one of three clients in the sample. (See W247)	W 159	QIDP was in-serviced by Program Director on 9/5/2011. To ensure the coordination of outside services to promote the health and safety of Client' #1, #2, and #3. QIDP will continue to insure all outside services to Client' are provided with the proper documentation in which the meals are prepared and served in accordance to their prescribed diet. QIDP has developed a new tracking system to accurately, in a timely and consistent manner; all financial records will be reconciled and reviewed weekly. QIDP will ensure all individuals will be provided the encouragement of choosing which community activities/outings they would like to do on a regular basis of their choice.	9/5/11 9/5/11

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W 159	Continued From page 4 5. The QIDP failed to ensure that staff accurately documented data relative to clients' training objectives, for one of the three clients in the sample. (See W252) 6. The QIDP failed to ensure all clients received their meals in the texture prescribed by the primary care physician, for one of three sampled clients. (See W474) 7. On 9/2/2011, at 10:45 a.m., review of Client #3's ISP revealed that it was dated 7/28/2010. The training programs in the client'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 Client #3's interdisciplinary team (IDT) had met to review the client'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. The QIDP failed to ensure timely implementation of Client #3's ISP after the IDT had formalized the plan. There was also no evidence presented at the time of the survey to substantiate that the QIDP made efforts to obtain the plan to ensure timely implementation.	W 159	QIDP was in-serviced by Program Director on 9/5/2011. To ensure accuracy of data with training goals progress based on program objectives. In the future programs will be revised as warranted. QIDP will ensure that all the individuals'meals are prepared and served in accordance to their prescribed diet. QIDP was in-serviced by Program Director on 9/5/2011. To ensure implementation of new goals and objectives that are implemented and documented per the IDT team review of the annual plan for all individuals. In the future programs will be revised as warranted. QIDP was in-serviced by Program Director on 9/5/2011. To ensure goals are implemented of Client #3 ISP. In the future programs will be implemented per efforts made by QIDP to IDT team annual plan.	9/5/11 9/5/11 9/5/11 9/5/11
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN	W 247		

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W 247	Continued From page 5 The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that clients were provided opportunities for choice, encouraged and taught to make choices, for one of three clients in the sample. (Client #3) The finding includes: Client #3 was interviewed at his day program on 8/31/2011. At 1:57 p.m., the client stated that he liked to go with staff when they went to the grocery store. When asked when he last went grocery shopping, Client #3 replied "Not in a long time... They don't ever tell me they're going to the grocery store." On 9/2/2011, at 11:09 a.m., the qualified intellectual disabilities professional (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. Grocery shopping was generally done on Wednesdays, between the morning and afternoon van runs. They stated that Client #3 had accompanied staff to the grocery store on the week before. When asked if they ever went grocery shopping on evenings or weekends, the QIDP replied "rarely." He further stated that staff were to document outings in the client's "Activity Sheets, in his IPP book."	W 247	QIDP will ensure Client #3 participates in community activities/outings of his choice on a regular basis. A staff documentation schedule has been created which identifies each staff who shall be responsible for tracking and recording Client' #3 daily/shift, progress notes, and activity logs as required. This will allow Client #3' QIDP to identify and train staff who has incompletely or inaccurately documented on client #3, daily/shift, progress notes, and activity log, etc. as required.	9/5/11 9/5/11

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W 247	Continued From page 6 On 9/2/2011, beginning at 11:42 a.m., review of Client #3's "Monthly Activity Sheets" and "Daily/Shift Progress Notes" in his IPP book failed to show evidence of grocery shopping with staff in May, June, July or August 2011. Subsequent review of the client's Activity Schedule failed to show evidence that the facility afforded Client #3 opportunities for choice and self-management, with regards to shopping for groceries.	W 247		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to accurately document data relative to clients' training objectives, for one of the three clients in the sample. (Client #2) The findings include: 1. On 8/31/2011, at 6:51 a.m., the house manager approached Client #2, who was seated in the TV room, and asked if he would like to come with her to get some yogurt. The client, who is non-verbal, stood up, stomped his foot once (hard) on the floor then quickly followed her out of the room. Moments later, at 7:12 a.m., Client #2 stomped his foot again when the medication nurse called him to come for his medications. On 8/31/2011, at approximately 6:55 p.m.,	W 252	The ABC data sheet was revised by the behavior specialist. Staff was trained on the revised data sheet. All proceeding data sheets from Client #2 program book. In the future, the facility will ensure that client #2 ABC data sheet is designed to ensure that all target behaviors could be documented.	9/5/11

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W 252	Continued From page 7 telephone 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 'foot stomp' when staff asked him to do something. The behaviors had been shared with the psychologist and others participating on the psychotropic medication review team in June 2011. Beginning in late June or early July 2011, the psychiatrist prescribed Prozac to address "anxiety." The RN further stated that staff had been instructed to record any behavior they observe and there had been no incidents of 'foot stomping' behavior lately. On 9/2/2011, at 11:18 a.m., interview with the qualified intellectual disabilities professional (QIDP) confirmed Client #2 had begun displaying new behaviors, including foot stomping, in June 2011. The QIDP further stated that the new behaviors were being "base lined." At 11:31 a.m., review of the client's behavior data sheets revealed staff had written "no behaviors" on 8/31/2011, even though the client had displayed the 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 hand-over-hand (HOH) assistance while he struggled to punch his three medications from their respective blister packs into the medication cup. At 8:13 a.m., review of Client #2's medication administration records (MARs) revealed that he had a training objective for acquiring	W 252	The nurse was in-served on Client #2 self medication program. In the future the designated nurse will ensure that accurate documentation is completed for each medication administration.	9/5/11

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W 252	Continued From page 8 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 morning 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 shopping, Client #3 replied "Not in a long time... They don't ever tell me they're going to the 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 Client #3 had accompanied staff to the grocery store on the week before. The QIDP stated that staff were to document outings in the client's "Activity Sheets, in his IPP book." However, beginning at 11:42 a.m., review of Client #3's "Monthly Activity Sheets" and "Daily/Shift 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,	W 252	A staff documentation schedule has been created which identifies each staff that shall be responsible for tracking and recording Client' #3 community outing as required. This will allow Client #3' QIDP to identify and train staff who has incompletely or inaccurately documented client #3, community outings as required.	9/5/11

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W 252	Continued From page 9 were unable to verify the information shared in interviews.	W 252		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review revealed the facility failed to ensure effective monitoring and change to address a client's declining oral health for one of three sampled clients. (Client #1) The finding includes: Observation on 8/31/2011 at approximately 11:40 a.m. revealed Client #1's teeth appeared discolored and he also appeared to be missing a few teeth. Record review on 9/1/2011 beginning at 11:00 a.m., revealed the following dental history: 1. 12/13/2010 Dental Assessment outlined the following findings: "This patient (oral health) is poor. He needs frequent dental treatment. This 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 electric toothbrush and floss 1 times a day." 2. 12/28/2010 Dental Assessment outlined the	W 356	At the time of Survey, there was no evidence of client #1 brushing his teeth 2 times a day with soft toothbrush & rinsing with an oral mouth rinse 1 time a day. In the future the designated nurse and QIDP will make sure staff is documenting after each toothbrush & rinse is completed. This will ensure recommendations made by the Dentist are completed.	9/5/11 9/5/11

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W 356	Continued From page 10 following findings: "This patient is to have his care taker brush his teeth 2 times a day with a soft toothbrush & rinse with an oral mouth rise 1 times a day." 3. 2/10/2011 Dental Assessment outlined the following findings: "This patient has excessive 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 Client #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 client's current treatment plan for effectiveness and had not developed a formalized plan to address this client'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 client's oral health.	W 356	QIDP and DDS Service Coordinator ensured that the resident was prescribed supportive device for the individual was delivered January 1, 2011 at 1:00 pm. Although the Medicaid vendor for the device did not expedite service in a timely manner.	9/5/11
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	W 474		

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W 474	Continued From page 11 received their meals in the texture prescribed by the primary care physician for one of three sampled clients. (Client #1) The finding includes: Observation on 8/31/2011 at approximately 4:15 p.m., revealed he returned home from his day program and received his afternoon snack which consisted of a bag of Sunchips and a banana. The Sunchips and the banana were served whole. Later the same day, at approximately 6:45 p.m., Client #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. Record review on 9/1/2011 at 10:00 a.m. revealed Client #1's Initial Nutrition Assessment dated 6/24/2011 recommended that he receive a "High Fiber, Low Lactose (2000 calories) - Ground consistency" diet. Additional record review revealed Client #1's physician also prescribed on 7/6/2011 that he receives a "ground consistency" diet. Interview with the LPN on 9/2/2011 at 2:38pm revealed Client #1's meals should be served in a "ground" texture as prescribed by the primary care physician. The facility failed to ensure all client's meals were served in the manner prescribed by the primary care physician.	W 474	QIDP will ensure that all the individuals'meals are prepared and served in accordance to their prescribed diet.	9/5/11

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 31, 2011 through September 2, 2011. A sample of three residents was selected from a population of five men with various intellectual and developmental disabilities. The findings of the survey were based on observations and interviews with staff and residents in the home and at three day programs, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure outside services provided all residents received their meals in the prescribed form and consistency for one of three sampled residents. [Resident #1] The finding includes: Observation on 8/31/2011 at approximately 4:15 p.m., revealed he returned home from his day program and received his afternoon snack which consisted of a bag of Sunchips and a banana. The Sunchips and the banana were served	I 047		

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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. Record review on 9/1/2011 at 10:00 a.m. revealed Resident #1's Initial Nutrition Assessment dated 6/24/2011 recommended that he receive a "High Fiber, Low Lactose (2000 calories) - Ground consistency" diet. Additional record review revealed Resident #1's physician also prescribed on 7/6/2011 that he receives a "ground consistency" diet. Interview with the LPN on 9/2/2011 at 2:38pm revealed Resident #1's meals should be served in a "ground" texture as prescribed by the primary care physician. The facility failed to ensure all resident's meals were served in the manner prescribed by the primary care physician.	I 047	QIDP will ensure that all the individuals' meals are prepared and served in accordance to their prescribed diet.	9/5/2011
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following	I 090		

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I 090	Continued From page 2 observations, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) The findings include: 1. On 8/31/2011, at 8:30 a.m., a large tear in the fabric was observed on the left arm rest of the sofa located in the TV room. 2. On 8/31/2011, at 8:30 a.m., a large tear (approximately 3 ft. in length) was observed in the carpet located in the TV room. The tear presented a potential trip hazard. 3. On 8/31/2011, at 9:33 a.m., two large tears were observed in the carpet located in the upstairs hallway, outside of the bathroom. The tears presented a potential trip hazard. 4. On 8/31/2011, at 9:33 a.m., rinse water was observed backed up in the sink in the upstairs bathroom when it was used for hand washing. Further observation revealed that the sink was missing a lever to adjust the drain. 5. On 9/2/2011, at 2:52 p.m., large scrapes were observed on the paint in Resident #3's bedroom. A direct support staff person stated that the resident was known to push a chair, his TV and other items against the walls.	I 090	MarJul Homes, Inc. will purchased new furniture for the five residents of the facility. QIDP and house manager will continue to monitor and ensure all individual' environment is clean, safe and pleasant. MarJul Homes, Inc. replaced the carpet in the home for the five residents. MarJul Homes, Inc. has had the sink in the upstairs bathroom repaired. MarJul Homes, Inc. had individual #3 bedroom repainted September 22, 2011.	10/31/2011 10/31/2011 9/5/2011 9/22/2011
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation, interview and record	I 108		

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I 108	Continued From page 3 review, the group home for persons with intellectual disabilities (GHPID) failed to ensure an adequate supply of shoes and clothing, for one of the three residents in the sample. (Resident #3) The findings include: On 8/31/2011, at 1:56 p.m., interview with Resident #3 revealed that he did not think he had a sufficient number of clothes items and that the shoes he was wearing at the time were his only pair. He further indicated that he did not like the shoes, describing them as "too soft." The resident also stated that he enjoyed shopping. Observations in Resident #3's bedroom on 9/2/2011, beginning at 2:35 p.m., revealed one long sleeve shirt hanging in his bedroom closet. There were another 4 shirts balled up at the foot of his bed. The direct support staff present at the time stated those shirts were soiled and she advised against inspecting them more closely. There were four pairs of clean slacks observed in a dresser drawer, and two pairs of slacks observed in a laundry basket. There were four pairs of socks in a dresser drawer. There were no shoes observed in his bedroom. The staff person said Resident #3 had destroyed another pair of shoes several months before the survey and she confirmed that he was wearing his only pair of shoes. A short time later, at 3:45 p.m., the qualified intellectual disabilities professional (QIDP) stated that Resident #3 had declined recent 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.	I 108	QMRP and house manager will continue to monitor and ensure Individual' #3 has adequate clothing and personal hygiene products.	9/5/2011

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I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure adequate administrative staff to effectively meet the residents' needs, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) The findings include: 1. The qualified intellectual disabilities professional (QIDP) failed to ensure outside services provided residents' meals in the form and consistency prescribed, for one of three sampled residents. (See W120) 2. The QIDP failed to ensure a full and accurate accounting of residents' personal funds, for three of three sampled residents. (See W140) 3. The QIDP failed to ensure that residents were provided opportunities for choice, encouraged and taught to make choices, for one of three residents in the sample. (See W247) 5. The QIDP failed to ensure that staff accurately documented data relative to residents' training objectives, for one of the three residents in the sample. (See W252) 6. The QIDP failed to ensure residents were provided the prescribed supportive device, for one of three sampled residents. (See W436)	I 180	(See W120) (See W140) (See W247) (See W252) (See W252)	9/5/2011 9/5/2011 9/5/2011 9/5/2011 9/5/2011

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I 180	Continued From page 5 7. The QIDP failed to ensure all residents 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. The QIDP failed to ensure timely implementation of Resident #3's ISP after the IDT had formalized the plan. There was also no evidence presented at the time of the survey to substantiate that the QIDP made efforts to obtain the plan to ensure timely implementation.	I 180	(See W474)	9/5/2011
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on record review and staff interview, the	I 189		

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I 189	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] The findings include: [Cross Reference Federal Deficiency Citation 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: 1. Record review on 9/2/2011 at 10:00 a.m. revealed Resident #1's financial records were missing receipts for $1125.00 worth of withdrawals and banking transfers between the dates of 7/7/2011 and 9/14/2011. 2. Record review on 9/2/2011 at 11:58 a.m. revealed Resident #2's financial records were missing receipts for $758.00 worth of withdrawals between the dates of 11/8/2010 and 6/24/2011. 3. Record review on 9/2/2011 at 11:38 a.m. revealed Resident #3's financial records were missing receipts for $880.00 worth of withdrawals between the dates o f11/8/2010 and 6/24/2011. Interview with the facility's lead staff and the QMRP on 9/2/2011 at 3:45pm confirmed there were no receipts on file at the time of survey for the transactions listed above.	I 189	QIDP has incorporated a more comprehensive financial review system which has been developed for use in tracking and reconciling individuals' funds. With this system, all receipts received for funds used will be accurately filed, in a timely and consistent manner, and all financial records will be reconciled and reviewed weekly.	9/5/2011
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been	I 206		

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I 206	Continued From page 7 performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on 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.]	I 206	MarJul Homes, Inc. submitted all health certificates, for the five consultants to the Department of Health September 22, 2011	9/22/2011

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I 232	Continued From page 8	I 232	MarJul Homes, Inc. has initiated re-training of all DSP' on oral health and hygiene. Also the importance of accurate documentation as well as the importance of consistent completion of all entries, including data sheets and log notes. MarJul Homes, Inc. has implemented a program of on-going training of DSPs, as well as re-training, whenever the need arises	9/5/2011
I 232	3510.5(i) STAFF TRAINING Each training program shall include, but not be limited to, the following: (i) Training of the residents in the maintenance of oral health and hygiene. This Statute is not met as evidenced by: Based on observation, staff interview and record review revealed the facility failed to enact an effective treatment program to address a resident's declining oral health for one of three sampled residents. [Resident #1] The finding includes: Observation on 8/31/2011 at approximately 11:40 a.m. revealed Resident #1's teeth appeared discolored and he also appeared to be missing a few teeth. Record review on 9/1/2011 beginning at 11:00 a.m., revealed the following dental history: 1. 12/13/2010 Dental Assessment outlined the following findings: "This patient (oral health) is poor. He needs frequent dental treatment. This 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 electric toothbrush and floss 1 times a day." 2. 12/28/2010 Dental Assessment outlined the following findings: "This patient is to have his care taker brush his teeth 2 times a day with a soft toothbrush & rinse with an oral mouth rise 1 times a day." 3. 2/10/2011 Dental Assessment outlined the following findings: "This patient has excessive	I 232		

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I 232	Continued From page 9 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.	I 232		