

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2013
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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002
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W 000	INITIAL COMMENTS A recertification survey was conducted from April 22, 2013 through April 23, 2013. A sample of two clients was selected from a population of three females with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process. The findings of the survey were based on observations in the home and one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.	W 000		
W 189	[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.] 483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff were effectively trained to safely transfer wheelchair bound clients onto the van for one of two clients in wheelchairs (Client #2). The finding includes: On April 22, 2013, at 8:39 a.m., Staff #5 was observed to wheel Client #2 onto the wheelchair van lift. Staff #5 then hit a button to elevate the	W 189	W189 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective action all DSP's working at the 24 th street home have been retrained on Wheelchair Transfer Safety as of 4/23/13. In addition, all DSP's at 24 th street are scheduled for transportation training through Melwood Transportation Agency on 5/15/13 which will also include lockdown and loading training. How will you identify other residents having the potential to be affected by the same deficient practice	5/17/13

Received 5/17/13
 Department of Health
 Health Regulation & Licensing Administration
 Intermediate Care Facilities Division
 899 North Capitol St., N.E.
 Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *[Signature]* (X6) DATE: 5/17/13

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESFORM APPROVED
OMB NO. 0938-0391

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W 189	Continued From page 1 client off the ground. After the client was elevated, Staff #5 walked away from Client #2 and went inside the van while she was on the wheelchair lift. During this time, Staff #5 was observed securing Client #1's wheelchair with tie downs in the van. Staff #5 then returned to Client #2 after the surveyor indicated that Client #2 cannot be left alone on the wheelchair lift. Interview with Staff #5 on April 22, 2013, at 8:43 a.m., revealed that she was trained on transferring clients on and off the van. She further stated that a staff on the van always wheels the clients in the van as soon as she elevates them on the wheelchair lift. On April 22, 2013, the qualified intellectual disabilities professional (Staff #1), registered nurse (Staff #3) and the program manager (Staff #2), held a meeting on wheelchair safety, transferring clients on and off the van, and adaptive equipment. Interview with Staff #1 at approximately 3:00 p.m., revealed that the staff were trained and they know not to walk away from clients until they are secured. Review of the facility's staff in-service training record on April 22, 2013, beginning at 9:30 a.m., failed to reveal training on wheelchair safety when utilizing the van wheelchair lift prior to April 22, 2013. At the time of the survey, there was no evidence that the aforementioned staff had received effective training on wheelchair safety.	W 189	and what corrective actions will be taken As of 5/1/13 Marjul Homes will identify all other residents potentially affected through Transition and Adaptive equipment training through QA checks and daily DSP health care monitoring. At that point if issues of concern are identified corrective action will immediately be put into place by following emergency protocols and procedures. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: As of 5/1/13 Marjul homes will implement monthly training on Wheelchair transfer safety by our training specialist which will cover wheelchair bound clients being transferred onto the van for one to two clients in wheelchairs. This training will be monitored by the QIDP's Adaptive Equipment & Transfer Safety Tool.		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical	W 325	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; as a corrective Action MarJul		

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W 325	<p>Continued From page 2</p> <p>examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide routine laboratory testing as determined necessary by the physician, for one of two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On April 23, 2013, beginning at approximately 1:00 p.m., review of Client #2's physician order sheets (POS) revealed that beginning on February 21, 2013, her physician had ordered a urinalysis test by catheterization. At 1:27 p.m., review of the lab reports, however, failed to reveal a urinalysis test for Client #2. At approximately 1:45 p.m., review of the nursing notes dated February 25, 2013, stated, "Attempted urinalysis by in and out catheterization without success, primary care physician made aware." Further review revealed the primary care physician said to "try again."</p> <p>When interviewed on April 23, 2012, at approximately 2:00 p.m., the registered nurse (Staff #3) stated that they were not able to use a in and out catheterization to obtain urine from Client #2, but she will try to use a bed pan instead.</p> <p>The facility failed to provide laboratory testing as determined necessary by the physician.</p>	W 325	<p>Homes has received a date of 5/16/13 for Individual #2 laboratory results as identified by the physician. As the results of this lab for #2 the PH levels were slightly elevated which implies that #2 need to drink more water. This has been identified by the RN and will be recommend to the DSP to offer #2 more water with her meals. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: MarJul Homes will identify other individuals who may possibly be affected by the same deficient practice with our Nursing recommendation follow up tool (Please see attached) which identifies all individuals appointments, follow up dates, specific recommendations to ensure that we provide the necessary follow up for maximum level of care per each individual. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: As of 5/1/13 MarJul homes will implement the Nursing recommendation Follow up tool in the 24th St home as well as all homes, to ensure the health care follow up and safety of our individuals is initial and most of all critical.</p>		
W 440	483.470(l)(1) EVACUATION DRILLS	W 440			

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W 440	<p>Continued From page 3</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts for three of three residents residing in the facility. (Clients #1, #2, and #3)</p> <p>The finding includes:</p> <p>The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On April 22, 2013, at approximately 9:45 a.m., interview with the qualified intellectual disabilities professional (Staff #1) revealed that there were three designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday and two designated shifts (8:00 a.m. - 8:00 p.m., and 8:00 p.m. - 8:00 a.m.) for Saturday and Sunday.</p> <p>Review of the facility's fire drill records on April 22, 2013, beginning 9:55 a.m., revealed that no drills were held during the weekday shift at 8:00 a.m. - 4:00 p.m. from November 2012 through March 2013. Further review revealed there were no fire drills held during the weekend at 8:00 a.m. - 8:00 p.m., and 8:00 p.m. - 8:00 a.m., from May 2012 through December 2012. Continued interview with the qualified intellectual disabilities professional (Staff #1) verified that there were no evidence that fire drills were conducted during the aforementioned timeframe during the time of</p>	W 440	<p>W440</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective measure as of 5/1/13 MarJul Homes will ensure the facility holds evacuation drills at least quarterly for each shift of personnel, this will include simulated fire drills at least four times a year (PER SHIFT).How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: Through monthly QA inspections , Evacuation drills will be monitored and documented on the QIDP's monthly monitoring tool. This will identify any other residents having the potential to be affected by this same practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: As of</p>		

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W 440	Continued From page 4 survey.	W 440	5/15/13 all staff have been retrained on the emergency protocols systems including evacuations and fire drills. In addition, as a proactive measure, the staff will be trained monthly on the evacuation systems and procedures until training specialist can ensure that the staff feel confident in the process.	

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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from April 22, 2013 through April 23, 2013. A sample of two residents was selected from a population of three females with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and one day programs, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1 000		
1 043	<p>3502.2(c) MEAL SERVICE / DINING AREAS</p> <p>Modified diets shall be as follows:</p> <p>(c) Reviewed at least quarterly by a dietitian.</p> <p>This Statute is not met as evidenced by: Based on observation, record review and interview, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that the modified diet for residents had been reviewed at least quarterly by a dietitian, for one of the two residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Observation of Resident #2's dinner meal on April 22, 2013, at 5:48 p.m., revealed the resident was served an 1800 calorie meal consisting of pureed chicken, macaroni and cheese, and string beans.</p>	1 043	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective action, all consultants with outstanding or late assessments have been notified as of 4/25/13 and are responsible for having all assessments completed by 2/25/13. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: Other residents will be identified by using our Quality Assurance tool designed for the Q to review consultants assessments monthly. The assessments that were identified had already been cited by MarJul Homes and the consultants were previously contacted. However if the current consultants do not comply by 5/23/13</p>	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Vashem All* TITLE *Program Director* (X6) DATE *5/17/13*

STATE FORM

6889

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If continuation sheet 1 of 4

Health Regulation & Licensing Administration

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I 043	<p>Continued From page 1</p> <p>Record review of Resident #2's nutritional assessment dated October 2, 2012, on April 22, 2013, at 1:42 p.m., revealed the resident was prescribed an 1800 calorie, low fat, low cholesterol, high fiber, pureed diet. Further review failed to show evidence that the facility's nutritionist had reviewed Resident #2's diet on a quarterly basis.</p> <p>On April 23, 2013, at approximately 2:00 p.m., interview with the program manager (Staff #2) confirmed that there was no evidence that the nutritionist conducted a quarterly review after the residents' nutritional assessment.</p> <p>At the time of the survey, the GHIID failed to have a nutrition review after the residents' assessment.</p>	I 043		
I 135	<p>3505.5 FIRE SAFETY</p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to hold evacuation drills quarterly on all shifts, for three of three residents residing in the GHPID. (Residents #1, #2, and #3)</p> <p>The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On April 22, 2013, at approximately 9:45 a.m., interview with the qualified intellectual disabilities professional (Staff #1) revealed that there were three designated shifts (8:00 a.m. - 4:00 p.m.;</p>	I 135	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective measure as of 5/1/13 MarJul Homes will ensure the facility holds evacuation drills at least quarterly for each shift of personnel, this will include simulated fire drills at least four</p>	

times a year (PER SHIFT). How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: Through monthly QA inspections ,

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I 135	Continued From page 2 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday and two designated shifts (8:00 a.m. - 8:00 p.m., and 8:00 p.m. - 8:00 a.m.) for Saturday and Sunday. Review of the facility's fire drill records on April 22, 2013, beginning 9:55 a.m., revealed that no drills were held during the weekday shift at 8:00 a.m. - 4:00 p.m. from November 2012 through March 2013. Further review revealed there were no fire drills held during the weekend at 8:00 a.m. - 8:00 p.m., and 8:00 p.m. - 8:00 a.m., from May 2012 through December 2012. Continued interview with the qualified intellectual disabilities professional (Staff #1) verified that there were no evidence that fire drills were conducted during the aforementioned timeframe during the time of survey.	I 135	Evacuation drills will be monitored and documented on the QIDP's monthly monitoring tool. This will identify any other residents having the potential to be affected by this same practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: As of 5/15/13 all staff have been retrained on the emergency protocols systems including evacuations and fire drills. In addition, as a proactive measure, the staff will be trained monthly on the evacuation systems and procedures until training specialist can ensure that the staff feel confident in the process.	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician 's certification that a health inventory has been performed and that the employee 's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all health care professionals had current health certificates on file, for one of seven consultants (Consultant #1). The finding includes:	I 206	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective action, Marjul Homes will ensure that our health care professionals are in current standards with DOH and DDS regulations, Marjul has requested several times to our consultants, for the current Health Care Certificate. Marjul homes has given all our consultants a due date of	

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1206		<p>Continued From page 3</p> <p>On April 23, 2013, beginning at approximately 3:00 p.m., review of the personnel records for all employees, including licensed professionals, revealed there was no evidence of a current physician's health inventory/certificate for the pharmacist (Consultant #1)</p> <p>Interview with the program manager (Staff #2) on April 23, 2013, at approximately 5:00 p.m., revealed she would retrieve the aforementioned documents.</p>	1208	<p>5/23/13 to have all current information in the main office. If the information is not given to us by this date, services with Marjul homes will be ended and MarJul Homes will contract with other vendors to provide services needed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: Currently Marjul homes sends a monthly spread sheet out to all QIDDP's informing them of certificates including health which are soon to expire. This process was put in place to inform QIDDP's of DSP's and Consultants who are soon to be out of compliance in regards to DOH personnel policy. Therefore if a DSP or Consultant does not comply with the current certificates required by DOH and DDS they are sent out a letter by which the DSP is taken off the schedule to work, and the Consultant is sent a warning letter of contractual services to be terminated with MarJul Homes. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented Identification has been put in place by a Quality Assurance Monitoring tool that will be done monthly by the QIDDP to ensure that all Consultants and DSP; s have current health certificates. This tool was implemented on 5/1/13.</p>	