

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

PRINTED: 07/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2011
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NAME OF PROVIDER OR SUPPLIER MARJUL HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1639 ROXANNA ROAD, NW WASHINGTON, DC 20012
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W 000	INITIAL COMMENTS A recertification survey was conducted from June 28, 2011 through June 29, 2011. A sample of two clients was selected from a population of four women with various intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process.	W 000		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The findings of the survey were based on observations and interviews with staff and clients in the home and at one day program, as well as a review of client and administrative records, including incident reports. The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of client records, including incident reports and investigations, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA), for one of the four clients residing in the facility. (Client #3) The findings include: On June 28, 2011, at 10:00 a.m., review of the binder in which the facility's incident report forms	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Julia B. Nowson* TITLE: *Executive Director* (X6) DATE: *7/18/2011*

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 153	<p>Continued From page 1</p> <p>were stored revealed two incident forms that had been placed in the front pocket of the binder, behind some blank forms. By contrast, all other incident report forms were filed by the month in which the incident had occurred. Review of the two forms revealed the following:</p> <p>1. At 10:00 a.m., review of an incident report dated January 19, 2011, revealed that staff had observed blood on Client #3's hand at 7:15 a.m. A nurse documented having assessed the client's hand that morning and determined that she had a scrape on her right middle finger. The nurse also indicated that the injury was of unknown etiology. The only two persons documented on the form as having been notified of the incident were the house manager and the nurse.</p> <p>2. At 10:04 a.m., review of an incident report dated January 31, 2011, revealed that staff had observed "a dark looking gash on" Client #3's right heel at 8:30 p.m., while assisting the client in the shower. The only two persons documented on the form as having been notified of the incident were the house manager and the nurse.</p> <p>That afternoon, at 4:19 p.m., interview with the facility's incident management coordinator revealed that he was unaware of the two incidents. He then acknowledged that neither incident had been reported to their administrator or to HRLA, nor had they been investigated. The facility's registered nurse, who was present at the time, stated that Client #3 had picked dry skin from her right heel on January 31, 2011. She presented nurse progress notes that documented the dry skin.</p>	W 153	<p>All incidents are routinely reported and investigated as required by the IMEU/DDS investigation guidelines.</p> <p>In fact, a training was conducted on 5/23/2011 to address this and many other issues related to incident management.</p> <p>Another training will be done on 7/20/11 at 11:00am</p>	7/20/2011	

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W 153	Continued From page 2 [Note: State agency records also revealed no evidence that either of the two aforementioned incidents had been reported.]	W 153			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's self-medication skills training program was implemented at the frequency identified in the plan, for one of the four clients residing in the facility. (Client #3) The finding includes: The morning medication administration was observed on June 28, 2011. At 7:42 a.m., the licensed practical nurse (LPN) punched Client #3's medications out of their blister packs, poured water into Client #3's beverage glass and handed them to the client. Following the medication administration pass, at 8:55 a.m., review of Client #3's medication administration records revealed a data collection sheet for the following training program: <client's name> will punch out her medicine from one	W 249	The administration of MarJul Homes Inc. acknowledges the importance of participation in self medication programs. All medication nurses were trained on the purpose and compliance with self medication programs during medications passes on 07/14/2011. The LPN Coordinators and RN will monitor medication passes occasionally to ensure compliance.	7/14/2011	

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W 249	Continued From page 3 blister pack given by the nurse with verbal prompt 75% of the opportunities across 6 consecutive months."	W 249			
W 394	483.460(n)(2) LABORATORY SERVICES If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Certificate of Waiver as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA) before administering finger stick tests for blood sugar glucose levels, for the one client in the facility (out of four) with diabetes. (Client #1) The finding includes: On June 28, 2011, at 7:23 a.m., the morning medication nurse was observed lancing Client #1's finger and testing her blood sugar levels on a glucometer. Review of Client #1's medical record	W 394			

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W 394	Continued From page 4 on 8:26 a.m. revealed a physician order (PO) to take blood sugar readings daily via finger stick before breakfast and dinner.	W 394	The administration of MarJul Homes Inc. has applied for a CLIA Certificate of Waiver.	6/28/2011
W 436	On June 28, 2011, at 5:45 p.m., the facility's registered nurse (RN) was asked if the facility had obtained a Certificate of Waiver, as required under the CLIA. The RN indicated that she would have to ask their executive director. On June 29, 2011, at 9:50 a.m., the RN reported that there was no evidence at their main office that the facility had sought a CLIA Certificate of Waiver. 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to furnish clients' assistive communication devices as recommended, for one of the three clients assessed with hearing deficits. (Client #2) The finding includes: On June 28, 2011, at 7:39 a.m., Client #2 was observed using signs, gestures and facial expressions to communicate with the morning medication nurse. She made similar signs and gestures while interacting with direct support staff that morning and again that evening, between	W 436		

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W 436	<p>Continued From page 5 5:14 p.m. - 6:30 p.m.</p> <p>On June 29, 2011, at 12:34 p.m., interview with the facility's registered nurse (RN) revealed that Client #2's interdisciplinary team had met on June 10, 2011, at which time the team discussed her sign language, communication needs.</p> <p>On June 29, 2011, at 3:21 p.m., review of Client #2's speech-language records revealed an assessment dated June 18, 2010. The assessment indicated that the client used signs, gestures and facial expressions to communicate. The speech-language pathologist recommended that the client be exposed to use of a "low tech device" for a trial period. She also recommended "re-evaluate language and communication skills in one year to continue to monitor progress." There was no evidence of a more recent assessment.</p> <p>On June 29, 2011, beginning at 4:11 p.m., review of Client #2's monthly progress reports written by the qualified intellectual disabilities professional (QIDP) for the period June 2010 - June 2011 revealed no evidence that the client had been exposed to a low tech communication device. This was confirmed at 5:32 p.m. through interview with the RN and QIDP. They also stated that to date, the client had not been re-evaluated by a speech-language pathologist to monitor her progress.</p>	W 436	With the new Speech and Language Consultant and current Director of Nursing the "low tech device" will be selected and purchased via a 719A Form after an assessment has been completed.	8/11/2011

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from June 28, 2011 through June 29, 2011. A sample of two residents was selected from a population of four women with various intellectual and developmental disabilities.</p> <p>The findings of the survey were based on observations and interviews with staff and residents in the home and at one day program, as well as a review of resident and administrative records, including incident reports.</p>	I 000		
I 260	<p>3512.1 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each Residence Director shall maintain current and accurate records and reports as required by this section.</p> <p>This Statute is not met as evidenced by: Based on interview and record verification, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the maintenance of each resident's record to make certain they are current and accurate, for one of the two residents in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>The facility's nursing staff failed to document administration of Debrox ear drops in accordance with Resident #1's physician's order sheets (POS), as follows:</p> <p>Following the observation of the morning medication administration on June 28, 2011, review of Resident #1's June 2011 POS and Medication Administration Records (MARs), at 8:43 a.m., revealed that she was to receive</p>	I 260		

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Julie B Howson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: *Executive Director* (X6) DATE: *7/18/2011*

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I 260	<p>Continued From page 1</p> <p>generic Debrox "ear drops 6.5%, 5 drops in each ear 2 times a week on Thursday and Sunday...to prevent wax build-up." The June 2011 MAR had been marked such that the outer edge of the boxes/ spaces designated on Thursdays and Sundays had been marked with black ink. Continued review of the MAR revealed no initials indicating administration of the ear drops on June 12, 2011 and June 26, 2011. Although the spaces had been left blank on those two dates, there were no corresponding notations on the back of the MAR. On June 29, 2011, at 10:40 a.m., review of Resident #1's past MARs showed similar spaces which had been left blank, with no corresponding notations on the back of the page. Said documentation was missing on October 10, 2010, November 7, 2010, February 20, 2011, May 22, 2011 and the two aforementioned dates in June 2011.</p> <p>On June 29, 2011, at 11:20 a.m., the facility's registered nurse (RN) stated that she "tries to review <the MARs> at the end of the month." When shown the six blank spaces on Resident #1's MARs from October 2010 - June 2011, the RN stated that she thought the ear drops weren't "being missed...I think it isn't being documented." The RN then stated that she would review the documents to "see if there's a pattern."</p> <p>It should be noted that on June 28, 2011, the morning nurse was observed administering the four residents' medications before documenting any of the administrations in the residents' MARs. When asked on June 29, 2011, at 11:30 a.m. whether the facility had a protocol regarding how and when a medication nurse should document the medication administration, the RN stated yes; nurses had been trained to "administer medications, put the medications away, sit down</p>	I 260	<p>The administration of MarJul Homes Inc. acknowledges the importance of timely, accurate documentation. On 07/14/2011, all med nurses were retrained on the proper medication pass procedures that stressed the importance of documenting administration of medication prior to administering meds to the next individual. The LPN Coordinator /RN will monitor the MAR' for discrepancies weekly</p>	7/14/2011

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I 260	Continued From page 2 and sign-off the card...then move on to the next person." At 1:19 p.m., the RN presented a Medications Administration Procedures document that corresponded to what she had described. At 1:51 p.m., the RN presented a signature page dated July 15, 2010, with corresponding agenda, that documented that the morning nurse observed on the day before had attended the training. During the Exit conference later that day, the qualified intellectual disabilities professional and the RN acknowledged that it was unclear whether the resident went without the ear drops or if the resident received the ear drops but the nurse failed to consistently document the administration.	I 260		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Persons With Intellectual Disabilities (GHPID) failed to furnish residents' assistive communication devices and re-assess annually as recommended, for one of the three residents assessed with hearing deficits. (Resident #2) The finding includes: On June 28, 2011, at 7:39 a.m., Resident #2 was	I 401		

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I 401	Continued From page 3 observed using signs, gestures and facial expressions to communicate with the morning medication nurse. She made similar signs and gestures while interacting with direct support staff that morning and again that evening, between 5:14 p.m. - 6:30 p.m. On June 29,2011, at 12:34 p.m., interview with the facility's registered nurse (RN) revealed that Resident #2's interdisciplinary team had met on June 10, 2011, at which time the team discussed her sign language, communication needs. On June 29, 2011, at 3:21 p.m., review of Resident #2's speech-language records revealed an assessment dated June 18, 2010. The assessment indicated that the resident used signs, gestures and facial expressions to communicate. The speech-language pathologist recommended that the resident be exposed to use of a "low tech device" for a trial period. She also recommended "re-evaluate language and communication skills in one year to continue to monitor progress." There was no evidence of a more recent assessment. On June 29, 2011, beginning at 4:11 p.m., review of Resident #2's monthly progress reports written by the qualified intellectual disabilities professional (QIDP) for the period June 2010 - June 2011 revealed no evidence that the resident had been exposed to a low tech communication device. This was confirmed at 5:32 p.m. through interview with the RN and QIDP. They also stated that to date, the resident had not been re-evaluated by a speech-language pathologist to monitor her progress.	I 401	See response to W436 on page 5 of 6.	8/11/2011
I 436	3521.7(f) HABILITATION AND TRAINING	I 436		

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I 436	<p>Continued From page 4</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure each resident was taught to administer their medications, for one of the four residents of the facility. (Resident #3)</p> <p>The finding includes:</p> <p>The morning medication administration was observed on June 28, 2011. At 7:42 a.m., the licensed practical nurse (LPN) punched Resident #3's medications out of their blister packs, poured water into Resident #3's beverage glass and handed them to the resident.</p> <p>Following the medication administration pass, at 8:55 a.m., review of Resident #3's medication administration records revealed a data collection sheet for the following training program: <resident's name> will punch out her medicine from one blister pack given by the nurse with verbal prompt 75% of the opportunities across 6 consecutive months."</p> <p>On June 29, 2011, at 11:37 a.m., interview with the facility's registered nurse verified that Resident #3 should be encouraged to punch out a medication from its blister pack at each medication administration. During the observed</p>	I 436	<p>The administration of MarJul Homes Inc. acknowledges the importance of participation in self medication programs. All medication nurses were trained on the purpose and compliance with self medication programs during medications passes on 07/14/2011. The LPN Coordinators and RN will monitor medication passes occasionally to ensure compliance.</p>	7/14/2011

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I 436	Continued From page 5 medication pass on June 28, 2011, however, Resident #3 was not provided the opportunity to punch any of her medications from their blister pack in accordance with her training program.	I 436			