

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

09G232

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

05/16/2012

NAME OF PROVIDER OR SUPPLIER

MARJUL HOMES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
**5706 14TH STREET, NW
WASHINGTON, DC 20011**

(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 May 15, 2012, through May 16, 2012. A sample of two clients was selected from a population of three women with various degrees of intellectual disabilities. The survey was conducted utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and two clients, 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 5/07/12

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

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 maintain a complete accounting of all clients' funds for one of the two clients in the sample. (Client #2)

The finding includes:

Interview with the house manager (HM) on May 15, 2012, at 6:18 p.m., revealed that the facility assisted the client with maintaining her finances. Continued interview and record review revealed

W 140 W140

What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; Financial Methods and book will be revised and restructured to capture not only monetary purchases over \$50.00 but each monetary purchase in its entirety no later than 6/15/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; Program Director along with QIDDP will complete an Initial review of all financial books no later than 6/15/12 as a quality assurance method to identify and ensure that all funds are accounted for properly. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all finances show proof of receipt as well as identification for each purchase made. This process will be implemented no later than 6/15/12.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
V. Shaenell

TITLE
Program Director

(X6) DATE
6/7/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011	
(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 140	Continued From page 1 that the client received Supplemental Security Income (SSI) monthly. Review of Client #2's bank statements on May 15, 2012, beginning at 6:18 p.m., revealed a withdrawal of \$259.00 on June 24, 2011, and another withdrawal of \$59.00 on July 7, 2011. From the aforementioned \$318.00, there were no receipts available to justify a total of \$95.00 Interview with the HM on May 16, 2012, at approximately 3:00 p.m., revealed that she did not have the receipts. Further interview revealed that the program director was currently working on a new record keeping system for the clients' finances. At the time of the survey, the facility failed to provide a complete accounting of Client #2's personal funds.	W 140		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident, for one of the three clients residing in the facility. (Client #3)	W 156	W156 What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; IMC Coordinator will be retrained on Incident Policies and Procedures to ensure accuracy of policy guidelines when reporting incidents. This training will take place no later than 6/15/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; IMC will review most recent incidents to ensure that all parties have been informed and all policies and guidelines were followed in regards to informing proper parties as well as reporting methods. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 policy that mandates all IMC reports be reviewed by a second party with a Certified Investigator's license.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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 156	<p>Continued From page 2 The finding includes:</p> <p>Review of the facility's incident management records on May 15, 2012, beginning at 9:57 a.m., revealed that on July 19, 2011, at 7:30 p.m., Client #2 "attacked [Client #3], pushed her in the face and called her a [derogatory name]." Review of the corresponding investigative report revealed the investigation was initiated on July 20, 2011, and completed on July 29, 2011 (ten days after the incident occurred).</p> <p>Interview with the incident management (IMC) coordinator on May 15, 2012, at approximately 4:00 p.m., revealed that a meeting was held every Tuesday with the administrator to review the status of all incidents. The IMC, however, acknowledged that the investigation was not completed within five days of the incident. Further interview revealed that the facility failed to provide documented evidence that the results of the investigation were reported to the administrator.</p> <p>At the time of the survey, the facility failed to ensure that the administrator was notified of the results of the investigation within five working days, as required by federal regulations.</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff were</p>	W 156	<p>W189</p> <p>What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; All staff for this particular home have been retrained on BSP, Addressing and Redirecting Behaviors, Privacy & Independence etc. This training took place on 5/19/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP will continue to address these issues in training and monthly staff meetings. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all Training including in-service training is done on a refresher basis quarterly. This QA will be completed as of 7/1/12.</p>	
W 189		W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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 189	<p>Continued From page 3</p> <p>provided with initial and continuing training that enable them to perform their duties effectively, efficiently, and competently, for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Observation on May 15, 2012, at 4:10 p.m., revealed Client #1's shirt was positioned on the top part of her breast, exposing her bra. During this time Staff #1 was stacking blocks with Client #1. At 4:11 p.m., Client #1 reached inside her pants and pulled her underwear above her stomach. Staff #1 looked at her and continued to stack the blocks ignoring this behavior and her exposed bra. At 4:13 p.m., Staff #1 said "why don't you pull your shirt down." However, Client #1 continued to pull on her underwear.</p> <p>Staff #1 was interviewed at 4:45 p.m., about the client exposing her bra and pulling on her underwear, and she stated "it's ok as long as she is not hurting herself, we just check for irritation."</p> <p>Review of the facility's training book on May 15, 2012, at approximately 6:00 p.m., failed to reveal staff training on redirecting Client #1 during the aforementioned behavior.</p>	W 189		
W 242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of</p>	W 242	<p>W242</p> <p>What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice: All staff for this particular home have been retrained on BSP, Addressing and Redirecting Behaviors, Privacy & Independence etc. This training took place on 5/19/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP will continue to address these issues in training and monthly staff meetings. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all Training including in-service training is done on a refresher basis quarterly. This QA will be completed as of 7/1/12.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5766 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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 242	<p>Continued From page 4 acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to train each client in personal skills essential for independence and privacy, for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Observation on May 15, 2012, at 4:10 p.m., revealed Client #1's shirt was positioned on the top part of her breast, exposing her bra. During this time Staff #1 was stacking blocks with Client #1. At 4:11 p.m., Client #1 reached inside her pants and pulled her underwear above her stomach. Staff #1 looked at her and continued to stack the blocks ignoring this behavior and her exposed bra. At 4:13 p.m., Staff #1 said "why don't you pull your shirt down." However, Client #1 continued to pull on her underwear.</p> <p>Staff #1 was interviewed at 4:45 p.m., about the client exposing her bra and pulling on her underwear, and she stated "it's ok as long as she is not hurting herself, we just check for irritation."</p> <p>Review of Client #1's training book on May 15, 2012, at approximately 6:00 p.m., failed to reveal training on redirecting Client #1 during the aforementioned behavior.</p>	W 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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
--------------------	--	---------------	---	--------------------

1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 15, 2012 through May 16, 2012. A sample of two residents was selected from a population of three women with various degrees intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and two clients, 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 persons with intellectual disabilities (GHPID) failed to ensure that the modified diet for residents had been reviewed at least quarterly by a dietitian, for two of the two residents in the sample. (Resident #1 and #2)</p> <p>The findings include:</p> <p>1. Observations on May 15, 2012, at 8:20 a.m., revealed Resident #1 was missing her top and bottom teeth. Continued observations at 5:28 p.m., of the dinner meal revealed Resident #1</p>	1 043	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Nutritionist will send all quarterly notes to be placed in the book no later than 6/30/12. If Nutritionist does not comply with mandates Marjul homes will terminate services with current Nutritionist and obtain new Nutritionist by 7/15/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP will review all book to identify all current nutritional plans and ensure that all plans are current and updated. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all assessments are updated and in compliance with all protocols and procedures of DOH and DDS. All QIDDP's & DSP's will be retrained on Food Protocol and Nutrition plans by SLP no later than 6/15/12 and Nutrition plans by SLP no later than 6/15/12.</p>	
-------	---	-------	---	--

Health Regulation & Licensing Administration

[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]
TITLE

[Signature]
VUN111

(X6) DATE
6/7/12

DATE FORM 6899 If continuation sheet 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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
1043	<p>Continued From page 1</p> <p>was served pureed fish, spinach, noodles and peaches. For her beverage she was served 2% milk.</p> <p>Record review of Resident #1's nutritional assessment dated May 12, 2011, on May 16, 2012, at 11:06 a.m., revealed that the resident was prescribed a 1500 calorie, low fat, low cholesterol, pureed diet. Further review failed to show evidence that the facility's nutritionist had reviewed Resident #1's diet on a quarterly basis.</p> <p>On May 16, 2012, at approximately 12:00 p.m., interview with the house manager and the facility's registered nurse confirmed that the last quarterly for Resident #1 was dated December 20, 2011.</p> <p>2. Observation on May 15, 2012, at 5:31 p.m., of the dinner meal revealed Resident #2 was served a low calorie fish, spinach, noodles and peaches. For her beverage she was served lactaid milk.</p> <p>Record review of Resident #2's nutritional assessment dated September 15, 2011, on May 16, 2012, at 3:00 p.m., revealed that the resident was prescribed a 1500 calorie, low fat, low cholesterol, 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 May 16, 2012, at approximately 3:15 p.m., interview with the house manager and the facility's registered nurse confirmed that the last quarterly for Resident #2 was dated December 20, 2011.</p> <p>Interview with the program director on May 16, 2011, at approximately 4:00 p.m., revealed she</p>	1043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011		
(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 043	Continued From page 2 was currently seeking a new nutritionist. At the time of the survey, the GHPID failed to have a third quarterly review for Resident #2.	I 043		
I 060	3502.18 MEAL SERVICE / DINING AREAS Perishable foods shall be stored at proper temperatures in order to conserve nutritive value. This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure that equipment necessary for monitoring refrigeration temperatures was provided for one of two refrigerators in the home. The finding includes: Observations during the environmental walk-thru on May 16, 2012, at approximately 4:30 p.m., revealed no thermometers were located in the kitchen refrigerator and freezer. Interview with facility's house manager (HM) and the qualified intellectual disabilities professional (QIDP) acknowledged that there was no thermometer in the refrigerator and freezer.	I 060	1060 What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; New Thermometers were purchased and placed in each freezer and refrigerator located in the home on 6/7/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP's will conduct their normal monthly environmental assessment to identify any issue or maintenance concerns involving the home or surrounding grounds. This will identify any issues of this nature and should be addressed and fixed immediately. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all environmental aspects of the home including necessary monitoring of refrigeration. This tool will be implemented as of 7/1/12.	
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.	I 090	1090 What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; 1. The doorbell was fixed on 6/4/12 2. The Toilet seat was replaced and put on the toilet on 6/4/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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
--------------------	--	---------------	---	--------------------

1090 Continued From page 3

This Statute is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was in a safe and orderly manner for three of three residents in the facility. (Residents #1, #2 and #3)

The findings include:

On May 16, 2012, at 4:25 p.m., the house manager and the qualified intellectual disabilities professional (QIDP) accompanied the surveyor through the facility to conduct environmental observations. The following concerns were identified:

1. The front door bell failed to operate. Interview with the house manager revealed the door bell was not operable for two months.
2. The bathroom toilet located in Resident #1's bedroom had no toilet seat. The seat was observed laying on the floor. Interview with the house manager at the same time revealed Resident #1 broke the toilet seat by constantly slamming it. Further interview revealed it was scheduled for repair.
3. The grass and weeds in the front yard and back yard was observed to be 7 to 9 inches tall.

1090

3. The Grass was on 6/4/12

How you will identify other residents having the potential to be affected by the same
Deficient practice and what corrective action will be taken; as New Policy Regulation of Marjul Homes implemented 6/5/12 all House Supervisors and or QIDDP's or Residential Coordinators must bring in Maintenance request forms every Tuesday. This will identify all maintenance and or environmental issues on a weekly basis, giving the corporate office a limited time to fix all issues. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all environmental aspects of the home including necessary monitoring of refrigeration. This tool will be implemented as of 7/1/12.

1095

What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; All staff for this home was trained on proper storage of Caustic agents. Chemical Reactions to Caustic Agents and Marjul homes Policies and Procedures of Keeping Chemicals in a Locked Cabinet. This training was done on 5/19/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP as well as House Supervisor will review all homes under their supervision before 6/15/12 to ensure all caustic agents are stored in a locked cabinet, ensuring DOH regulations and procedures. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all environmental aspects of the home including necessary monitoring of Caustic Agents and their proper storage. This tool will be implemented as of 7/1/12.

1095 3504.6 HOUSEKEEPING

Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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
1095	<p>Continued From page 4</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure all caustic agents were kept in a locked cabinet and out of the direct reach of its residents as required by this section. (Residents #1, #2 and #3)</p> <p>The finding includes:</p> <p>Observation and interview with the facility's house manager (HM) and qualified intellectual disabilities professional (QIDP) on May 16, 2012, at approximately 4:25 p.m., verified cleaning supplies were kept under the sink in the kitchen.</p> <p>Interview with the HM and QIDP at the same time revealed that all caustic agents are required to be stored in a locked cabinet.</p>	1095		
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 persons with intellectual disabilities (GHPID) failed to conduct simulated fire drills at least four times (4) a year for each shift for three of the three residents residing in the GHPID. (Residents #1, #2 and #3)</p> <p>The finding includes:</p> <p>The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as</p>	135	<p>135</p> <p>What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; Staff for this home was retrained on Fire Drill Procedures to include simulated Fire Drills at least 4 times a year on each shift. This training was done on 5/19/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; All QIDDP's & Residential Coordinator's will review all Fire Drill books to identify and ensure that each home is following the proper procedures for fire drills mandated by DOH Policies. The review will take place no later than 6/15/12. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all environmental aspects of the home including necessary monitoring of Fire Drill Procedures including quarterly monitoring per shift. This tool will be implemented as of 7/1/12.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011	

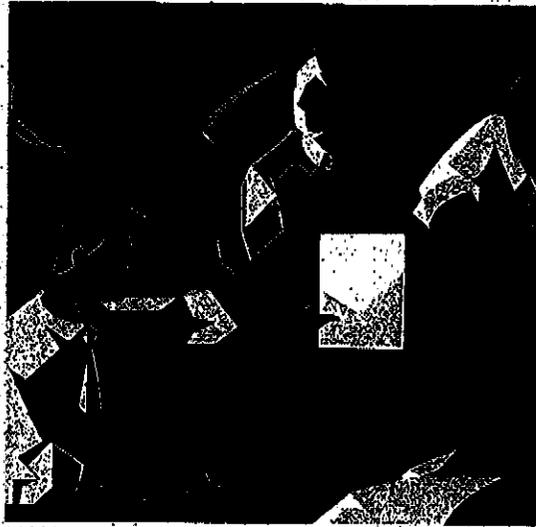
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 135	<p>Continued From page 5</p> <p>evidenced below:</p> <p>On May 15, 2012, beginning at 6:43 a.m., interview with the house manager (HM) 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.), Sunday through Saturday.</p> <p>Review of the GHPID's fire drill log records on May 15, 2012, beginning at 6:43 p.m., revealed that no drills were held on the weekend during the 8:00 a.m. - 4:00 p.m., shift and the 4:00 p.m. - 12:00 a.m., shift from June 2011 to May 2012.</p> <p>Interview with the house manager on May 16, 2012, at approximately 4:45 p.m., revealed that she was not aware that fire drills were not conducted during the aforementioned timeframes listed above.</p>	I 135		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for one of twelve staff and five of the seven consultants. (Staff #2, Consultant #1 #2, #3, #4, and #5)</p>	I 206	<p>I206</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; the one of twelve Direct Support Professionals have received their updated Health Certificate (Please see attached documents). However, Nutritionist and Psychiatrist have been notified several times of the Health Certificate update and if comply is not made by June 30, 2012, Marjul homes will terminate services with consultants and obtain new consultants by 7/15/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; Marjul homes does a monthly review of all certificates such as health for all employee's as well as consultants. This process identifies all upcoming expiration dates to avoid being out of compliance with DOH and DDS regulations. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all certifications including health are updated and in compliance with all protocols</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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	<p>Continued From page 6</p> <p>The finding includes:</p> <p>On May 16, 2012, beginning 3:15 p.m., review of the personnel records failed to show evidence of a current physician's health inventory/ certificate for Staff #2, Consultant #1, #2, #3, #4, and #5. At approximately 3:20 p.m., on the same day, interview with the house manager (HM) confirmed that there was no evidence of health inventories performed by a physician for the aforementioned personnel.</p>	I 206		

**Please see
attached
supporting
documents**



Monthly Staff Meeting Agenda for 14th Street

5/19/12

Agenda

Choice & Decision Making

Individual's Privacy

New Fire Drill Policy and Procedures

BSP /Redirecting Behaviors

Privacy & Independence

Chemical Reactions to Caustic Agents, Keeping Caustic Agents Locked in a Cabinet

Measuring Individuals Food

Properly Handling Individuals Funds and Receipts

Individual HMCP, HP, & Diet

Open Discussion for Questions

MarJul Homes, Inc.

RECORD OF FIRE DRILL

DATE OF DRILL: 5/19/12

TIME OF DRILL: 9:00 PM

ADDRESS OF HOME:

GENERAL INFORMATION

Method of Fire Drill

PULL STATION SMOKE DETECTOR FLOW SWITCH

Location of Device:

Method Of Egress:

FRONT DOOR (FIRST FLOOR) BACK DOOR (FIRST FLOOR)
 SIDE DOOR (FIRST FLOOR) FIRE ESCAPE (SECOND FLOOR)

NUMBER OF CONSUMERS AT HOME: 3

NUMBER OF STAFF IN THE HOME: 10

TOTAL DRILL TIME: 3 MINUTES 00 SECONDS

WEATHER CONDITIONS DURING DRILL: Sunny

SYSTEM CHECKLIST (Check YES if operated correctly)

ALARM PANEL	<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO
BELLS	<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO
STROBES	<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO
MAGNETIC DOORS	<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO

OTHER INFORMATION

Was the fire department notified? YES NO

Describe consumers general activity:

Individuals were in the living room watching TV.

Other notes:

Staff were trained on doing fire drills on weekend, on each shift.

Signature/Title: Mary Susan Stone Supervisor

MARJUL HOMES, INC

160 Bryant Street, NW
Washington, DC 20001

Ph. 202-588-7256/Fax. 202-588-7225

EMPLOYEE HEALTH CERTIFICATE

EMPLOYEE NAME: Cecilia Kamara SEX F

ADDRESS: _____

DATE OF BIRTH: _____

POSITION: _____

DATE OF EXAM: 5/17/12

I HAVE EXAMINED THE ABOVE NAMED PERSON AND HEREBY CERTIFY THAT HE/SHE IS:

- 1. FREE OF COMMUNICABLE DISEASES
- 2. AS OF THIS DATE THIS PERSON APPEARS TO BE IN GOOD PHYSICAL AND MENTAL CONDITION AND CAPABLE OF PERFORMING HOUSEHOLD TASKS, GIVE CARE TO OTHERS AND/OR SUPERVISOR (IF APPLICABLE).
- 3. PPD/TINE TEST

RESULTS: _____ DATE: _____
4. HEPATITIS ANTIBODIES: () NEGATIVE () POSITIVE

REMARKS: CXR: 1/12 - YGH - negat-

SIGNATURE OF EXAMINING PHYSICIAN [Signature]

DATE COMPLETED: 6/2/12

FACILITY NAME AND ADDRESS: _____

United Medical Center, LLC
6201 Greenbelt Road # L5
Beverly Heights, MD 20740
Tel: 301-441-1234 Fax: 301-441-1235

Washington, D.C.
DRIVERS LICENSE

DLN: 2109725
EXPIRES: 05-04-2012

MICHELLE YVETTE BROWNE
3617 18TH ST NE
WASHINGTON, DC 20018-2701

DATE OF BIRTH: 05-04-1973 ISSUE DATE: 05-01-2012

SEX: F HEIGHT: 5-05 WEIGHT: 167 HAIR: D

Michelle Browne

★ ★ ★ GOVERNMENT
OF THE
DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION
BOARD OF PHYSICAL THERAPY

certifies that

MICHELLE Y. BROWNE

has met all requirements prescribed by law and regulations and is hereby licensed as a(n):

PHYSICAL THERAPIST
License Number: **PT870714**

ISSUE DATE: 02/01/2011

EXPIRATION DATE: 01/31/2013


Director, Department of Health

LICENSE, REGISTRATION, OR CERTIFICATION RENEWAL

SAVE THIS PORTION OF CARD AND USE REVERSE SIDE FOR NAME AND/OR ADDRESS CHANGES. BOARD MUST BE NOTIFIED OF THESE CHANGES IMMEDIATELY.

Board of
PHYSICAL THERAPY EXAMINERS
4201 PATTERSON AVENUE
BALTIMORE, MARYLAND 21216

MICHELLE YETTE BROWNE
3617 1/2 ST STREET, NE
WASHINGTON DC 20018

158347

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LICENSE, REGISTRATION, OR CERTIFICATION RENEWAL
THE MARYLAND STATE BOARD OF
PHYSICAL THERAPY EXAMINERS

CERTIFIES THAT
MICHELLE YETTE BROWNE
IS AN AUTHORIZED
PHYSICAL THERAPIST

In accordance with the Health Occupations Article of the Annotated Code of Maryland

LIC. REG. CERT. NO.	20108
EXPIRATION DATE	5/31/2014

Michelle Yette Browne
SIGNATURE OF EXAMINEE

R. L. Spence
EXECUTIVE DIRECTOR

158347



DEPARTMENT OF HEALTH AND MENTAL HYGIENE

LICENSE, REGISTRATION, OR CERTIFICATION RENEWAL

THE MARYLAND STATE BOARD OF PHYSICAL THERAPY EXAMINERS
CERTIFIES THAT MICHELLE YETTE BROWNE
IS AN AUTHORIZED PHYSICAL THERAPIST

IN ACCORDANCE WITH THE HEALTH OCCUPATIONS ARTICLE OF THE ANNOTATED CODE OF MARYLAND

LIC. REG. CERT. NO.	20108
EXPIRATION DATE	5/31/2014

WHERE REQUIRED BY LAWS THIS MUST BE CONSPICUOUSLY DISPLAYED IN OFFICE TO WHICH IT APPLIES

R. L. Spence
EXECUTIVE DIRECTOR

Michelle Yette Browne
SIGNATURE OF EXAMINEE


**HEALTHCARE PROVIDERS SERVICE
ORGANIZATION PURCHASING GROUP**
Certificate of Insurance

OCCURRENCE POLICY FORM

PRODUCER	BRANCH	PREFIX	POLICY NUMBER	Policy Period:
018098	970	HPG	0282013582-8	From 05/19/12 to 06/19/13 at 12:01 AM Standard Time

Named Insured

Michelle Y Browne
3617 18th St NE
Washington, DC 20018-2701

Program Administered by:

Healthcare Providers Service Organization
159 E. County Line Road
Hatboro, PA 19040-1218
1-800-982-9491
www.hpso.com

Medical Specialty

Physical Therapist

Code

80995

Insurance is provided by:

American Casualty Company of Reading, Pennsylvania
333 South Wabash Avenue Chicago, Illinois 60604

Professional Liability

\$1,000,000 each claim

\$3,000,000 aggregate

Your professional liability limits shown above include the following:

- Good Samaritan Liability
- Malplacement Liability
- Personal Injury Liability
- Sexual Misconduct included in the PL Limit shown above subject to \$25,000 aggregate sublimit

Coverage Extensions

License Protection	\$ 25,000 per proceeding	\$ 25,000 aggregate
Defendant Expense Benefit	\$ 1,000 per day limit	\$ 25,000 aggregate
Deposition Representation	\$ 10,000 per deposition	\$ 10,000 aggregate
Assault	\$ 25,000 per incident	\$ 25,000 aggregate
<i>Includes Workplace Violence Counseling</i>		
Medical Payments	\$ 25,000 per person	\$ 100,000 aggregate
First Aid	\$ 10,000 per incident	\$ 10,000 aggregate
Damage to Property of Others	\$ 10,000 per incident	\$ 10,000 aggregate
Information Privacy (HIPAA) Fines & Penalties	\$ 25,000 per incident	\$ 25,000 aggregate

Workplace Liability

Workplace Liability	Included in Professional Liability Limit shown above
Fire and Water Legal Liability	Included in the PL limit above subject to \$150,000 aggregate sublimit
Personal Liability	\$1,000,000 aggregate

Total: \$157.00

Premium reflects employed, full-time rate.

Policy Forms & Endorsements (Please see attached list for a general description of many common policy forms and endorsements.)

G-121500-D G-121501-C G-121503-C G-145184-A G-147292-A GSL3886 GSL3908 GSL13424
GSL15563 GSL15564 GSL15565 GSL17101 G-123846-C08

Thomas F. Motamed
Chairman of the Board

John M. Vetter
Secretary

Keep this Certificate of Insurance in a safe place. This Certificate of Insurance and proof of payment are your proof of coverage. There is no coverage in force unless the premium is paid in full. In order to activate your coverage, please remit premium in full by the effective date of this Certificate of Insurance.

Form #: G-141241-B (3/2010)

Master Policy: 188711433

HEALTHCARE PROVIDER

**Healthcare
Provider**



Michelle Browne

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association ELS for Healthcare Provider (CPR and AED) Program.

OCT - 2011

OCT - 2013

Issue Date

Recommended Renewal Date

HEALTHCARE PROVIDER

Training Center Name **A. Murphy & Co. M-1590 #**

TO Info **Upper Marlboro, Md. 20772 (301) 787-8901**

Course Location **Doctors Community Hospital**

Instructor Name *Aisne K. [Signature]*

Holder's Signature *[Signature]*

**DOCTORS COMMUNITY HOSPITAL
EMPLOYEE HEALTH DEPARTMENT**

8118 Good Luck Road
Lanham, MD 20706

Phone: 301-552-8693 FAX: 301-552-5123

EMPLOYEE ANNUAL HEALTH UPDATE

Employee Name: BROWN, MICHELLE
Employee Department: BCI PHYSICIAN LEAD

Annual Date Due: 05/04/2011

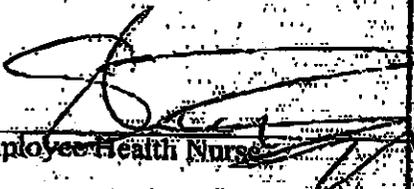
Annual Date Done: 05/11/2011

Blood Pressure: 118/67

PPD Administration Date: 05/11/2011 PPD Date Read: 05/13/2011
PPD Result: Negative

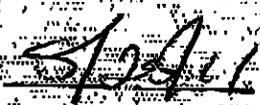
Mask Fit Test Date: 05/11/2011
Mask Size/Type: Regular Teal

Signature:



Employee Health Nurse

Date:



Sherry Bumpers RN
Employee Health Services



EMPLOYEE HEALTH DEPARTMENT

Date: 04/19/2012

RE: MICHELLE BROWNE

This letter certifies that the above named employee was fit tested. He/She successfully passed using the:

<input checked="" type="checkbox"/>	N95 3M 1860 SMALL
<input type="checkbox"/>	N95 3M 1860 REGULAR
<input type="checkbox"/>	N95 3M 1870 ONE SIZE
<input type="checkbox"/>	N95 MOLDEX 1517 LOW PROFILE
<input type="checkbox"/>	PAPR

EXERCISE NAME: FIT TEST

1. NORMAL BREATHING	200
2. DEEP BREATHING	200
3. HEAD SIDE TO SIDE	200
4. HEAD UP AND DOWN	200
5. TALKING	200
6. GRIMACE	N/A
7. BENDING OVER	200
8. NORMAL BREATHING	200

OVERALL FIT FACTOR: 200

PASS VALUE: 100

Signature: _____

Employee Health Nurse

USER: NRSNSD

LAB SPECIMEN INTERNAL INQUIRY

PATIENT: BROWNE, MICHELLE Y. ACCT : V00002037611 LOC: EH U : M000587650
 REG DR: EMPLOYEE HEALTH AGE/SX: 38/F ROOM: REG: 04/19/12
 DOB: 05/04/1973 BED: DIS:
 STATUS: REG REF TLOC:

SPEC : 0419:MT00004R QAD FOR: 04/19/12-1428 STATUS: COMP REQ : 00158968
 COLL: 04/19/12-1445 SUBM DR: EMPLOYEE HEALTH
 RECV: 04/19/12-1612 PT AGE AT COLL: 38

PT ID: ATT DR: CLIENT PHONE: 301-552-8693

REASON FOR VISIT: LABS

ORDERED: EH QUANTIF TB

Test	Result	Flag	Reference
------	--------	------	-----------

QUANTIFERON TB	NEGATIVE		NEGATIVE
----------------	----------	--	----------

Negative; *M. tuberculosis* (TB) infection NOT likely.

A negative Quantiferon(R)-TB Gold IT result does not preclude the possibility of *M. tuberculosis* infection or tuberculosis disease: false-negative results can be due to stage infection (e.g., specimen obtained before development of cellular immune response), comorbid conditions which affect immune functions, or other immunological variables.

Heterophile antibodies or nonspecific INF- γ production from other inflammatory conditions may mask specific responses to ESAT-6, CFP-10, or TB7.7 peptides.

The predictive value of a negative Quantiferon(R)-TB Gold IT result in immunosuppressed persons and pregnant women has not been determined.

*** End of Report ***

Employee Name: Michelle Y. Braune

Would you like to have your blood sugar checked today? Yes No

Tuberculosis Screening:

Date of last TB test: 5/2011 Date of last CXR: _____

- | | | | |
|------------------------------------|---|----------------------------|---|
| Cough lasting more than 3 weeks? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Unexplained night sweats? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Coughing up Blood? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Unintentional weight loss? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Chest Pain or Shortness of Breath? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Poor appetite? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Fever lasting longer than 3 weeks? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Unexplained tiredness? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND THAT ANY FALSE OR MISLEADING INFORMATION SHALL LEAD TO DISCIPLINARY ACTION.

EMPLOYEE SIGNATURE: [Signature] DATE: 4/19/2012

PLEASE STOP HERE.

TO BE COMPLETED BY EMPLOYEE HEALTH NURSE

Blood Pressure 118/64 Pulse 78 Height 5'5 1/2 Weight 167.6 BMI 27.0W

Tests ordered: APT-GOLD CBC COMP HB TITER VARICELLA TITER MMR TITER HIV FS BS: 112

N95 Mask Type: 1860 Small 1860 Regular 1870 one size PAPR Other _____ N/A

TB Skin Testing:

Date given _____	Dose 0.1ml Site: L / R _____	Date given _____	Dose 0.1ml Site: L / R _____
Lot # _____	Exp. Date: _____	Lot # _____	Exp. Date: _____
Signature _____		Signature _____	
Date read _____	Induration _____ mm	Date read _____	Induration _____ mm
Signature _____		Signature _____	

Quantiferon Gold: Date 4/19/12 Result: Normal / Abnormal Attach copy of lab report

Chest x-ray: Date _____ Result: Normal / Abnormal Attach copy of lab report

Pagerstrom Score: 0 Cage Score: 0

- Discussions (check those reviewed/handouts given)
- Diet Exercise Smoking Cessation Self Breast Exam
 - Self Testicular Exam Alcohol Awareness Routine Health Screening Immunizations

Referral given: _____

Notes: _____
Employee Health Nurse Signature: [Signature] Date: 4/19/12

MARJUL HOMES, INC.

160 Bryant Street, NW
Washington, D.C. 2001
202.588.7258 202.588.7225 FAX

DATE:	6/17/12 Laura A. Junde	
Send to:	Sharon Mobane	From: Marjul Homes
Attention:	Dott	Office Location: Division 1-Central Office
RE:	Delinquencies	Phone Number: 202.588-7256
Fax Number:	25442-9430	Number of Pages, Including Cover: 29

URGENT

REPLY ASAP

PLEASE COMMENT

PLEASE REVIEW

FOR YOUR INFORMATION

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Health Regulation & Licensing Administration



Intermediate Care Facilities Division



Sent via Email and US Mail

MAY 29 2012

Marshall Gahagan
Administrator
Marjul Homes, Inc.
160 Bryant Street NW
Washington, DC 20001

Re: 5706 14th Street, N.W.

Dear Mr. Gahagan:

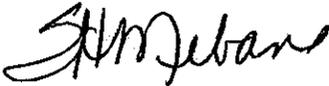
You will find enclosed Statement of Deficiency reports for federal certification and licensure. The reports enumerate deficiencies found as a result of the survey completed on May 16, 2012. You are required to respond to each deficiency. Although a reasonable period may be allowed for actual correction of these deficiencies, it is imperative that your plan be signed with a specific date for anticipated completion and returned to this office prior to **June 7, 2012**. Since these reports are subject to public disclosure, it is necessary that the responses be indicated on the original forms (and not on an attachment, except if submitting a copy of a policy change). NOTE: "Corrected" is not an accepted reply. The plan MUST also include the following.

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented.

PLEASE NOTE: Plans of Correction not adhering to the above requirements will not be considered acceptable.

If you have any questions regarding this matter, please contact Laura A. Hunte, Supervisory Health Services Program Specialist, Intermediate Care Facilities Division on (202) 724-8800.

Sincerely,



Sharon H. Mebane
Program Manager

Enclosures

cc: Catherine Yadamec
Chief Quality Enhancement Unit
Department on Disability Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from May 15, 2012, through May 16, 2012. A sample of two clients was selected from a population of three women with various degrees of intellectual disabilities. The survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and two clients, as well as a review of client 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>	W 000		
W 140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain a complete accounting of all clients' funds for one of the two clients in the sample. (Client #2)</p> <p>The finding includes: Interview with the house manager (HM) on May 15, 2012, at 6:18 p.m., revealed that the facility assisted the client with maintaining her finances. Continued interview and record review revealed</p>	W 140	<p>What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; Financial Methods and book will be revised and restructured to capture not only monetary purchases over \$50.00 but each monetary purchase in its entirety no later than 6/15/12 How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; Program Director along with QIDDP will complete an Initial review of all financial books no later than 6/15/12 as a quality assurance method to identify and ensure that all funds are accounted for properly. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all finances show proof of receipt as well as identification for each purchase made. This process will be implemented no later than 6/15/12.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
VaShawn Bell *Program Director* *6/7/12*

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011		
(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 140	Continued From page 1 that the client received Supplemental Security Income (SSI) monthly. Review of Client #2's bank statements on May 15, 2012, beginning at 6:18 p.m., revealed a withdrawal of \$259.00 on June 24, 2011, and another withdrawal of \$59.00 on July 7, 2011. From the aforementioned \$318.00, there were no receipts available to justify a total of \$95.00 Interview with the HM on May 16, 2012, at approximately 3:00 p.m., revealed that she did not have the receipts. Further interview revealed that the program director was currently working on a new record keeping system for the clients' finances. At the time of the survey, the facility failed to provide a complete accounting of Client #2's personal funds.	W 140			
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident, for one of the three clients residing in the facility. (Client #3)	W 156	W156 What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; IMC Coordinator will be retrained on Incident Policies and Procedures to ensure accuracy of policy guidelines when reporting incidents. This training will take place no later than 6/15/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; IMC will review most recent incidents to ensure that all parties have been informed and all policies and guidelines were followed in regards to informing proper parties as well as reporting methods. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 policy that mandates all IMC reports be reviewed by a second party with a Certified Investigator's license.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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 156	<p>Continued From page 2</p> <p>The finding includes:</p> <p>Review of the facility's incident management records on May 15, 2012, beginning at 9:57 a.m., revealed that on July 19, 2011, at 7:30 p.m., Client #2 "attacked [Client #3], pushed her in the face and called her a [derogatory name]." Review of the corresponding investigative report revealed the investigation was initiated on July 20, 2011, and completed on July 29, 2011 (ten days after the incident occurred).</p> <p>Interview with the incident management (IMC) coordinator on May 15, 2012, at approximately 4:00 p.m., revealed that a meeting was held every Tuesday with the administrator to review the status of all incidents. The IMC, however, acknowledged that the investigation was not completed within five days of the incident. Further interview revealed that the facility failed to provide documented evidence that the results of the investigation were reported to the administrator.</p>	W 156		
W 189	<p>At the time of the survey, the facility failed to ensure that the administrator was notified of the results of the investigation within five working days, as required by federal regulations.</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff were</p>	W 189	<p>What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; All staff for this particular home have been retrained on BSP; Addressing and Redirecting Behaviors, Privacy & Independence etc. This training took place on 5/19/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP will continue to address these issues in training and monthly staff meetings. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all Training including in-service training is done on a refresher basis quarterly. This QA will be completed as of 7/1/12.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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 189 Continued From page 3
provided with initial and continuing training that enable them to perform their duties effectively, efficiently, and competently, for one of two clients in the sample. (Client #1)

The finding includes:

Observation on May 15, 2012, at 4:10 p.m., revealed Client #1's shirt was positioned on the top part of her breast, exposing her bra. During this time Staff #1 was stacking blocks with Client #1. At 4:11 p.m., Client #1 reached inside her pants and pulled her underwear above her stomach. Staff #1 looked at her and continued to stack the blocks ignoring this behavior and her exposed bra. At 4:13 p.m., Staff #1 said "why don't you pull your shirt down." However, Client #1 continued to pull on her underwear.

Staff #1 was interviewed at 4:45 p.m., about the client exposing her bra and pulling on her underwear, and she stated "it's ok as long as she is not hurting herself, we just check for irritation."

Review of the facility's training book on May 15, 2012, at approximately 6:00 p.m., failed to reveal staff training on redirecting Client #1 during the aforementioned behavior.

W 189

W242

W 242 483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN

The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of

W 242

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All staff for this particular home have been retrained on BSP, Addressing and Redirecting Behaviors, Privacy & Independence etc. This training took place on 5/19/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP will continue to address these issues in training and monthly staff meetings. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all Training including in-service training is done on a refresher basis quarterly. This QA will be completed as of 7/1/12.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011		
(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 242	<p>Continued From page 4 acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to train each client in personal skills essential for independence and privacy, for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Observation on May 15, 2012, at 4:10 p.m., revealed Client #1's shirt was positioned on the top part of her breast, exposing her bra. During this time Staff #1 was stacking blocks with Client #1. At 4:11 p.m., Client #1 reached inside her pants and pulled her underwear above her stomach. Staff #1 looked at her and continued to stack the blocks ignoring this behavior and her exposed bra. At 4:13 p.m., Staff #1 said "why don't you pull your shirt down." However, Client #1 continued to pull on her underwear.</p> <p>Staff #1 was interviewed at 4:45 p.m., about the client exposing her bra and pulling on her underwear, and she stated "it's ok as long as she is not hurting herself, we just check for irritation."</p> <p>Review of Client #1's training book on May 15, 2012, at approximately 6:00 p.m., failed to reveal training on redirecting Client #1 during the aforementioned behavior.</p>	W 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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
--------------------	--	---------------	---	--------------------

1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 15, 2012 through May 16, 2012. A sample of two residents was selected from a population of three women with various degrees intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and two clients, 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 persons with intellectual disabilities (GHPID) failed to ensure that the modified diet for residents had been reviewed at least quarterly by a dietitian, for two of the two residents in the sample. (Resident #1 and #2)</p> <p>The findings include:</p> <p>1. Observations on May 15, 2012, at 8:20 a.m., revealed Resident #1 was missing her top and bottom teeth. Continued observations at 5:28 p.m., of the dinner meal revealed Resident #1</p>	1 043	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Nutritionist will send all quarterly notes to be placed in the book no later than 6/30/12. If Nutritionist does not comply with mandates Marjul homes will terminate services with current Nutritionist and obtain new Nutritionist by 7/15/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP will review all book to identify all current nutritional plans and ensure that all plans are current and updated. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all assessments are updated and in compliance with all protocols and procedures of DOH and DDS. All QIDDP's & DSP's will be retrained on Food Protocol and Nutrition plans by SLP no later than 6/15/12 and Nutrition plans by SLP no later than 6/15/12.</p>	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Program Director* (X6) DATE: *6/7/12*

STATE FORM 6899 VUN111 If continuation sheet 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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
--------------------	--	---------------	---	--------------------

1043	<p>Continued From page 1</p> <p>was served pureed fish, spinach, noodles and peaches. For her beverage she was served 2% milk.</p> <p>Record review of Resident #1's nutritional assessment dated May 12, 2011, on May 16, 2012, at 11:06 a.m., revealed that the resident was prescribed a 1500 calorie, low fat, low cholesterol, pureed diet. Further review failed to show evidence that the facility's nutritionist had reviewed Resident #1's diet on a quarterly basis.</p> <p>On May 16, 2012, at approximately 12:00 p.m., interview with the house manager and the facility's registered nurse confirmed that the last quarterly for Resident #1 was dated December 20, 2011.</p> <p>2. Observation on May 15, 2012, at 5:31 p.m., of the dinner meal revealed Resident #2 was served a low calorie fish, spinach, noodles and peaches. For her beverage she was served lactaid milk.</p> <p>Record review of Resident #2's nutritional assessment dated September 15, 2011, on May 16, 2012, at 3:00 p.m., revealed that the resident was prescribed a 1500 calorie, low fat, low cholesterol, 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 May 16, 2012, at approximately 3:15 p.m., interview with the house manager and the facility's registered nurse confirmed that the last quarterly for Resident #2 was dated December 20, 2011.</p> <p>Interview with the program director on May 16, 2011, at approximately 4:00 p.m., revealed she</p>	1043		
------	---	------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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 043	Continued From page 2 was currently seeking a new nutritionist. At the time of the survey, the GHPID failed to have a third quarterly review for Resident #2.	I 043		
I 060	3502.18 MEAL SERVICE / DINING AREAS Perishable foods shall be stored at proper temperatures in order to conserve nutritive value. This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure that equipment necessary for monitoring refrigeration temperatures was provided for one of two refrigerators in the home. The finding includes: Observations during the environmental walk-thru on May 16, 2012, at approximately 4:30 p.m., revealed no thermometers were located in the kitchen refrigerator and freezer. Interview with facility's house manager (HM) and the qualified intellectual disabilities professional (QIDP) acknowledged that there was no thermometer in the refrigerator and freezer.	I 060	1060 What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; New Thermometers were purchased and placed in each freezer and refrigerator located in the home on 6/7/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP's will conduct their normal monthly environmental assessment to identify any issue or maintenance concerns involving the home or surrounding grounds. This will identify any issues of this nature and should be addressed and fixed immediately. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all environmental aspects of the home including necessary monitoring of refrigeration. This tool will be implemented as of 7/1/12.	
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.	I 090	1090 What corrective action(s) will be accomplished for those residents found to have been? Affected by the deficient practice; 1. The doorbell was fixed on 6/4/12 2. The Toilet seat was replaced and put on the toilet on 6/4/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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
--------------------	--	---------------	---	--------------------

1090	<p>Continued From page 3</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was in a safe and orderly manner for three of three residents in the facility. (Residents #1, #2 and #3)</p> <p>The findings include:</p> <p>On May 16, 2012, at 4:25 p.m., the house manager and the qualified intellectual disabilities professional (QIDP) accompanied the surveyor through the facility to conduct environmental observations. The following concerns were identified:</p> <ol style="list-style-type: none"> 1. The front door bell failed to operate. Interview with the house manager revealed the door bell was not operable for two months. 2. The bathroom toilet located in Resident #1's bedroom had not toilet seat. The seat was observed laying on the floor. Interview with the house manager at the same time revealed Resident #1 broke the toilet seat by constantly slamming it. Further interview revealed it was scheduled for repair. 3. The grass and weeds in the front yard and back yard was observed to be 7 to 9 inches tall. 	1090	<p>3. The Grass was on 6/4/12</p> <p>How you will identify other residents having the potential to be affected by the same</p> <p>Deficient practice and what corrective action will be taken; as New Policy Regulation of Marjul Homes implemented 6/5/12 all House Supervisors and or QIDDP's or Residential Coordinators must bring in Maintenance request forms every Tuesday. This will identify all maintenance and or environmental issues on a weekly basis, giving the corporate office a limited time to fix all issues. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all environmental aspects of the home including necessary monitoring of refrigeration. This tool will be implemented as of 7/1/12.</p>	
1095	<p>3504.8 HOUSEKEEPING</p> <p>Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.</p>	1095	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All staff for this home was trained on proper storage of Caustic agents, Chemical Reactions to Caustic Agents and Marjul homes Policies and Procedures of Keeping Chemicals in a Locked Cabinet. This training was done on 5/19/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; QIDDP as well as House Supervisor will review all homes under their supervision before 6/15/12 to ensure all caustic agents are stored in a locked cabinet, ensuring DOH regulations and procedures. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all environmental aspects of the home including necessary monitoring of Caustic Agents and their proper storage. This tool will be implemented as of 7/1/12.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011		
(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 095	Continued From page 4 This Statute is not met as evidenced by: Based on observation and staff interview, the group home for persons with Intellectual disabilities (GHPID) failed to ensure all caustic agents were kept in a locked cabinet and out of the direct reach of its residents as required by this section. (Residents #1, #2 and #3) The finding includes: Observation and interview with the facility's house manager (HM) and qualified intellectual disabilities professional (QIDP) on May 16, 2012, at approximately 4:25 p.m., verified cleaning supplies were kept under the sink in the kitchen. Interview with the HM and QIDP at the same time revealed that all caustic agents are required to be stored in a locked cabinet.	I 095		
I 135	3505.5 FIRE SAFETY 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. 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 conduct simulated fire drills at least four times (4) a year for each shift for three of the three residents residing in the GHPID. (Residents #1, #2 and #3) The finding includes: The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as	I 135	1135 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Staff for this home was retained on Fire Drill Procedures to include simulated Fire Drills at least 4 times a year on each shift. This training was done on 5/19/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; All QIDP's & Residential Coordinator's will review all Fire Drill books to identify and ensure that each home is following the proper procedures for fire drills mandated by DOH Policies. The review will take place no later than 6/15/12. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all environmental aspects of the home including necessary monitoring of Fire Drill Procedures including quarterly monitoring per shift. This tool will be implemented as of 7/1/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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 135 Continued From page 5
evidenced below:

On May 15, 2012, beginning at 6:43 a.m., interview with the house manager (HM) 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.), Sunday through Saturday.

Review of the GHPID's fire drill log records on May 15, 2012, beginning at 6:43 p.m., revealed that no drills were held on the weekend during the 8:00 a.m. - 4:00 p.m., shift and the 4:00 p.m. - 12:00 a.m., shift from June 2011 to May 2012.

Interview with the house manager on May 16, 2012, at approximately 4:45 p.m., revealed that she was not aware that fire drills were not conducted during the aforementioned timeframes listed above.

I 135

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 persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for one of twelve staff and five of the seven consultants. (Staff #2, Consultant #1 #2, #3, #4, and #5)

I 206

I206
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; the one of twelve Direct Support Professionals have received their updated Health Certificate (Please see attached documents). However, Nutritionist and Psychiatrist have been notified several times of the Health Certificate update and if comply is not made by June 30, 2012, Marjul homes will terminate services with consultants and obtain new consultants by 7/15/12. How you will identify other residents having the potential to be affected by the same Deficient practice and what corrective action will be taken; Marjul homes does a monthly review of all certificates such as health for all employee's as well as consultants. This process identifies all upcoming expiration dates to avoid being out of compliance with DOH and DDS regulations. What measures will be put into place or what systemic changes you will make to Ensure that the deficient practice does not recur; and How the corrective action(s) 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 tool that will be done monthly by the QIDDP to ensure that all certifications including health are updated and in compliance with all protocols

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARJUL HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW WASHINGTON, DC 20011
--	---

(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	<p>Continued From page 6</p> <p>The finding includes:</p> <p>On May 16, 2012, beginning 3:15 p.m., review of the personnel records failed to show evidence of a current physician's health inventory/ certificate for Staff #2, Consultant #1, #2, #3, #4, and #5. At approximately 3:20 p.m., on the same day, interview with the house manager (HM) confirmed that there was no evidence of health inventories performed by a physician for the aforementioned personnel.</p>	I 206		